Maria Margarita Díaz Montenegro

O PAPEL DA EDUCAÇÃO NA MELHORIA DA QUALIDADE DE ATENÇÃO EM PLANEJAMENTO FAMILIAR

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O PAPEL DA EDUCAÇÃO NA MELHORIA DA QUALIDADE DE ATENÇÃO EM PLANEJAMENTO FAMILIAR

MARGARITA DIAZ

Este exemplar corresponde à redação final da tese defendida por Margarita Díaz e aprovada pela Comissão Julgadora, sob orientação de Anibal Faúndes e co-orientação de Ana Maria Faccioli de Camargo.

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Educar e educar-se, na prática da liberdade, não é estender algo desde a "sede do saber", até a "sede da ignorância" para "salvar", com este saber, os que habitam nesta.

Ao contrário, educar e educar-se, na prática da liberdade, é tarefa daqueles que sabem que pouco sabem – por isto sabem que sabem algo e podem assim chegar a saber mais – em diálogo com aqueles que, quase sempre, pensam que nada sabem, para que estes, transformando seu pensar que nada sabem em saber que pouco sabem, possam igualmente saber mais. (Freire, 1992, p. 25)

Este trabalho é dedicado...

Aos meus filhos, Rodrigo e Toca, por compreenderem e apoiarem minha vida profissional.

A Juan, meu companheiro há 25 anos, compartilhando minha vida pessoal e profissional com amor e alegria.

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Lista de Abreviaturas e Siglas Utilizadas

BEMFAM	Sociedade Civil Bem-Estar Familiar no Brasil
Cemicamp	Centro de Pesquisas Materno-Infantis de Campinas
CIPD	Conferência Internacional sobre População e Desenvolvimento
CO	Citologia Oncótica
DIU	Dispositivo Intra-uterino
DO	Desenvolvimento Organizacional
DST	Doença Sexualmente Transmissível
HERA	Health, Empowerment, Rights & Accountability
HIV	Vírus da Imunodeficiência Humana
IBGE	Instituto Brasileiro de Geografia e Estatística
ICPD	International Conference on Population and Development Program of Action
ICRW	International Center for Research on Women
IEC	Informação, Educação e Comunicação
IRSSA	Instrutores de Referência à Saúde Sexual do Adolescente
MAC	Métodos Anticoncepcionais
OMS	Organização Mundial da Saúde
PAISM	Programa de Assistência Integral à Saúde da Mulher
PATH	Program for Appropriate Technology in Health
SUS	Sistema Único de Saúde
UNICAMP	Universidade Estadual de Campinas

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Resumo

Nos últimos anos, têm-se observado grandes mudanças na área de Planejamento Familiar, desde seu próprio conceito, que de controle da natalidade passou a uma abordagem em que se reconhece o direito das pessoas de decidir quando e quantos filhos quer ter e de, livremente e de maneira informada, escolher o método anticoncepcional. Também houve, nas últimas décadas, grandes avanços na tecnologia de desenvolvimento de novos Métodos Anticoncepcionais, visando contribuir para a melhoria da saúde sexual e reprodutiva. Entretanto, também se pôde notar uma distância entre a teoria e a prática, ou seja, apesar dos avanços, eles não se traduziram numa melhoria das condições de saúde das pessoas, nem dos serviços de saúde. Isso motivou o desenvolvimento de uma nova metodologia desenvolvida pela Organização Mundial da Saúde, chamada de "Enfoque Estratégico para a Introdução de Métodos Anticoncepcionais". O Brasil foi o primeiro país no mundo a pôr em prática essa abordagem teórica, cujo objetivo é melhorar a qualidade de atenção em saúde sexual e reprodutiva. Esse projeto, coordenado pela autora deste estudo, incluiu três etapas de atividades: o diagnóstico estratégico (Etapa I), a pesquisa participativa (Etapa II) e a expansão (Etapa III). A avaliação mostrou que é possível, com os recursos existentes no município envolvido no projeto, melhorar o acesso e a qualidade de atenção em planejamento familiar e outros componentes da saúde sexual e reprodutiva, como a detecção precoce do câncer cérvico-uterino, a atenção a adolescentes etc. Essa avaliação também mostrou que, além da metodologia utilizada, um dos aspectos fundamentais dessas mudanças no âmbito dos serviços de saúde foi o componente educativo, que esteve presente ao longo de todo o processo. Com o propósito de contribuir para a expansão de um projeto bem-sucedido, fez-se uma revisão e análise do processo educativo, oportunidade em que foram identificadas suas principais características: a própria visão de educação com que se trabalhou, orientada em grande parte pelo pensamento de Paulo Freire, a concepção da educação como um processo, o papel do/a educador/a, os marcos de referência, os materiais educativos e a metodologia participativa adotados nos cursos de capacitação, a seleção dos participantes, a supervisão e a avaliação contínua. Baseada nessa experiência, a autora propõe a revisão dos conceitos de saúde e educação atualmente utilizados na formação de profissionais, para facilitar a integração das duas áreas e a incorporação desse tipo de experiência nas faculdades. Atualmente o projeto encontra-se em fase de expansão em maior escala tanto no Brasil quanto em outros países latino-americanos.

Abstract

During the last years there have been great changes in family planning, beginning by the concept itself that changed from birth control to an approach where family planning is recognized as a right of people to decide when and how many children have and to freely choose, after receiving appropriate information, the method to be used. Also in the last decades occurred a great technological progress in the development of new contraceptive methods, with the objective of improving sexual and reproductive health. Nevertheless, it was also observed that there was a big gap between theory and practice. Despite of the progress, there was not a real improvement of people's health conditions and services had not improved either. This situation stimulated the development of a new methodology, developed by the World Health Organization, known as "Strategic Approach for the Introduction of Contraceptive methods". Brazil was the first country that put in practice this theoretical approach that had as objective the improvement of the quality of services in sexual and reproductive health. The author was the coordinator of this project that was developed in three stages: the strategic assessment (Stage I), participatory research (Stage II), and expansion (Stage III). The evaluation of that project showed that it is possible, with the resources already available at the municipalities, to improve the access to and the quality of care in family planning and other components of sexual and reproductive health, such as early cervical cancer detection, adolescents health care, etc. This evaluation also showed that besides the methodology used, one of the fundamental factors contributing to the improvement of health services, was the educational component that was present throughout the process. With the purpose of contributing for the expansion of this successful project, it was done an analysis and revision of the educational process used and it was identified that the main characteristics were the vision of education that was used, that follows closely Paulo Freire's thinking, the concept that education is a process, the role of the educator, the framework used, the educational materials and the participatory methodology used incorporated in the training process. Also the selection of participants and the continuous evaluation and supervision, as part of the educational process, were very important. Based on this experience, the author proposes a revision of the concepts of health and education currently used in the formation of professionals, to facilitate the integration of these two areas and the incorporation of this type of experiences in the faculties. Currently the project is in a process of large-scale expansion in Brazil and other Latin-American countries.

1. Introdução

1.1. Apresentação

Este trabalho é o resultado de minha experiência profissional, adquirida no desempenho concomitante das funções de enfermeira obstétrica e educadora, numa ação contínua sempre voltada para a transformação de nossa sociedade, buscando humanizar e melhorar a qualidade da saúde sexual e reprodutiva.

Neste estudo são apresentados os resultados de um projeto que tem como escopo a melhoria da qualidade de atenção em planejamento familiar. Orientado por uma nova metodologia, desenvolvida pela Organização Mundial da Saúde (OMS), sob o título de "Enfoque Estratégico para a Introdução de Métodos Anticoncepcionais", ele vem sendo implantado no Brasil desde 1993, sob minha coordenação.

Esses resultados, um sucesso segundo reconhecimento da própria OMS, têm servido de inspiração e já foram inclusive adotados como modelo por outros países. Atualmente o projeto encontra-se na etapa de expansão em larga escala no Brasil e em outros países da América Latina.

No diálogo com outros profissionais que estão utilizando esse novo enfoque, percebi que em nossa experiência o componente educativo teve um peso muito importante na preparação e execução de todas as etapas do projeto. Foi daí que nasceu a motivação para submetê-lo a uma revisão sob o enfoque da educação.

O trabalho teve como objetivo analisar e identificar as principais características do processo educativo presentes no projeto, de maneira a oferecer uma contribuição a outras pessoas e instituições engajadas na mesma luta pela melhoria da qualidade de atenção na área da saúde sexual e reprodutiva e sua integração com a educação.

Considerando que as áreas de educação e saúde têm sua linguagem e códigos próprios, expresso aqui a primeira dificuldade encontrada: atender a dois universos sem ser muito coloquial e ao mesmo tempo satisfazer as exigências acadêmicas.

O trabalho está dividido em capítulos e inicia-se com uma revisão do conceito e da situação geral do planejamento familiar no Brasil.

Embora possa ser muito extenso para grande parte dos profissionais da área da saúde, optei por manter assim o capítulo inicial, tendo em vista o limitado acesso dos educadores a publicações do gênero.

O capítulo 2 apresenta os principais marcos de referência que são a base do projeto: o enfoque estratégico da OMS, a pesquisa participativa e a concepção de educação com a qual trabalhei, relacionando-a com o pensamento de Paulo Freire. Outros marcos de referência, como o próprio conceito de saúde sexual e reprodutiva, os direitos sexuais e reprodutivos e o conceito de qualidade de atenção estão inseridos no capítulo 1.

O capítulo 3 foi dividido de acordo com as etapas do projeto, com destaque em cada uma delas para os objetivos, o método utilizado e os principais resultados, apresentados por meio de algumas publicações.

Optei por deixar para o final o capítulo que aborda de maneira mais específica a questão que nos propusemos a analisar, ou seja, com base na experiência e lições aprendidas, avaliar o peso do componente educativo, suas principais características, a relevância da integração de educação e saúde para a melhoria da qualidade de atenção e, finalmente a possibilidade da utilização dessa experiência no futuro.

1.2. A Evolução do Conceito: do Controle da Natalidade à Saúde Sexual e Reprodutiva

Os primeiros programas de planejamento familiar no mundo surgiram na década de 50 e tiveram um grande desenvolvimento nas décadas de 60 e 70, principalmente nos países em via de desenvolvimento.

Esses programas tinham como objetivo o controle de natalidade, que foi a motivação inicial do planejamento familiar. O objetivo desses programas era estender o uso de métodos anticoncepcionais para controlar os nascimentos, nessa época considerados excessivos pelos governos e outras instituições que os apoiavam.

O argumento se assentava na preocupação com a chamada "explosão demográfica", resultado do desequilíbrio entre uma rápida queda da mortalidade não acompanhada de uma queda simultânea da fertilidade (García, Stycos, Arias, 1968).

Vários autores, especialmente demógrafos e outros cientistas sociais de orientação neo-malthusiana, pregavam que o aumento explosivo da população levaria a uma exaustão dos recursos, especialmente alimentos, o que resultaria em fome generalizada e uma situação mundial caótica. Esses autores propunham o controle da natalidade como principal solução. Argumentava-se que o retorno às taxas de crescimento da primeira metade do século era condição necessária para resolver os problemas econômicos e sociais dos países em desenvolvimento. Ou seja, havia um crescimento exagerado da população, e pensava-se que, se o fenômeno fosse controlado, automaticamente se chegaria ao desenvolvimento. Também vinculava-se o controle da natalidade ao problema da fome e da miséria. Por esse motivo esses programas se concentraram em países subdesenvolvidos com altos índices de natalidade e graves níveis de pobreza (Gysling, 1994).

Nesse contexto, não há eco para a voz das mulheres, que já nessa época começavam a reivindicar o direito de regular sua fertilidade, enquanto suas necessidades eram negligenciadas. Ao invés disso, a estratégia da redução da natalidade centra-se no controle da fertilidade das mulheres, que passam a ser o "objeto" dos programas adotados.

No final da década de 60 e durante os anos 70 a ocorrência de uma série de eventos internacionais foi decisiva para a mudança do conceito de planejamento familiar, que acabou resultando no reconhecimento do direito de as pessoas decidirem quantos filhos queriam ter e o espaçamento entre eles.

Entre esses eventos, destacam-se (Gysling, 1994):

a) Em 1968, a conferência sobre Direitos Humanos, realizada em Teerã, no Irã, estabeleceu que a decisão sobre o número de filhos e o espaçamento entre eles constitui um direito dos casais.

b) Em 1974 foi realizada, em Bucareste, na Romênia, a Conferência de População, na qual se reconhecem dois elementos centrais: o direito de casais e indivíduos determinarem o número de filhos e seu espaçamento e o papel do Estado na garantia desses direitos, incluindo-se a informação e o acesso a métodos de controle da natalidade.

c) Em 1975 realizou-se, no México, a Conferência Mundial do Ano Internacional da Mulher, que deu início ao Decênio da Mulher, no qual se reconheceu o direito à integridade física e às decisões sobre o próprio corpo, o direito a diferentes opções sexuais e os direitos reprodutivos, entre eles a maternidade opcional.

d) Em 1978 realizou-se a Conferência de Alma Ata, na União Soviética (atual Casaquistão) em que foi emitida a Declaração de Alma Ata sobre Atenção

Primária, que reconheceu as vantagens de um enfoque holístico dos temas de saúde reprodutiva, vinculando os temas de saúde à vida das mulheres.

e) Em 1979 a Assembléia Geral das Nações Unidas aprovou o documento principal do Decênio da Mulher: “A Convenção sobre a Eliminação de Todas as Formas de Discriminação Contra a Mulher”. Entre as medidas propostas, incluem-se várias relacionadas com a saúde reprodutiva, como o direito à igualdade de homens e mulheres nas decisões sobre reprodução e a responsabilidade compartilhada em relação aos filhos.

Posteriormente, ocorreram outros eventos nos quais se chegou a um consenso em que se reconhece o direito à regulação da fecundidade e, conseqüentemente, a legitimidade dos métodos anticoncepcionais.

Vale destacar que, embora os programas de planejamento familiar tivessem um objetivo puramente demográfico e não se preocupassem com o direito ao exercício da sexualidade pelas mulheres, elas os receberam de bom grado, já que, na época, estavam saindo para conquistar um lugar no mercado de trabalho e precisavam, para isso, regular sua fecundidade. Esse fato contribuiu, de maneira importante, para a aceitação desses programas (Ávila e Corrêa, 1999).

Durante essa época houve um intenso debate sobre as políticas que promoviam o planejamento familiar como solução para os problemas demográficos. Um dos questionamentos mais importantes partiu do próprio John D. Rockefeller III, cuja atuação foi fundamental na implantação de programas de controle da natalidade. Ele surpreendeu ao declarar, na Conferência de Bucareste, que a solução dos problemas de crescimento populacional estava no desenvolvimento (Faúndes e Hardy, 1995). Além disso, foram publicados vários artigos questionando a maneira autoritária com que os serviços e profissionais de saúde tomavam decisões pelas usuárias, considerando-as objetos e não os sujeitos dos programas. Abriu-se então oportunidade para se reivindicar uma atenção mais humanizada para se

instituir uma filosofia de atenção centrada na usuária, ou seja, que os serviços de planejamento familiar passassem a se orientar para a solução dos problemas da mulher, reconhecendo como válida a perspectiva da usuária (Hull, 1996).

O clamor de maior consideração em relação às necessidades e desejos das usuárias de métodos anticoncepcionais partiu de muitas vozes em todas as regiões do mundo. Uma declaração de George Zeidenstein, na época presidente do The Population Council, exemplifica muito bem esse novo conceito quando salienta que, ao focalizar números globais de população e projeções, não podemos deixar de prestar atenção na importância e na necessidade urgente de melhorar a qualidade de vida das pessoas. A pergunta que devemos nos fazer é: como seria possível, na década de 1980, fazer que as necessidades, desejos e problemas das pessoas que usavam (ou desejavam usar) anticoncepcionais fossem o centro de atenção e o objetivo dos serviços de planejamento familiar. (Zeidenstein, 1980).

Esse novo conceito de atendimento das necessidades das usuárias coloca o planejamento familiar como uma das ações que devem ser integradas a outros serviços dedicados à mulher, visando contribuir para melhorar sua saúde.

Neste ponto, vale a pena ressaltar que para muitos médicos ginecologistas, obstetras e outros profissionais de saúde pública a motivação para oferecer serviços de anticoncepção não era o controle da natalidade, mas sim a saúde da mulher. Desta maneira, em alguns países da América Latina, como Chile, Cuba e Costa Rica, as atividades de planejamento familiar chegaram a ser parte do programa de saúde da mulher por razões totalmente diferentes do controle da natalidade (Faúndes e Hardy, 1995).

Como exemplo, no Chile, onde havia uma alta taxa de abortos induzidos ilegalmente, a informação e os serviços de planejamento familiar foram contribuições realmente importantes para ajudar as mulheres a prevenir

gravidezes não desejadas e, portanto, os abortos provocados (Faúndes, Rodríguez-Galant, Avendaño, 1968).

No Brasil, em meados dos anos 80, o planejamento familiar passava a ser um dos componentes do Programa de Assistência Integral à Saúde da Mulher (PAISM), cuja conceitualização teórica surgiu de um trabalho conjunto entre docentes da Universidade Estadual de Campinas (UNICAMP) e líderes do movimento feminista que, na época, eram muito atuantes no Ministério da Saúde.

O PAISM é um programa que, na análise realizada por Osis em 1998, representa um marco histórico e é pioneiro no cenário mundial, ao propor um modelo conceitual muito avançado que focaliza a saúde reprodutiva das mulheres no âmbito da atenção integral à saúde da mulher e não mais na utilização de ações isoladas de planejamento familiar. Nele se incluem: a saúde da mulher durante todo o seu ciclo vital e não apenas durante a gravidez e a lactação; atenção a todos os aspectos de sua saúde, englobando a detecção do câncer ginecológico, atenção ginecológica, planejamento familiar e tratamento da infertilidade; atenção pré-natal, no parto e pós-parto, diagnóstico e tratamento das DST, assim como das doenças ocupacionais e mentais. Além disso ampliou sua cobertura para atender adolescentes e mulheres na pós-menopausa.

Dentro da nova concepção de considerar a perspectiva da usuária, uma das contribuições mais importantes foi a de Judith Bruce (1989), que descreveu um marco teórico, vigente até os dias de hoje, no qual se enumeram os seis elementos fundamentais para caracterizar a qualidade de atenção em planejamento familiar.

Esses elementos são:

1. *Livre Escolha de Métodos*

   Isso significa que deve haver uma ampla gama de métodos disponíveis, a fim de que as/os usuárias/os possam escolher livremente o método mais adequado nas diferentes etapas e momentos de sua vida reprodutiva. Por exemplo: métodos limitadores, espaçadores etc.

   Também se deve ter presente que a/o usuária/o pode trocar de método quando desejar. Estar disponível significa ser possível recomendar à/ao usuária/o um serviço que ofereça um determinado método e que o custo seja acessível.

2. *Informação às/aos Usuárias/os*

   Este elemento tem dois componentes:

   - *Compreensão das/os usuárias/os.* Refere-se à informação obtida das/dos usuárias/os para a compreensão de seus antecedentes, atitudes, preferências, história contraceptiva, saúde reprodutiva e metas pessoais. Essa compreensão é necessária para a determinação das alternativas contraceptivas disponíveis e apropriadas para a/o usuária/o e para ajudá-la/o a realizar a escolha de um método adequado baseado em informações e feita de maneira consciente e voluntária.

   - *Informação para as/os usuárias/os.* Refere-se às informações que devem ser dadas às/aos usuárias/os nos seguintes itens: todos os métodos disponíveis (no programa ou por recomendados), e para cada método devem-se incluir informações sobre suas características. São elas: modo de usar, como o método evita a gravidez, eficácia, efeitos colaterais e os critérios de elegibilidade. Também os serviços devem informar as/os usuárias/os sobre o seguimento e a conduta frente aos possíveis efeitos secundários e/ou complicações com o uso do método. O provedor também tem que deixar muito claro o direito das/dos usuárias/os de trocar de método, se isso for conveniente.

3. *Competência Técnica dos Provedores/as*

Significa que é de fundamental importância que as pessoas que desenvolvem atividades de planejamento familiar tenham competência técnica adequada e, para tanto, é necessário que recebam capacitação nessa área. Mais importante que a formação acadêmica ou título profissional (médico, enfermeira) é a formação específica em planejamento familiar.

A competência técnica supõe conhecimentos e habilidades para lidar com métodos anticoncepcionais (colocação de DIU, medição de diafragma etc.) e capacidade para resolver ou, pelo menos, identificar e encaminhar quaisquer problemas que possam surgir durante o uso do método. O provedor também deve estar preparado para se comunicar com as/os usuárias/os de maneira aberta, com respeito e numa linguagem simples, de forma a permitir ou facilitar uma escolha livre, baseada em informações, e promover um acompanhamento adequado.

4. *Relações Interpessoais Usuárias/os–Provedores/as*

Este item refere-se também à comunicação entre o serviço e a/o usuária/o. É imprescindível a empatia entre eles e a equipe de saúde, cuja compreensão e adoção de vários mecanismos possam ajudar as/os usuárias/os a compreender seus sentimentos sobre o planejamento familiar, traduzindo essa informação em ação. Além disso, refere-se à privacidade e confidencialidade que deve ser brindada às/aos usuárias/os durante a atenção.

O processo de comunicação interpessoal é o veículo pelo qual se estabelecem as relações entre provedores e usuárias/os e delas depende seu sucesso.

5. *Continuidade e Seguimento*

Refere-se ao interesse e habilidades para organizar o serviço de maneira a promover as visitas de seguimento, seja por intermédio de usuárias/os bem

informadas/os que voltam às visitas agendadas para o retorno, seja por meio de mecanismos formais de apoio ao serviço, como por exemplo cartas, telefonemas e/ou visitas domiciliares. A facilidade de acesso às consultas é uma das principais maneiras de garantir que as/os usuárias/os voltem para o acompanhamento.

6. *Constelação Apropriada de Serviços*

Significa que o serviço deve estar preparado para atender outras necessidades das/dos usuárias/os em saúde sexual e reprodutiva. O planejamento familiar deve estar inserido, ser parte, de um atendimento global à saúde reprodutiva, no qual se atendam também outras necessidades fortemente ligadas ao planejamento familiar, tais como a prevenção e tratamento das DST e HIV/Aids, prevenção e tratamento do câncer ginecológico, orientação e, idealmente, tratamento ou referência para problemas de sexualidade etc. Além disso, os serviços também deveriam contribuir para a educação e prevenção de doenças de alta prevalência, tais como a hipertensão arterial.

Por exemplo, uma mulher que procura um método anticoncepcional obviamente está tendo uma vida sexual ativa e corre o risco de ser infectada por uma DST ou ter um câncer cérvico-uterino. O serviço de planejamento familiar deve atender também a essas necessidades, ter capacidade de orientar e tratar ou, pelo menos, fazer referência a um serviço especializado.

O conceito de qualidade de atenção recebeu um reforço, nos anos 90, que foi marcado por dois grandes eventos: a Conferência Internacional sobre População e Desenvolvimento (CIPD), realizada no Cairo, Egito, em 1994, e a Conferência da Mulher, realizada em Beijim (Pequim), China, em 1995.

Essas duas Conferências constituem um marco no sentido de estabelecer que as atividades de planejamento familiar devem ser parte do atendimento integral à Saúde Sexual e Reprodutiva, levando em consideração as desigualdades sociais

e de gênero e garantindo apropriados níveis de qualidade de atenção. Esse novo conceito de planejamento familiar muda definitivamente de direção: de um enfoque centrado no problema populacional passa para outro, dirigido às pessoas e seus direitos. Pela primeira vez os governos, pelo menos a grande maioria deles, reconhecem oficialmente que os direitos reprodutivos são também parte dos direitos humanos fundamentais.

> Esses direitos baseiam-se no reconhecimento do direito básico, que todos os casais e indivíduos devem ter, para decidir livre e responsavelmente o número de filhos, o espaçamento dos nascimentos e o intervalo entre estes, e a dispor da informação e dos meios para isto, e o direito a alcançar o nível mais elevado possível de saúde sexual e reprodutiva. (Family Care International, 1994, p. i)

Em linhas gerais, a CIPD, além do direito fundamental ao planejamento familiar, que já havia sido estabelecido longo tempo atrás, afirmou o direito universal à saúde sexual e reprodutiva. A opção livre e informada, o respeito à integridade física e o direito a não sofrer discriminação nem coerção em todos os assuntos relacionados com a vida sexual e reprodutiva da pessoa foram sustentados como princípios fundamentais.

Embora as taxas de fecundidade tenham declinado globalmente, o marco dessa Conferência foi ressaltar que o crescimento da população ainda é muito importante. Nunca, na história da humanidade, tantos novos seres se agregaram à população mundial. Atualmente, mais de 90 milhões de indivíduos se juntam a ela por ano. A população mundial demorou 123 anos para passar de um para dois bilhões de habitantes e só 11 anos para pular de cinco para seis bilhões (Family Care International, 1994). O reconhecimento do problema e dos erros cometidos no passado trouxe como conseqüência um novo critério para enfrentar essas mudanças demográficas, um critério centrado nas necessidades e no desenvolvimento humano.

Em vez de ver as pessoas como simples números e objetos de políticas governamentais e de considerar o tema “população” de maneira isolada, a

comunidade internacional reunida no Cairo assumiu o compromisso de prestar serviços centrados nas pessoas, baseados no desenvolvimento delas próprias.

A partir dessa Conferência surgiu um Programa de Ação que se diferencia dos anteriores, basicamente por reconhecer:

- A necessidade de que os governos garantam aos cidadãos a proteção e o exercício dos direitos humanos fundamentais, bem como sua aplicação em todos os aspectos da prestação de serviços na área de saúde.

- Que os assuntos relativos à população, o meio ambiente, as pautas de consumo, os estilos de vida, a pobreza, a migração e o gênero estão inter-relacionados e formam interações complexas e dinâmicas que devem ser tratadas no contexto de um marco de desenvolvimento sustentável.

- A necessidade do enfoque integrado em matéria de saúde reprodutiva que inclua o planejamento familiar mas atenda à variedade de necessidades fundamentais relacionadas com a saúde, entre elas a maternidade sem risco, a prevenção das doenças sexualmente transmissíveis e HIV/Aids, com especial atenção às perspectivas, emancipação e direitos da mulher.

- A qualidade da atenção é essencial para o sucesso dos sistemas de prestação de serviços e para melhorar continuamente a saúde em geral.

- Uma questão fundamentalmente significativa e em grande medida descuidada: a participação e responsabilidade masculina em todas as esferas da vida doméstica e pública, não só para estabelecer igualdade social e de gênero, mas também para conseguir normas ótimas de saúde e bem-estar para todos: para homens, mulheres e crianças.

- As necessidades e os direitos das/dos adolescentes a receber informação e serviços que lhes permitam conduzir sua vida sexual e reprodutiva de forma responsável, informados, para que desfrutem de uma vida sadia e satisfatória.

- A necessidade de que os governos protejam todas as formas de família, em especial os lares com um só progenitor e chefiados por mulheres.

- Que os governos devem dar prioridade à mobilização de recursos humanos, técnicos e financeiros, o que se reflete no fato de que (nesta Conferência), pela primeira vez, os governos concordaram em fixar metas específicas para a alocação de fundos com a finalidade de dar atendimento à saúde reprodutiva (Family Care International, 1994).

Durante a década de 1980, o conceito de saúde reprodutiva tem sido amplamente discutido. Como resultado disso, vários grupos têm proposto definições de saúde reprodutiva, das quais a mais citada é a sugerida pela OMS, utilizada por numerosas instituições nacionais e internacionais, governamentais e não governamentais, e por instituições de ensino e pesquisa no direcionamento de suas políticas públicas, programas e estudos (Galvão, 1999). Esta definição foi adotada também pelos países presentes nas Conferências do Cairo e Beijim.

> A saúde reprodutiva é um estado de completo bem-estar físico, mental e social, e não de mera ausência de enfermidade ou doença, em todos os aspectos relacionados ao sistema reprodutivo e a suas funções e processos. Conseqüentemente, a saúde reprodutiva implica a capacidade de desfrutar de uma vida sexual satisfatória e sem riscos, de procriar e de ter a liberdade para escolher entre fazê-lo ou não, no período e na freqüência desejada. Nessa última condição, encontram-se implícitos os direitos do homem e da mulher de serem informados e de terem acesso a métodos anticoncepcionais seguros, efetivos, aceitáveis e de custo acessível, assim como o direito de buscarem/usarem métodos de sua escolha para a regulação da fecundidade, que não estejam legalmente proibidos. Está também implícito o direito de receber serviços apropriados de atenção à saúde que permitam gravidez e parto sem riscos e ofereçam aos casais as melhores possibilidades de terem filhos sadios. Define-se como *atenção à saúde reprodutiva* o conjunto de métodos, técnicas e serviços que contribuem para a saúde e o bem-estar reprodutivos, mediante a prevenção e solução dos problemas de saúde reprodutiva. Inclui também a *saúde sexual*, cujo objetivo é a melhoria da vida e das relações pessoais e não somente o aconselhamento e a atenção referentes à reprodução e às doenças sexualmente transmissíveis. (ICPD, 1994) (*apud* Galvão, 1999, p. 172)

Essa evolução do conceito de planejamento familiar, de início uma abordagem puramente demográfica (controladora), chega a um novo conceito, no qual se reconhece a pessoa, seus direitos à própria sexualidade e sua liberdade de escolha, sem dúvida, mostra um avanço fundamental e da maior relevância. Os serviços de saúde passam a reconhecer sua responsabilidade com a pessoa, em vez de ter como único objetivo a melhoria dos índices, seja no âmbito da saúde pública (morbi-mortalidade materna), seja demográficos (crescimento populacional, taxa de natalidade). Dito de outra forma, os serviços começam a, pelo menos em teoria, preocupar-se com o bem-estar das pessoas, ou seja, com o fato de que as pessoas devem viver sua vida e sua sexualidade de maneira saudável.

Várias avaliações realizadas cinco anos após a CIPD mostraram que haviam sido implementados vários projetos cujo objetivo era promover e garantir o exercício dos direitos sexuais e reprodutivos. Isso mostra que, mesmo não sendo um movimento homogêneo e universal, um longo caminho já foi percorrido. Por outro lado, ainda há outro tanto a trilhar, uma vez que existem países, instituições e pessoas que continuam vendo o crescimento populacional como um perigo para a estabilidade política e social dos países e o planejamento familiar como a solução integral, sem se preocupar com os direitos das pessoas, principalmente das mulheres.

O grande desafio é passar da teoria à prática, ou seja, testar estratégias que consigam melhorar definitivamente a qualidade de atenção em planejamento familiar e que este realmente seja incorporado ao enfoque de saúde sexual e reprodutiva, enfatizando e tendo como ponto central a promoção do respeito aos próprios direitos sexuais e reprodutivos.

1.3. Visão Geral da Situação do Planejamento Familiar no Brasil

Desde que surgiram os primeiros programas de Planejamento Familiar, na década de 1960, até os dias de hoje, tem havido muitas mudanças no próprio conceito e nos objetivos propostos. O número de métodos anticoncepcionais disponíveis cresceu e houve também, especialmente nas últimas duas décadas, profundas mudanças nas políticas e sistemas de saúde em que esses programas se inserem (Faúndes e Hardy, 1995).

No Brasil, durante a mesma época, também ocorreram importantes transformações de ordem econômica, política e social, as quais, de uma ou outra forma, influenciaram os indicadores de saúde, inclusive a diminuição da mortalidade e da taxa total de fecundidade. Na década de 1986-1996, a queda da taxa total de fecundidade foi muito rápida, chegando, em 1996, a 2,5 filhos por mulher, número muito próximo do que se considera a taxa total de fecundidade que levaria a uma estabilização da população. Esse declínio caracterizou-se, principalmente, pela diminuição das taxas específicas de fecundidade por idade, mais significativa no grupo de mulheres com vinte anos ou mais (Tabela 1).

Embora seja evidente e acentuada, a queda dos índices de fecundidade ocorrida nas últimas décadas no Brasil não foi acompanhada de melhoria significativa na área da saúde reprodutiva das mulheres, já que a mortalidade materna ainda é importante causa de óbito entre mulheres de 15 a 49 anos (Berquó, Araújo, Sorrentino, 1995).

TABELA 1: Média da Taxa de Fecundidade por Grupos de Idade e Período[1]

GRUPO IDADE/ANOS	76 – 80	81 – 85	86 – 90	91 – 95
15 – 19	87	89	97	88
20 – 24	217	199	180	153
25 – 29	227	191	159	126
30 – 34	168	130	107	81

Fonte: BEMFAM, 1997.

Por outro lado, a trajetória da fecundidade nos grupos mais jovens mostrou que, nos últimos 20 anos, a fecundidade por idade apresentou uma queda de aproximadamente 30% no grupo de 20 a 24 anos, enquanto no grupo de 15 a 19 anos teve um aumento no qüinqüênio 1986-90. No entanto, no último qüinqüênio avaliado, retornou ao mesmo nível de 20 anos antes. Conseqüentemente, os filhos nascidos de mulheres com 15-19 anos representam uma proporção cada vez maior de todos os nascimentos. Por exemplo, enquanto a taxa específica de fecundidade no grupo de 15-19 anos era metade da observada em mulheres de 30-34 no qüinqüênio 76-80, ela passou a ser maior que a taxa deste último grupo no último qüinqüênio estudado (BEMFAM, 1997).

As importantes melhorias nas condições de saneamento básico, a disponibilidade crescente de vacinas, o aparecimento de antibióticos mais eficientes e maior facilidade de acesso aos serviços de saúde têm contribuído para melhorar, de maneira bastante significativa, alguns indicadores, como mortalidade geral, mortalidade infantil e, de maneira menos acentuada, a mortalidade materna (Pedro, 1995). Com indicadores ainda não tão satisfatórios, pelo menos em nosso meio, a mortalidade materna também é determinada por outros fatores de risco,

[1] Taxa Específica de Fecundidade: número de nascidos vivos por cada 1 000 mulheres em 1 ano.

como a idade materna avançada, a via de parto por cesárea e o nível socioeconômico (Cecatti, 1992).

Entende-se como morte materna aquela que, de alguma forma, relaciona-se direta ou indiretamente com o processo reprodutivo, a partir do início da gestação. Inclui, desta maneira, as mortes que resultam de uma gravidez ectópica ou de um aborto, assim como aquelas que derivam de complicações na gravidez, parto e puerpério (Cecatti, 1992).

Atualmente, propõe-se um conceito mais abrangente, que inclui também as mortes resultantes da prevenção da gravidez, devido a complicações pelo uso de anticoncepcionais reversíveis ou pela ligadura de trompas, denominado “morte reprodutiva” (Cecatti, 1992).

Outro fato importante é que a prevalência total do uso de anticoncepcionais tem aumentado de maneira muito significativa nos últimos anos. Já em 1986, a prevalência total de uso de anticoncepcionais era de 66 por 100 mulheres casadas ou unidas em idade fértil e estava num claro ritmo de aumento, depois confirmado na pesquisa nacional de demografia e saúde de 1996, em que a prevalência total chegou a 76% das mulheres casadas ou unidas de 15 a 49 anos (BEMFAM, 1997).

Se analisarmos o impacto que essas mudanças têm tido na vida das mulheres com base exclusivamente nesses indicadores, poderemos ficar muito satisfeitos no que se refere ao planejamento familiar, talvez concluindo que os problemas em relação a ele têm sido resolvidos. No entanto, ao fazer uma análise mais detalhada, à luz dos aspectos educativos, surge uma série de interrogações que merecem maior atenção:

- Se atualmente no Brasil o Planejamento Familiar é um direito reconhecido pela Constituição Brasileira[2], quantas pessoas (mulheres, homens e adolescentes) conhecem esse direito? Quantas têm acesso aos serviços de planejamento familiar e podem exercer esse direito?

A tecnologia teve um grande avanço nos últimos trinta anos, período em que muitos métodos anticoncepcionais foram desenvolvidos. Teoricamente, pelas normas do Ministério da Saúde, deveriam ser oferecidas pelo menos dez opções contraceptivas, mas as pesquisas demográficas, e especificamente as taxas de prevalência de uso de métodos anticoncepcionais, mostram que, praticamente, somente dois métodos são utilizados mais extensamente: a pílula e a ligadura de trompas. Acrescente-se a isso o fato de que a grande maioria das usuárias não tem acesso a tais métodos, oficialmente, nos serviços públicos de saúde. No caso da pílula, as mulheres a compram diretamente na farmácia e usam-na sem orientação adequada. A ligadura, pelo menos antes da sua legalização em 1997, era realizada no âmbito do setor público, mas de maneira irregular e, habitualmente, mediante o pagamento de honorários aos profissionais que faziam a cirurgia, quase sempre durante uma cesariana (Berquó, 1986, 1987).

- Por que razão os métodos anticoncepcionais, teoricamente disponíveis não são encontrados, na prática, nos serviços de saúde e estão sendo subutilizados ou inadequadamente usados pela população?

O avanço no campo das pesquisas biomédicas e das ciências sociais tem se traduzido num grande aumento de informação e novos recursos disponíveis, tais como os critérios médicos de elegibilidade dos métodos anticoncepcionais, as técnicas educativas e de orientação para a escolha informada de métodos

[2] Art. 226.
...
§ 7º - Fundado nos princípios da dignidade da pessoa humana e da paternidade responsável, o planejamento familiar é a livre decisão do casal, competindo ao Estado propiciar recursos educacionais e científicos para o exercício desse direito, vedada qualquer forma coercitiva por parte de instituições oficiais ou privadas.
Brasil. Constituição da República Federativa do Brasil. 1988

anticoncepcionais etc. (Global Working Group Meeting, 1999; Cabral e Díaz, 1998; WHO, 2000). Entretanto, ao visitar as unidades de saúde, observa-se que a grande maioria dos prestadores de serviços não tem tido acesso a essas informações e realiza as ações de acordo com informações e normas de atendimento desatualizadas.

- Por que essa produção de conhecimentos não chega aos serviços e por que, inclusive nas universidades, onde são gerados, eles não se incorporam ao ensino dos profissionais de saúde?

A intenção aqui é levantar a problemática que envolve a situação do planejamento familiar e não de oferecer respostas a essas perguntas, embora seja importante salientar que a falta de integração entre o ensino, a pesquisa e a assistência podem ser um fator que contribui para isso. Sob o enfoque da educação, também podemos dizer que outro aspecto importante é a maneira como se disseminam esses novos conhecimentos e a falta de intencionalidade de querer compartir o "poder do saber".

- Muitos eventos e acordos internacionais têm se realizado, como por exemplo as Conferências do Cairo e Beijim, nas quais finalmente foi consolidado o reconhecimento dos direitos sexuais e reprodutivos (Family Care International, 1994; Beijim, 1995). O Brasil foi um dos países signatários, mas como se explica que as pessoas, principalmente as mulheres, ainda nem conhecem seus próprios direitos, mais de cinco anos após tais conferências?

A reflexão sobre essas perguntas sugerem-nos uma realidade diferente da mostrada pelos indicadores quantitativos. Isto significa que ainda que tenha havido muitas mudanças e melhoria nos indicadores de saúde, os serviços nesse campo não acompanharam esses novos conceitos, descobertas e acordos.

Ainda temos um modelo de serviço de saúde que fixa sua atenção principalmente na assistência e inclui minimamente ações de prevenção e promoção. Com tal conceito de saúde, que se centra preferentemente na doença e/ou nos problemas, torna-se lógico entender por que o cuidado com a saúde está nas mãos dos profissionais, fazendo que as pessoas tenham pouca participação na atenção a sua própria saúde e na tomada de decisões em relação à sua sexualidade e reprodução.

Na atualidade convivemos com uma grande diversidade de concepções sobre saúde, entre elas a definição da OMS, que data de 1948: “Saúde é o estado de completo bem-estar físico, mental e social e não apenas a ausência de doença” (Brasil Secretaria de Educação Fundamental, 1998, p. 249).

Essas definições de saúde vêm sendo amplamente discutidas, assim como a necessidade de se promover a saúde. Nesse sentido, a primeira Conferência Internacional sobre a Promoção da Saúde foi realizada em Otawa, no Canadá, em 21 de Novembro de 1986, ocasião em que foi emitida a “Carta de Otawa”, cujo objetivo era a consecução deste objetivo, contido em seu próprio título: “Saúde para Todos no Ano 2000”.

Num dos trechos do documento afirma-se que para alcançar um estado adequado de bem-estar físico, mental e social, um grupo deve ser capaz de identificar e realizar suas aspirações, satisfazer suas necessidades e mudar ou adaptar-se ao meio ambiente. A saúde, então, não aparece como um objetivo, mas como a fonte de riqueza da vida cotidiana.

Trata-se de um conceito positivo que acentua os recursos sociais e pessoais, assim como as aptidões físicas. Portanto, dado que o conceito de saúde como bem-estar transcende a idéia de formas de vida sadias, a promoção da saúde não concerne, exclusivamente, ao setor sanitário (Carta de Otawa, 1986).

Cabe aqui incorporar também a perspectiva da educação em relação à saúde, expressa nos parâmetros curriculares (Brasil Secretaria de Educação Fundamental, 1998):

> É nos espaços coletivos que se produz a condição de saúde da comunidade e, em grande parte, de cada um de seus componentes. Nas relações sociais se afirma a concepção hegemônica de saúde e, portanto, é nesse campo que se pode avançar no entendimento da saúde como valor, na luta pela vida e pela qualidade de vida. (p. 279)

Mas também é verdade que...

> ... saúde tem uma dimensão pessoal que se expressa, no espaço e no tempo de uma vida, pelos meios de que cada ser humano dispõe para trilhar seu caminho em direção ao bem-estar físico, mental e social. Isso requer sujeitos com autonomia, liberdade e capacidade para regular as variações que aparecem no organismo e que se apropriem dos meios para tomar medidas práticas de autocuidado em geral e, especificamente, diante de situações risco. (p. 275)

Observamos que, tanto na saúde quanto na educação, o conceito de saúde tem uma ampla dimensão e pressupõe ações que contribuam para que as pessoas busquem o autocuidado e o bem-estar. Entretanto, também se observa uma prática distante do discurso teórico, já que a maior parte dos programas de saúde e de educação, em vez de incorporar as pessoas como seres capazes de tomar decisões, de obter sua autonomia e ser responsáveis por essas decisões, consideram-nas irresponsáveis, incapazes e muitas vezes “culpadas” por não assumirem condutas de autocuidado.

No campo da saúde sexual e reprodutiva, em especial no que se refere à anticoncepção, as necessidades, desejos e escolhas bem-informadas das pessoas deveriam ser o aspecto central da atenção. Muitas vezes os serviços de saúde colocam a responsabilidade de uma gravidez não planejada exclusivamente na pessoa. É freqüente que profissionais digam que elas conhecem mas não usam os métodos porque são irresponsáveis. Isso piora quando se trata de adolescentes. É também comum ouvir-se que adolescente tem pensamento mágico ou que é irresponsável, e essa postura e noção que se tem das pessoas e das causas pelas quais elas não adotam medidas de autocuidado tem

habitualmente determinado a prática, ou seja, a maneira como se abordará esse assunto. Por exemplo, se os adolescentes não usam métodos anticoncepcionais, os profissionais da saúde, os pais, a própria sociedade os “culpa”, em vez de dispensar-lhes um olhar crítico, no sentido de avaliar a situação de uma maneira mais ampla, de procurar entender a quantidade de fatores que estariam influenciando o uso de anticoncepcionais por adolescentes. Por exemplo, muitas vezes esses adolescentes não freqüentam as unidades de saúde porque os profissionais os julgam e não respeitam seu direito de escolha no tocante ao momento de iniciar sua vida sexual, outras vezes eles não encontram o método desejado na unidade de saúde.

Na realidade, a vontade e as habilidades das pessoas para fazer suas próprias escolhas são influenciadas por fatores como: políticas formais dos governos, disponibilidade de métodos anticoncepcionais, acesso aos serviços, organização das instituições, cultura, desigualdades de gênero, experiências e circunstâncias individuais e também a atitude e postura dos provedores (Global Working Group Meeting, 1999).

Há muitos anos os profissionais “vêm indicando” os métodos anticoncepcionais para as usuárias, ou seja, tomam a decisão no seu lugar, achando que sabem o que é melhor para elas. Porém, há estudos mostrando que quando uma usuária decide ou escolhe seu método anticoncepcional, a taxa de continuidade é maior do que quando o profissional de saúde faz isso por ela (Pariani, 1989).

Tudo o que se descreveu anteriormente aponta para uma série de mudanças que precisam ser realizadas para que as pessoas possam realmente ter acesso a serviços de planejamento familiar de boa qualidade, em que sejam considerados sujeitos e não objetos do programa, nos quais as pessoas participem da elaboração dos programas para que eles atendam às suas próprias necessidades e respeitem sua capacidade de fazer as próprias escolhas.

Entendo que essas mudanças não são fáceis nem possíveis de serem realizadas num curto período de tempo, já que isto implica uma mudança de cultura, uma transformação da sociedade. E é aqui que a educação tem um papel fundamental, porque para se promover uma mudança de cultura, para transformar, é preciso incorporar todos os atores envolvidos no sistema de saúde, socializar informações, facilitar o diálogo e o processo de reflexão, de forma que, com a participação e o compromisso de cada um seja possível “desconstruir” e “reconstruir” conceitos e significados, assim como novas formas de vida.

2. Principais Marcos de Referência

2.1. Enfoque estratégico da OMS

O enfoque estratégico para introdução de métodos anticoncepcionais, também chamado de "Estratégia da OMS", surgiu a partir de uma reunião de expertos realizada em Genebra, em dezembro de 1991 (Spincehandler e Simmons, 1994).

A força-tarefa sobre Pesquisa da Introdução e Transferência de Tecnologias para a Regulação da Fertilidade, do Programa Especial de Pesquisa, Desenvolvimento e Capacitação da OMS, preocupada com os problemas encontrados nas unidades de saúde nas quais novos métodos anticoncepcionais estavam sendo incorporados, convocou uma reunião especial para decidir como abordar esses problemas. Os profissionais que participaram da reunião contribuíram para realizar uma revisão do processo de introdução de métodos anticoncepcionais e, em vez de focalizar um método específico, examinaram a situação de uma maneira mais ampla, visando identificar o que se sabia e o que se poderia aprender sobre os serviços de saúde e as usuárias, em relação ao processo de tomada de decisão para escolha de um método anticoncepcional e ampliar a oferta.

A revisão começou com o processo de introdução da pílula em 1960, que dava início à chamada "Revolução Contraceptiva", com a utilização dos primeiros métodos modernos. Desde 1960 houve uma mudança radical na evolução da anticoncepção, com grandes avanços no desenvolvimento de tecnologias destinadas à regulação da fertilidade, que prometiam uma solução total para os problemas de aumento da população.

Na mesma década foram introduzidos os dispositivos intra-uterinos (DIU), inertes e medicados, e os injetáveis, de progestogênio. Durante três décadas foram desenvolvidos e introduzidos muitos métodos anticoncepcionais, inclusive os

implantes subdérmicos de levonorgestrel, que foram registrados e introduzidos na década de 80 em muitos países, entre eles os Estados Unidos.

Uma das grandes constatações dessa revisão foi que, embora houvesse uma ampla variedade de tecnologia anticoncepcional disponível, com métodos que apresentavam melhorias importantes, aumentando sua eficácia e diminuindo os efeitos colaterais, na prática seu uso permanecia muito limitado em várias regiões (Spicehandler e Simmons, 1994).

Num primeiro momento, a introdução de novas tecnologias ou métodos anticoncepcionais foi considerada o meio mais importante para aumentar a utilização de métodos anticoncepcionais e atender às necessidades não satisfeitas em matéria de contracepção.

A OMS publicou, em 1994, um manual sobre políticas e normas de serviço para regular a gama de métodos (WHO, 1994a). Nesse manual afirma-se enfaticamente que agregar métodos anticoncepcionais ao sistema aumenta a prevalência de seu uso, basicamente por atrair novas usuárias, que não estavam usando nenhum método. Uma análise por regressão, feita com dados de 36 países em desenvolvimento, mostrou que cada método agregado ao sistema e que esteja amplamente disponível aumenta a prevalência anticoncepcional em mais ou menos 6% (Westhoff, Moreno, Goldman, 1989).

No entanto, os esforços realizados pelo setor público para introduzir os métodos anticoncepcionais mostraram que a disponibilidade de novos métodos, sozinha, significava muito pouco para aumentar sua utilização e ampliar o leque de escolhas, se as dificuldades existentes nos programas destinados a oferecer uma atenção adequada não fossem solucionadas. Em outras palavras, o fundamental não é só agregar um método a um sistema, mas é preciso que o sistema seja capaz de tornar esse método realmente disponível, sem interferir na provisão dos outros métodos já à disposição (Spicehandler e Simmons, 1994).

Existem numerosos dados que confirmam o que foi exposto anteriormente. Talvez um dos mais ilustrativos seja o caso da Índia, onde dois anos após a introdução do DIU já se havia inserido mais de um milhão e meio de DIU. No entanto, o sucesso e o otimismo duraram muito pouco, já que exames inadequados antes da inserção, seguimentos deficientes, efeitos colaterais e mitos e rumores exagerados levaram a altas taxas de descontinuação e uma queda acentuada no número de inserções (Soni, 1984).

Depois de quase três décadas de disponibilidade do DIU na Índia, a porcentagem de mulheres que usam o método permanece baixa, por volta de 2%. Apesar dos muitos esforços realizados, os efeitos negativos da introdução inadequada do método ainda limitam sua aceitação ampla pela população (Spicehandler e Simmons, 1994; Simmons e Fajans, 1999).

Outro exemplo de introdução de métodos realizada com o objetivo de aumentar as opções e, portanto, de melhorar a qualidade foi a introdução do Cyclofem , o injetável mensal desenvolvido pela OMS na Indonésia.

O governo da Indonésia, com o apoio da OMS, iniciou um estudo introdutório de Cyclofem em vários centros de saúde de quatro províncias, com o objetivo de aumentar as opções contraceptivas, oferecendo outro injetável com características diferentes dos já disponíveis no país: a Depo-provera (injetável trimestral) e o Noretisterat (injetável bimestral). A justificativa para a introdução era que outro injetável, mensal e com menos efeitos sobre o padrão menstrual, aumentaria as opções de injetáveis, cobrindo uma faixa maior da população e, conseqüentemente, aumentaria a prevalência de uso dos injetáveis em geral. O estudo mostrou que, na prática, o Cyclofem , em vez de ser uma opção adicional,

começou a ser usado como substituto da Depo-provera e do NET-EN, quando eles ficaram em falta por deficiências no sistema logístico. Isso confirmou o fato de que as usuárias não tiveram verdadeiramente uma terceira opção e que não se ampliaram as escolhas.

Além disso, se o sistema logístico de abastecimento de métodos anticoncepcionais apresentava problemas, era fácil prever que o abastecimento de Cyclofem também viria a enfrentar problemas (Spicehandler e Simmons, 1994). O que aconteceu foi que as mulheres recebiam o injetável, que nesse momento estava acessível, mas as instruções muitas vezes não eram claras, levando ao uso inadequado (Simmons *et al.*, 1997).

Apesar desses fracassos relativos, a maioria dos serviços e programas continuou centrando seus esforços na tecnologia. Os cientistas continuaram a buscar métodos mais efetivos, de longa duração, fáceis de usar e de distribuir, e com poucos efeitos colaterais e sem um aumento paralelo na qualidade do modo como esses métodos eram oferecidos.

A esperança era que essas tecnologias inovadoras pudessem criar “métodos amigáveis para as usuárias”, com menos sobrecarga para os serviços de saúde. Mas, apesar dos grandes avanços nas pesquisas biomédicas, nenhum dos métodos mais recentemente disponíveis, tais como os implantes, novos DIU hormonais, pílulas com novos progestogênios, entre outros, têm cumprido perfeitamente sua função: ser um “método amigável para as usuárias”. Na verdade, em vez disso, a cada nova tecnologia, ambos, usuárias e provedores, recebem novas instruções quanto ao seu uso. Cada método tem diferentes padrões de efeitos colaterais e coloca uma sobrecarga potencial no sistema de fornecimento de serviços (Spicehandler e Simmons, 1994).

O foco em novos métodos, como a solução dos problemas enfrentados pelos serviços, também desviava a atenção de uma minuciosa análise das causas de

base dos baixos índices de aceitabilidade e de continuidade dos métodos disponíveis. O grupo de especialistas concluiu que ter informação adequada sobre como eram oferecidos os métodos existentes era vital para a compreensão de como um novo método funcionaria num determinado serviço. Essas informações foram consideradas essenciais para fortalecer o planejamento e para uma melhor utilização de uma ampla gama de serviços de planejamento familiar.

Também se constatou que, na última década, pouca atenção fora dada a pesquisas que estudassem o contexto em que a oferta de serviços era realizada quando se introduzia um novo método anticoncepcional.

Considerando que desde que um método anticoncepcional é idealizado, passando por todas as fases de estudo (fase I, fase II e fase III), até chegar à sua introdução, transcorrem em torno de 20 anos, e analisando as diferentes experiências de introdução e os resultados que mostravam que não haviam oferecido a contribuição esperada em beneficio das usuárias, tornou-se crucial o desenvolvimento de uma nova abordagem de introdução, que considerasse a experiência acumulada até então.

Surgiu então a nova estratégia da OMS ou enfoque estratégico para a introdução de métodos anticoncepcionais descrita originalmente por Joanne Spicehandler e Ruth Simmons (1994).

Esse enfoque é uma nova metodologia de trabalho que visa melhorar a qualidade de atenção dos serviços que oferecem métodos anticoncepcionais, que utiliza um marco conceitual de sistemas e um modelo de desenvolvimento organizacional. Isso significa que, para a introdução de um método anticoncepcional, a ênfase passa a se concentrar no sistema como um todo, e não no método específico a ser introduzido. Esse novo enfoque considera de maneira integrada e conjuntamente:

- as necessidades e perspectivas das usuárias que fazem parte do grupo no qual se pretende introduzir o método;
- as características das tecnologias ou métodos anticoncepcionais disponíveis; e
- a capacidade atual e potencial dos serviços de saúde.

Além disso, implica uma análise das inter-relações desses três fatores, considerando o contexto político, social, cultural e econômico da comunidade em que se pretende desenvolver as ações.

Em outras palavras, esse novo marco conceitual para a introdução de métodos anticoncepcionais focaliza, como mostra o desenho abaixo, não somente o método em si, mas também as necessidades das usuárias, bem como a capacidade dos serviços para manejar a nova tecnologia e atender as usuárias.

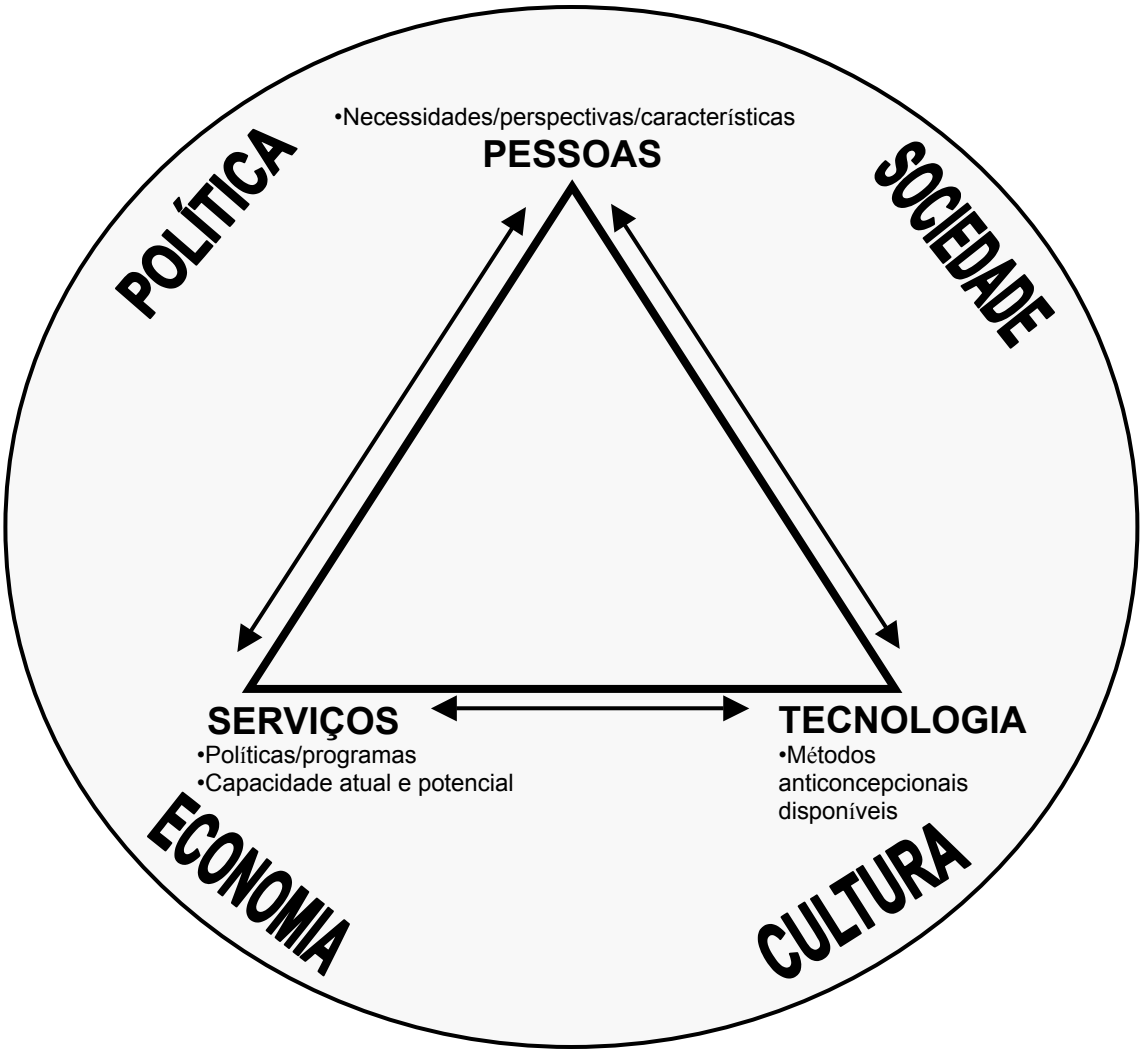

FIGURA 1: Marco conceitual de sistemas que orienta o enfoque estratégico

Os três vértices do triângulo guardam relação entre si e apresentam interfaces. Por exemplo, olhando para o vértice superior do triângulo, as pessoas (usuárias/os dos serviços): é necessário investigar quais são suas características, opiniões e necessidades. Em outro vértice, os serviços de saúde: é importante investigar qual é sua capacidade atual e potencial para introduzir um novo método sem interferir na qualidade com que se oferecem os serviços e métodos que estejam disponíveis. Isso implica investigar qual é a estrutura desses serviços, as políticas, como é o atendimento etc. No terceiro vértice, a tecnologia ou o método a ser introduzido, a pergunta é: qual é a gama de métodos anticoncepcionais disponíveis? Esses métodos são adequados para essa população usuária? Há a

necessidade de se introduzir mais um método? O método proposto é adequado para as necessidades da população e para a capacidade dos serviços?

Finalmente, o círculo que contém o triângulo representa o contexto político, social, cultural e econômico em que essas usuárias, os serviços e a nova tecnologia estão inseridos.

É importante lembrar que as necessidades e perspectivas das usuárias estão ancoradas numa estrutura social e num conjunto de relações de poder, entre elas, as relações de gênero. As normas culturais e valores religiosos, assim como as relações de gênero, determinam a opinião acerca dos métodos anticoncepcionais e afetam os esforços realizados para atender às necessidades de saúde sexual e reprodutiva.

Em outras palavras, o círculo que rodeia o triângulo representa o entorno social, cultural, econômico e político que influencia todos os vértices e suas relações ou interfaces. Nessas inter-relações aparecem muitas interrogações, e todas elas têm implicações na qualidade de atenção.

Por exemplo, na interface usuária/o-serviço surgem as seguintes perguntas:

- Como são as relações entre as usuárias e o serviço de saúde?
- Qual é a participação das usuárias no cuidado de sua saúde?
- O pessoal dos serviços trata com respeito a população usuária?
- Os serviços de saúde realmente são acessíveis às/aos usuárias/os?
- Qual é o preparo da equipe de saúde para oferecer um serviço humanizado e de boa qualidade?

A interface entre usuária/o-tecnologia sugere perguntas como estas:

- As/os usuárias/os expressam suas preocupações ou medos específicos em relação à saúde e aos métodos anticoncepcionais? Existe possibilidade de diálogo e espaço de discussão?
- Qual é a importância dos efeitos secundários dos MAC dentro do contexto cultural e social da vida das/os usuárias/os?
- Qual a informação ou orientação que a população recebe? Como é dada e recebida essa informação?

A interface entre serviço e tecnologia inclui perguntas como as que se seguem:

- Os novos métodos anticoncepcionais podem ser incorporados aos serviços, considerando os recursos limitados dos serviços de saúde?
- Existem profissionais preparados e recursos para os capacitar sobre o uso da nova tecnologia?
- Nas condições atuais dos serviços, o fato de agregar um método ou melhorar sua provisão contribuirá efetivamente para manter ou melhorar a qualidade de atenção sem alterar a provisão de outros serviços?

Esta nova metodologia, desenvolvida para guiar as decisões em relação à melhoria da oferta de métodos disponíveis na atualidade, a necessidade de eliminar métodos não-seguros ou impróprios num contexto determinado e de introduzir ou não novos métodos anticoncepcionais proporciona um marco lógico e flexível para identificar e resolver os problemas administrativos, técnicos, socioculturais e econômicos que afetam a capacidade de um determinado sistema de saúde para oferecer uma diversidade de métodos num contexto de livre escolha e com boa qualidade de atenção (Spicehandler e Simmons, 1994).

Princípios-Chave

Essa nova metodologia de trabalho, que tem um enfoque mais amplo do planejamento familiar no contexto da saúde sexual e reprodutiva, ao considerar de

maneira integrada e conjuntamente as necessidades e perspectivas das usuárias, as características dos métodos anticoncepcionais disponíveis (tecnologia anticonceptiva) e a capacidade atual e potencial dos serviços, é guiada basicamente por três princípios-chave:

- é de autoria local;
- é um processo aberto e transparente;
- é um processo participativo.

Este último princípio é a grande característica do enfoque estratégico e tem demonstrado ter um poder significativo no diagnóstico, no desenvolvimento de políticas, nas pesquisas, enfim, em todas as etapas de sua implementação. O conceito de participação aqui é entendido como a incorporação de todos os atores envolvidos no sistema de saúde (autoridades, provedores dos serviços de saúde, pesquisadores etc.) e principalmente da comunidade (grupos de mulheres) no processo de tomada de decisões em relação à saúde sexual e reprodutiva (Simmons *et al*., 1997).

O processo participativo possui muitas vantagens. As múltiplas perspectivas geram apoio e consenso amplo para as medidas propostas. Incluir os diferentes pontos de vista ajuda a tornar transparente e aberta a tomada de decisões (Spicehandler e Simmons, 1994).

De acordo com afirmação de Ruth Simmons: *"*...é importante escutar a população usuária porque habitualmente ela conhece os seus problemas (dificuldades de acesso, por exemplo), e também conhece as suas soluções". Muitas vezes encontramos profissionais de saúde que acham que sabem o que é melhor para as/os usuárias/os, ou pensam que conhecem sua opinião, mas quando realmente se escuta a opinião das pessoas, a situação é diferente.

É importante reconhecer que facilitar a participação, trabalhar de maneira integrada, considerar todos os atores no processo de tomada de decisão não se dá de maneira fácil nem natural, requerendo esforço, preparo, vontade e compromisso.

O enfoque estratégico inclui três etapas de trabalho:

- ✓ Diagnóstico Estratégico – Etapa 1
- ✓ Pesquisa Participativa – Etapa 2
- ✓ Expansão – Etapa 3

Essas três etapas estão orientadas para a tomada de decisões no contexto das capacidades dos serviços e das necessidades das usuárias num país ou entorno específico. Em vez de iniciar atividades destinadas a incorporar um determinado método, o enfoque estratégico considera uma gama de possibilidades à luz de circunstâncias concretas e põe a responsabilidade sobre as decisões nas mãos dos participantes do lugar onde esse trabalho for realizado.

A finalidade dessas etapas é garantir que se identifiquem e se tomem as medidas necessárias para proporcionar serviços de qualidade. Em cada uma delas está incorporado o componente de investigação e ação, de maneira que as pessoas que tomam decisões possam dispor tanto de informações como de oportunidades para ações, as quais poderão ser incorporadas nas políticas e programas, para assim maximizar os resultados em matéria de saúde sexual e reprodutiva.

- *Etapa I – Diagnóstico Estratégico*

  É um exercício de planejamento participativo e multidisciplinar que utiliza um enfoque predominantemente qualitativo de recopilação de dados e está orientado pelo marco conceitual de sistemas (pessoas, serviço, tecnologia e o entorno social, cultural, político e econômico).

  O diagnóstico estratégico é guiado pelas três perguntas abaixo:

1. É necessário melhorar a entrega dos métodos anticoncepcionais atualmente disponíveis?
2. É necessário eliminar algum método anticoncepcional do sistema?
3. É necessário introduzir novos métodos anticoncepcionais?

Geralmente as respostas às perguntas têm como resultado recomendações no sentido de se efetuarem, em vários setores que afetam a saúde reprodutiva, mudanças de políticas destinadas a melhorar a qualidade da assistência. Esse diagnóstico estratégico ou avaliação preliminar também sugere áreas para o desenvolvimento das pesquisas de ação, que geralmente são realizadas na Etapa II. Outras recomendações podem ser incorporadas imediatamente às rotinas de serviço.

- *Etapa II – Pesquisa Participativa*

  Esta segunda etapa do enfoque estratégico é constituída pela pesquisa, principalmente as pesquisas participativas ou pesquisas de ação, e se baseia nas prioridades estabelecidas pela Etapa I. Também se inicia com um diagnóstico da situação local, incorporando a participação de autoridades, equipe de saúde e representantes da comunidade. Os resultados são discutidos numa instância de decisão chamada Comitê Executivo, no qual são definidas as ações/intervenções e principais pesquisas. Com freqüência, implica testar maneiras de melhorar os serviços de saúde, dentro das limitações institucionais e com os recursos existentes. Por exemplo, a pesquisa pode estar centrada nas possibilidades, aceitabilidade e impacto potencial de introduzir um determinado anticoncepcional com um enfoque na qualidade de atenção. Também podem-se investigar os meios para melhorar o abastecimento de serviços com o fim de aumentar o acesso, a disponibilidade e a qualidade da assistência na provisão de todos os métodos anticoncepcionais. Isto implica a necessidade do desenvolvimento de projetos piloto ou de demonstração para avaliar inovações nos serviços, por exemplo,

implantar a participação comunitária na supervisão dos serviços de saúde. Nesta etapa são importantes os estudos sobre a perspectiva das/dos usuárias/os, que podem proporcionar valiosos conhecimentos acerca das experiências e percepção das usuárias/os e das pessoas que não utilizam os serviços, como também sobre a relação dessas questões com as escolhas de métodos anticoncepcionais e a qualidade de atenção.

- *Etapa III – Expansão*

  O principal objetivo da Etapa III é usar os resultados das pesquisas para o desenvolvimento de programas e políticas. Nesta etapa, deve-se tomar a decisão de como e quando replicar ou, melhor dizendo, expandir projetos pilotos realizados em um lugar determinado em nível regional ou nacional.

  Passar da Etapa II para a III implica uma revisão das três perguntas estratégicas da Etapa I.

  Ao examinar o quadro maior, ou a situação macro, as pessoas que tomam as decisões devem determinar como expandir o processo. Também se devem definir as mudanças ou adaptações necessárias à manutenção da ênfase na qualidade de atenção e na gama de opções contraceptivas, em vez de focalizar um determinado método.

  Antes de começar a expansão ou Etapa III, deve-se elaborar um plano estratégico que inclua cursos de capacitação, materiais de informação, educação e comunicação (IEC), infra-estrutura, sistema de logística e abastecimento de métodos anticoncepcionais etc.

  Esta etapa implica novas pesquisas em relação ao processo de expansão, desde projetos piloto para um número de programas em maior escala, até a assistência técnica, a disseminação de resultados e a avaliação contínua.

Para garantir que as inovações sejam sustentáveis, as atividades da Etapa III devem continuar considerando questões relacionadas com o custo, disponibilidade de recursos a longo prazo e outras atividades iniciadas durante a Etapa II (Spicehandler e Simmons, 1994; Simmons *et al*., 1997; Simmons e Fajans, 1999).

Países nos quais se Aplicou a Estratégia

O Brasil foi o primeiro país não só a iniciar a implementação da estratégia como o pioneiro na aplicação das três etapas. A etapa de diagnóstico foi instituída em fins de 1993, a etapa de pesquisa começou em 1994 e a terceira etapa – de utilização dos conhecimentos adquiridos nas etapas anteriores, expansão e replicação – se iniciou em 1997 e continua até o presente.

Pouco tempo depois de iniciado o processo no Brasil, outros países o adotaram, alguns deles já introduzindo algumas modificações para torná-lo mais amplo, deixando de centrar a atenção apenas na anticoncepção.

Na América Latina, o segundo país a implementar a estratégia foi a Bolívia. A etapa diagnóstica foi implementada em 1997, e seu foco recaiu na anticoncepção e na situação do atendimento obstétrico, com ênfase nos fatores que se associados à mortalidade materna. Para isso, foram agregadas duas perguntas:

1. Em que nível científico, técnico, organizacional e operativo funcionam os serviços obstétricos no país?
2. Que aspectos da atenção obstétrica devem ser melhorados para garantir maior cobertura e melhor evolução das emergências?

As perguntas estratégicas são fundamentais para o diagnóstico. Sem elas, existe a possibilidade de que a avaliação perca seu foco. Agregar perguntas acerca de outras questões prioritárias sobre saúde reprodutiva pode levar a uma maior

compreensão desses temas, mas sacrifica a profundidade com que se avalia a introdução de métodos anticoncepcionais (WHO, 2001).

Em 1997 iniciou-se um projeto de pesquisa de ação participativa em sete centros de saúde de dois departamentos: La Paz e Santa Cruz, com o objetivo de melhorar a qualidade de atenção e introduzir os injetáveis trimestrais às opções disponíveis, necessidade detectada na Etapa 1. Na área obstétrica, o Ministério da Saúde iniciou um programa com o objetivo de reduzir a mortalidade materna, apontada por todos como um dos problemas mais importantes no país.

A seguir listam-se os países fora da América Latina nos quais também foi implementada uma ou mais etapas do enfoque estratégico:

- ✓ **China:** O projeto tem como objetivo fundamental a melhoria da qualidade da atenção em planejamento familiar com ênfase na adequada provisão do dispositivo intra-uterino (DIU).

- ✓ **Etiópia:** Neste país, o objetivo principal foi realizar um diagnóstico global da situação da saúde reprodutiva nacional, a fim de definir estratégias para melhorar o acesso e a qualidade dos serviços, especialmente da população jovem.

- ✓ **Laos:** Aqui o enfoque também foi global, mas com ênfase em programas de impacto a curto prazo, focalizando, como área prioritária, as infecções originadas de transmissão sexual.

- ✓ **Myanmar:** O diagnóstico estratégico foi mais centrado na mescla de métodos e na qualidade da provisão do DIU. Na Etapa 2 foi implementado um projeto de ação participativa para melhorar a qualidade em dois distritos.

- ✓ **Romênia:** O diagnóstico estratégico, em fase de planejamento, se centrará basicamente na qualidade dos serviços que oferecem aborto, de prática legal no país.

- ✓ **África do Sul:** O diagnóstico estratégico foi realizado em 1994, logo após as primeiras eleições democráticas no país. O diagnóstico identificou muitos problemas sérios na qualidade dos serviços de planejamento familiar. Na Etapa II deu-se ênfase à reintrodução do *condom*.

- ✓ **Vietnam:** O diagnóstico estratégico tinha como objetivo fundamental estudar o modo como eram oferecidos os métodos. A altíssima prevalência relativa do DIU sugeria que pudesse haver deficiências na instituição da livre escolha de métodos. Na Etapa II, a preocupação fundamental foi melhorar a qualidade da orientação oferecida nos serviços de planejamento familiar e na implementação da livre escolha informada.

- ✓ **Zâmbia:** O foco principal do diagnóstico estratégico foi a mescla de métodos anticoncepcionais. Na Etapa II foi implementado um projeto para melhorar tanto a escolha de métodos quanto a qualidade dos serviços de planejamento familiar. Atualmente está sendo iniciado um projeto de Etapa III para expandir e replicar os procedimentos que demonstraram ser efetivos na Etapa II.

2.2. Pesquisa Participativa

A pesquisa participativa nasceu no seio de movimentos que compartilham uma visão de sociedade na qual não existe dominação. Tais movimentos, trabalhando na área de ciências sociais e na educação de adultos, têm questionado o processo e os propósitos do trabalho nos seus respectivos campos de ação. Eles têm se perguntado se sua atuação está representando uma força que sustenta a dominação, ou como uma força de liberação dos oprimidos. A pesquisa

participativa emerge da experiência de pessoas que convivem e enfrentam francamente as conseqüências políticas de seu trabalho, levando-os a corroborar a correção da observação de Paulo Freire: “A dominação é o tema fundamental da nossa época e a liberação é a meta” (Maguire, 1987, p. 31).

Esse tipo de pesquisa, segundo Patrícia Maguire (1987), combina três atividades: investigação, educação e ação. É um método de investigação social de problemas que envolve a participação de pessoas comuns e oprimidas para identificar e solucionar problemas. É um processo educacional destinado a pesquisadores e participantes que analisam as causas estruturais dos problemas por meio de interação e discussão coletiva. Finalmente, é uma maneira de pesquisadores e pessoas oprimidas juntarem-se solidariamente e tomarem decisões para a adoção de ações coletivas, a curto e longo prazo, a fim de realizar mudanças sociais radicais.

Carlos Rodrigues Brandão reuniu, em seu livro *Pesquisa Participante*, uma série de textos, incluindo os de Paulo Freire e Orlando Fals Borda, entre outros autores comprometidos com esse tipo de pesquisa. Em sua opinião,

> A *participação* não envolve uma atitude do cientista para conhecer melhor a cultura que a pesquisa. Ela determina um compromisso que subordina o próprio projeto científico de pesquisa ao projeto político dos grupos populares cuja situação de classe, cultura ou história se quer conhecer porque se quer agir. (Brandão, 1988, p. 12).

A ligação direta entre a pesquisa e a ação talvez seja o aspecto mais específico da pesquisa participativa. Combinando a criação de conhecimento sobre a realidade social com ações concretas, elimina a dicotomia da pesquisa tradicional entre o saber e o fazer.

Compartilho a idéia de Patrícia Maguire de que a pesquisa participativa é mais que um novo modelo técnico para pesquisas. A pesquisa participativa visa a três tipos de mudanças, que incluem:

- desenvolvimento de uma consciência crítica de ambos: pesquisadores e participantes;
- melhoria de vida das pessoas envolvidas no processo de pesquisa;
- transformação das estruturas e relações sociais fundamentais.

Cabe aqui uma pergunta: Quem educa o/a pesquisador/a para participar desse tipo de pesquisa?

A educação que o/a pesquisador/a precisaria ter uma qualidade diferente. Eles teriam que aprender mais que técnicas de investigação. Seria necessário que o pesquisador assumisse uma posição, um compromisso com a sociedade.

Na opinião de Carlos Brandão,

> Aprender a rede de relações sociais e de conflitos de interesse que constitui a sociedade, captar os conflitos e contradições que lhe imprimem um dinamismo permanente, explora as brechas e contradições que abrem caminho para as rupturas e mudanças, eis o itinerário a ser percorrido pelo pesquisador que se quer deixar educar pela experiência e situação vividas. (Brandão, 1988, p. 25)

Na pesquisa participativa, o pesquisador tem que mudar a mentalidade e os paradigmas aprendidos no que se refere a objetividade e neutralidade e assumir plenamente um compromisso e intencionalidade. Esse é um impasse que muitos pesquisadores vivenciam por terem aprendido uma concepção de pesquisa em que a neutralidade e objetividade eram a regra.

Guacira Louro, como pesquisadora feminista, manifesta o impasse entre ser cientista/pesquisadora ou ser feminista. Segundo ela, seria impossível ser uma pesquisadora feminista se fossem considerados os paradigmas teóricos. Habitualmente a pesquisa se caracteriza por uma atitude objetiva, desinteressada e isenta. Pelo contrário, o feminismo implica um posicionamento político, interessado e comprometido (Louro, 1998).

2.3. Visão da Autora sobre a Educação e suas Interfaces com o Pensamento de Paulo Freire

A concepção de educação que cada pessoa, grupo social e sociedade têm varia de acordo a concepção de homem, de mundo, de sociedade e do próprio processo educativo.

A educação é um processo universal pelo qual todo mundo passa do nascimento à morte, mas que varia de acordo com a sociedade em que se realiza (Piletti, 1990).

Minha visão a respeito da educação foi se construindo a partir das vivências, interações, reflexões, discussões, questionamentos, impasses, leituras, processos formais e informais de aprendizagem, da prática profissional, enfim, de minha própria trajetória pessoal e política.

A educação está imbricada em minha atuação profissional, ou seja, ser enfermeira e educadora ao mesmo tempo tem sido minha práxis.

Considero que educação e saúde são processos dinâmicos interligados, na medida em que se centram na pessoa humana e seu entorno. Como profissional de saúde, meu papel é contribuir para que as pessoas busquem e alcancem bem-estar e, como educadora, ajudá-las em seu crescimento pessoal e social, o que certamente será uma contribuição para seu bem-estar.

Dentro dessa visão de integração de educação e saúde, minha compreensão de pessoa é a de (re)conhecer as pessoas como seres únicos, históricos, com o entorno social, cultural, político e econômico que os influencia e é influenciado por eles. Em minha opinião, todas as pessoas, inclusive as que não freqüentaram a escola, são sujeitos que possuem conhecimentos próprios, construídos como parte de sua vivência no mundo. Também são pessoas que se relacionam com

outras, e nessas relações vão se produzindo novos conhecimentos. Cada pessoa tem o direito e a capacidade de pensar, de dialogar, de ter opiniões próprias e a partir daí fazer suas próprias escolhas. O problema é que muitas vezes essas pessoas não têm oportunidade de participar das decisões sobre sua própria vida.

Nossa sociedade reconhece, em teoria, esses direitos, e nesse contexto o discurso anterior passaria a ser óbvio, porém o modo de pensar e agir das pessoas e das instituições, na prática, mostra-se muito diferente. Ou seja, há uma distância entre a teoria e a prática, e não é difícil compreender a razão dessa distância, quando analisamos nossa própria formação de profissionais de saúde.

O modelo de educação incorporado na formação dos profissionais de saúde é um modelo de "educação bancária", em que os educandos recebem conteúdos de maneira passiva, não tendo oportunidade de participar. Esse modelo é replicado na prática profissional, e o ser humano, o paciente, é visto como um ser orgânico, no qual se privilegiam os aspectos biológicos relacionados com as doenças. Essa pessoa, "o doente", é visto como uma pessoa passiva, daí "paciente", que espera que o médico ou a enfermeira decidam o que ele tem e lhe dêem instruções sobre o que fazer. Feito um diagnóstico, prescreve-se uma medicação e habitualmente nem sequer se pergunta se a pessoa tem condições de comprar e de usar o remédio.

Essa concepção "bancária" de educação tem sido amplamente criticada por muitos autores, embora continue se reproduzindo nas escolas, na formação de profissionais de saúde e dos próprios educadores. Paulo Freire dizia:

> Na visão "bancária" da educação o "saber" é uma doação dos que se julgam sábios aos que julgam nada saber. Doação que se funda numa das manifestações instrumentais da ideologia da opressão – a absolutização da ignorância, que constitui o que ele chama de alienação da ignorância, segundo a qual esta se encontra sempre no outro. (Freire, 2000, p. 58).

Em sua opinião, o educador que aliena sua ignorância será sempre o que sabe, enquanto os educandos serão sempre os que não sabem. Isso faz com que o educador se posicione sempre numa relação de poder, impedindo-os de aprender. A rigidez dessas posições nega a educação e o conhecimento como processos de busca (Freire, 2000).

Na área de planejamento familiar, da mesma forma que nas demais, o profissional de saúde pensa que sabe o que é melhor para as pessoas e "indica o método anticoncepcional" em vez de lhes dar liberdade para escolher. Além disso, muitas vezes a ciência maneja informações que não são compartilhadas com as pessoas que estão fora desse círculo por se achar que elas não farão um bom uso dessa informação. Um exemplo é a informação sobre anticoncepção de emergência, que se manteve como conhecimento de pesquisadores por mais de vinte anos. Quando se decide compartilhar novos conhecimentos ou informações, habitualmente são usados métodos educativos como "palestras" (também réplica das próprias aulas que temos em nossa formação) em linguagem técnica, de difícil entendimento pelas pessoas não pertencentes à área.

Arrisco-me a ser contestada e criticada por alguns profissionais que não se identificam com essa descrição, porém penso que é só quando se reconhece a realidade que é possível fazer alguma coisa para transformá-la.

Compartilho a opinião de Paulo Freire quando ele diz que é pensando criticamente em relação à prática de hoje e/ou de ontem que se pode melhorar a seguinte e que essa reflexão crítica sobre a prática é fundamental na formação permanente dos educadores (Freire, 2001).

Paulo Freire também diz: "Não há palavra verdadeira que não seja práxis. Daí que dizer a palavra verdadeira seja transformar o mundo". (Freire, 2000, p. 77).

Entretanto, ele salienta que uma crítica sem compromisso de ação é uma crítica vazia.

Além de Paulo Freire, outros pensadores da teoria crítica, tais como Young, Bourdieu, Althusser, Apple e Giroux, afirmam que o papel da educação é construir o homem autônomo e vinculam a educação a um projeto emancipatório. Eles vêem a teoria crítica como um processo autoconsciente que visa necessariamente a uma vinculação entre teoria e prática, com o objetivo de transformar as estruturas sociais vigentes (Pucci, 1995).

Horkheimer, um dos mais expressivos integrantes da Escola de Frankfurt, relaciona a Teoria Crítica com a Teoria Tradicional e reconhece que uma das metas da Teoria Crítica é transformar a sociedade pela prática (*apud* Prestes, 1995).

Em termos mais específicos, os membros da Escola de Frankfurt apontam o pensamento crítico como uma das características construtivas da luta pela auto-emancipação e pela mudança social, argumentando que “era nas contradições da sociedade que se poderia começar a desenvolver formas de investigação social que analisassem a distinção entre o que é e o que deveria ser.” (Giroux, 1986, p. 23).

Há mais de quinze anos tive uma experiência que me fez tomar consciência da importância de se pensar criticamente em relação à prática e à necessidade de incorporar o componente educação como um elo entre as usuárias de métodos anticoncepcionais e os cientistas que trabalham nas pesquisas com novos métodos anticoncepcionais.

Fiz uma visita de supervisão a um país latino-americano para verificar se o protocolo de pesquisa estava sendo cumprido. Entre os itens a examinar incluí-se

a revisão das fichas clínicas para observar se elas estavam sendo preenchidas corretamente.

Segundo minha visão, as fichas representavam pessoas, e assim pedi para conversar com uma mulher que estava solicitando a retirada do método. A ficha dizia: “descontinuação por causa pessoal” (o marido queria que ela deixasse de usar o método). Conversando com a mulher perguntei: “Por que seu marido quer fazer isso?”. E ela respondeu: “Porque estou sangrando todos os dias e desse jeito a gente não pode ter relação sexual”. Percebi então que a verdadeira causa, que era o sangramento produzido pelo método, não estava sendo reconhecido pelos cientistas. Este, como muitos tantos exemplos ao longo dessa experiência, me mostrou que muitas vezes os dados colhidos pela investigação não correspondem à realidade, e isto se agrava quando a pessoa não tem oportunidade de falar além do que o investigador pergunta. E, baseados nesses dados são tomadas muitas decisões envolvendo essas mulheres, inclusive no nível de políticas públicas.

Nesse caso, em particular, aprendi que o diálogo e a informação podem mudar decisões cruciais para a vida das pessoas. Quando a pessoa me disse o que se passava, expliquei-lhe (saindo de meu papel de investigadora) que o sangramento escasso, se não a incomodava, não a impediria de ter relações sexuais (dei uma informação). A decisão de deixar de usar um método anticoncepcional mudou, e provavelmente algo em sua vida também mudaria futuramente.

A partir desse simples exemplo, pode-se pensar em diferentes aspectos que mereceriam ser analisados sob o enfoque da educação:

- A mulher e sua relação com o homem, na qual o homem decide que ela não deve usar mais um determinado método; ou seja, poder do homem para decidir sobre a vida da mulher.

- A atitude dos profissionais de saúde frente a essa situação, aceitando a desigualdade de gênero, não questionando o fato apresentado.
- A falta de informação impede que a usuária compreenda melhor o que está acontecendo e deixe de tomar uma decisão baseada na informação.
- A falta de diálogo entre profissional e usuária, que leva a uma compreensão equivocada da realidade por parte de ambos os lados.
- A falta de aprofundamento na forma de investigar resulta em dados que não representam a realidade.

Poderíamos continuar relatando outras experiências que, como esta, colaboraram na construção de minha postura crítica em relação à visão que os serviços de saúde tinham (e têm) das pessoas, as relações existentes entre profissionais e usuárias e as relações entre pesquisa, profissionais e pessoas.

Frente a essa realidade e tentando visualizar uma maneira de mudá-la, vai-se delineando e fortalecendo em mim a compreensão da dimensão e do poder da educação na transformação dos sistemas de saúde.

A educação, numa visão libertadora, pode permitir a diminuição da distância entre o mundo acadêmico e as pessoas, permite também que as pessoas tenham acesso ao diálogo, à participação, a compreensão dos novos conhecimentos e das novas tecnologias, ou seja, parte do reconhecimento de que há uma distância. Reconhece que existe opressão, como também vê no educador um facilitador, mas a busca de liberdade e autonomia é um movimento das próprias pessoas.

Vejo a educação na saúde com intencionalidade – a de humanizar as pessoas, diminuir as relações de poder existentes ou, melhor dizendo, restringir o abuso de poder, democratizando as relações e possibilitando com isso o conhecimento.

Na visão de Paulo Freire, o conhecimento é produto das relações dos seres humanos entre si e com o mundo. Nessas relações, homens e mulheres são

desafiados a encontrar soluções para as quais é preciso dar respostas adequadas. Para isso, as pessoas precisam reconhecer a situação, compreendê-la, imaginar formas diferentes de respostas e selecionar a mais adequada. A cada resposta, novas situações se apresentam e outros desafios vão se sucedendo. Essas respostas e suas conseqüências representam experiências adquiridas e constituem os conhecimentos das pessoas, que ficam registrados na memória, ajudando a construir novas respostas (Barreto, 1998).

Toda prática é influenciada por diferentes autores e pela própria experiência. Meu percurso profissional foi sendo solidificado ao longo de minha trajetória, e hoje reconheço grande identificação com as idéias de Paulo Freire.

Inscrevo-me em sua visão de mundo e de ser humano, em quem ele reconhece um ser de relação, um ser em busca de sua completude, um sujeito de sua história. Em sua visão, o ser humano tem uma vocação para “ser mais” e que esse “ser mais” se realiza pela educação. Mas tal vocação deixa de se concretizar quando as relações entre os homens se desumanizam. Ele afirma que isso se deu historicamente quando elas deixaram de se caracterizar pela cooperação e passaram a ser relações de dominação. Ou seja, os que detinham o poder passaram a abusar dele a fim de obter privilégios para si e seus iguais, em prejuízo dos outros (Barreto, 1998).

Penso que as políticas dos serviços de saúde apresentam em geral uma situação opressora e de desumanização em que se valoriza mais a tecnologia que o ser humano. Em muitos programas as pessoas são vistas como objetos em vez de sujeitos.

Frente a essa situação, considero fundamental incorporar uma proposta de educação que se traduza em força de mudança e de libertação. Como dizia Paulo Freire, deve-se fazer uma opção: “...‘educação’ para a ‘domesticação’, para a

alienação, e uma educação para a liberdade. ‘Educação’ para o homem-objeto ou educação para o homem-sujeito” (Freire, 1999, p. 44).

Nossa opção é uma educação voltada para as pessoas (homens e mulheres), a fim de que elas exerçam sua cidadania e busquem as transformações necessárias para viver melhor e com mais saúde.

3. O Projeto: A Implementação da Estratégia da OMS no Brasil

Por que a Estratégia Foi Implementada no Brasil

No ano de 1993, quando a Organização Mundial da Saúde decidiu implementar a Nova Estratégia de Introdução de Métodos Anticoncepcionais, eram numerosos os países que apresentavam grandes necessidades na área do planejamento familiar mostrando-se terrenos férteis para a semeadura da estratégia. Alguns, no entanto, não haviam definido políticas para o planejamento familiar nem tinham propostas voltadas para a melhoria da qualidade de atenção, não dispunham de recursos -- no presente ou potenciais – para a implementação, ou não havia disposição das autoridades para apoiar esse tipo de atividade.

O Brasil foi proposto como candidato a ser o primeiro país a implantá-la porque alguns membros da equipe encarregada da aplicação da estratégia já faziam parte da força-tarefa da OMS que coordenava o processo e porque o Centro de Pesquisas Materno-Infantis de Campinas[3] (Cemicamp) já tinha uma larga experiência na coordenação de estudos introdutórios de métodos anticoncepcionais,

A primeira reação do comitê da força-tarefa foi de relutância, porque alguns dos indicadores quantitativos de planejamento familiar no Brasil eram satisfatórios e mostravam uma situação parecida com a dos países desenvolvidos, com programas de planejamento familiar de alta qualidade.

[3] O Centro de Pesquisas Materno-Infantis de Campinas – Cemicamp é uma entidade civil, sem fins lucrativos, sem conotação política de qualquer ordem, autônomo, de iniciativa privada, podendo receber os auspícios de instituições universitárias federais, estaduais, municipais e particulares, tanto nacionais como internacionais, que pretendem colaborar com os objetivos preconizados, atuando na área de reprodução humana e planejamento familiar.

De fato, o crescimento populacional do Brasil estava diminuindo, como mostra a tabela 2.

TABELA 2: População do Brasil de 1940 a 2000 e Percentual de Aumento por Década

ANO	População	Percentual de aumento
1940	41.236.315	----------
1950	51.944.397	20,61
1960	70.070.457	25,87
1970	93.139.037	24,77
1980	119.002.706	21,73
1991	146.825.475	18,94
2000	169.590.693	13,42

Fonte: adaptado da História dos Censos. (www.ibge.gov.br)

As décadas de 1950 e 1960 apresentaram as taxas de crescimento populacional mais aceleradas da história, 25,87 e 24,77% respectivamente. Na década de 1970 o crescimento diminuiu para 21,73% e nos 11 anos entre 1980 e 1991, o crescimento foi só de 18,94%. Essa tendência continua e, entre 1991 e 2000, o crescimento foi só de 13,42% (www.ibge.gov.br).

Essa tendência se deve, pelo menos em parte, ao aumento significativo da prevalência do uso de métodos anticoncepcionais, que no ano 1986, segundo a Pesquisa Nacional de Demografia e Saúde, já era de 66% entre as mulheres unidas ou casadas de 15 a 44 anos (Tabela 3). No ano 1993, quando começou a ser implantada a estratégia, a prevalência já deveria estar acima de 70%, considerando que a Pesquisa Nacional de Demografia e Saúde de 1996 mostrou que a prevalência era de 76,7% (BEMFAM, 1997).

TABELA 3: Uso Atual de Métodos em Mulheres Unidas de 15-44 Anos (percentual)

Método	%
Pílula	25
Coito interrompido	5
Abstinência periódica Condom	4
Esterilização feminina	27
Outros métodos Vasectomia	5
Total	**66**

Fonte: BEMFAM, 1987

Uma análise mais detalhada, porém, mostrava que a situação não era tão boa como os indicadores quantitativos brutos sugeriam. Como exemplo, a alta taxa de uso de anticoncepcionais estava concentrada quase exclusivamente na pílula e na ligadura de trompas ou esterilização feminina. Apesar de vários autores atribuírem a alta prevalência da ligadura de trompas a múltiplos fatores culturais e sociais (Vieira, 1994; Minella, 1998), é indiscutível que isso também se deve à falta de acesso da população a métodos reversíveis aceitáveis. O único método disponível de maneira mais ou menos ampla para a população era a pílula e, no setor público, o acesso a esse método também era muito restrito. As pesquisas sobre população mostravam que mais de 75% das mulheres que usavam a pílula obtinham-na diretamente da farmácia, na grande maioria das vezes sem prescrição médica (WHO, 1994b).

Por outro lado, apesar da alta prevalência de uso de anticoncepcionais, o Brasil também tem se caracterizado por uma incidência igualmente muito alta de aborto. Embora as estatísticas sobre o aborto não sejam completamente fidedignas, a estimativa mais confiável, para 1992, é que nesse ano tenham ocorrido entre 800 000 e 1 400 000 abortos, a maioria induzidos e em condições sanitárias precárias, que põem a mulher em situação de alto risco de apresentar complicações graves e até de morte (The Alan Guttmacher Institute, 1994). É

também importante destacar que, apesar da fecundidade total estar baixa e com tendência a seguir diminuindo, a fecundidade do grupo etário 15-19 teve poucas variações nos últimos 20 anos, como já foi mostrado na Tabela 1.

Essa tendência da fecundidade tem se traduzido num aumento percentual dos partos em mulheres com menos de 20 anos, que representam, atualmente, mais do 20% do total e, em algumas regiões, mais de 30%. Infelizmente, as estatísticas mostram que o aborto também é muito freqüente nessa faixa etária, com uma alta taxa de morbidade (www.datasus.gov.br).

O Brasil tem atualmente a maior população de mulheres adolescentes de toda a sua história, e isso, somado à manutenção da alta fertilidade nesta faixa etária, explica por que esse grupo está passando a ser cada vez mais importante para os programas de saúde reprodutiva.

Além disso, o intervalo intergenésico também é menor na faixa etária de 15-19 anos. Nesse grupo, a mediana de tempo entre os partos é de 18,9 meses, enquanto é de 29,2 no grupo de 20-29 e 46,9 para o grupo de 30 a 39 anos (www.saude.gov.br).

A mortalidade materna também era um dado preocupante na época. Embora os dados sobre mortalidade materna não sejam muito confiáveis, as cifras oficiais sobre mortalidade materna no Brasil eram de 72 mortes por 100 000 nascidos vivos (WHO, 1994b). Entretanto, aceita-se que essa cifra deve multiplicar-se pelo fator 2, devido às grandes subenumerações das mortes maternas (Laurenti *et al.*, 1990).

O governo brasileiro estava muito preocupado com a situação da saúde reprodutiva no país e empreendia grandes esforços para completar a implementação do Programa de Atenção Integral à Saúde da Mulher (PAISM), razão pela qual considerou que a realização do diagnóstico estratégico seria de

grande utilidade para o planejamento das atividades futuras. O Cemicamp, em parceria com o Ministério da Saúde, solicitou à OMS colaboração técnica para implementar a estratégia, o que foi aceito pela Força Tarefa da OMS.

3.1. Etapa I

3.1.1. Objetivos

1. Realizar um diagnóstico estratégico da situação do planejamento familiar no Brasil, tendo como referência o enfoque e as três perguntas estratégicas.

2. Avaliar a integração do planejamento familiar no Programa de Atenção Integral à Saúde da Mulher (PAISM).

3. Avaliar o grau de compreensão e incorporação dos conceitos de saúde reprodutiva e direitos sexuais e reprodutivos.

4. Identificar intervenções prioritárias que pudessem contribuir para a melhoria do acesso e da qualidade dos serviços de saúde reprodutiva/planejamento familiar.

3.1.2. Método

O diagnóstico estratégico é um diagnóstico quantitativo e qualitativo da situação dos serviços na área da saúde reprodutiva, com ênfase no planejamento familiar. Difere de outras metodologias diagnósticas, tais como a análise situacional (*situation analysis*) ou diagnóstico rápido de necessidades (*rapid needs assessment*), por um particular: o diagnóstico estratégico visa propor intervenções para resolver os problemas detectados por meio das respostas às perguntas estratégicas, que devem ser formuladas antes da realização do trabalho de campo.

A Etapa I incluiu os seguintes passos:

1. *Compilação dos dados já existentes*

   Foram compilados os dados publicados até então sobre o que seria investigado, com ênfase nos documentos que pudessem ser úteis para responder às perguntas estratégicas para o planejamento familiar, as quais já haviam sido determinadas no documento original da estratégia. No entanto, a flexibilidade da metodologia permitiu que, depois da análise dos dados existentes, fossem incorporadas perguntas adicionais, por exemplo, como as questões de sexualidade e gênero eram abordadas nos serviços de saúde. A compilação de documentos foi distribuída para todos os membros da equipe de campo, para que eles conhecessem a informação antes de iniciar as visitas.

   Para facilitar a utilização dessa compilação na realização do diagnóstico estratégico nos países que o realizaram posteriormente, a compilação das informações foi organizada num documento básico, para ser lido por toda a equipe participante do diagnóstico, antes do trabalho de campo.

2. *Reunião com autoridades e representantes de instituições relevantes nessa área que pudessem estar interessados no diagnóstico*

   Essa etapa foi fundamental na obtenção do apoio das instituições locais, que devem se apropriar do processo desde o começo, e na clara definição dos objetivos do diagnóstico, entre eles a definição e a discussão das perguntas estratégicas.

   Nessa reunião, foi muito importante a participação de representantes tanto do Ministério da Saúde, quanto dos provedores de serviços e da comunidade, incluindo grupos de mulheres. Dela surgiram nomes dos possíveis

participantes no trabalho de campo e/ou pessoas que pudessem colaborar na identificação das que fariam parte da equipe.

3. *Definição da equipe*

A equipe de pesquisa foi formada por dois ou três profissionais com experiência prévia em pesquisa qualitativa (no caso do Brasil, pesquisadores da OMS e do Cemicamp). Esse núcleo básico de pesquisadores, num processo colaborativo com o Ministério da Saúde, e de acordo com as sugestões recebidas, selecionou os membros da equipe, levando em conta a representatividade de diversas instituições ou grupos que não deveriam ficar fora do processo, tais como:

- Ministério da Saúde
- Diretores de programas ou serviços de planejamento familiar
- Representantes de trabalhadores da área da saúde de diversos níveis profissionais
- Representantes de grupos de mulheres
- Representantes do setor universitário
- Representantes da comunidade

Além da representatividade na formação da equipe, o núcleo central de pesquisadores estabeleceu que os membros da equipe deveriam pertencer a diferentes áreas e ter variadas profissões, garantindo um equilíbrio entre pesquisadores da área biomédica e das ciências sociais. Além disso, houve uma preocupação em se obter também um equilíbrio de gênero, para garantir que a perspectiva das mulheres estivesse presente (os membros das equipes são os co-autores da publicação da OMS com os resultados do diagnóstico estratégico).

4. *Escolha dos lugares a serem visitados e pessoas a serem entrevistadas*

A definição dos lugares a pesquisar também é da maior importância. Na seleção foram levados em conta vários critérios, tais como qualidade estimada dos serviços, nível social e econômico da população, porcentagem de população urbana, nível de educação, disponibilidade de serviços de alta complexidade e colaboração prévia e/ou atual das agências internacionais. Além disso, foram escolhidos estados que representassem diversas regiões do país e onde o PAISM tivesse sido incorporado.

Considerando esses fatores, a decisão final foi escolher três estados e o Distrito Federal:

- Mato Grosso, estado com recursos limitados na área da saúde, com indicadores pobres em matéria de saúde reprodutiva, onde não tem havido colaboração importante das agências internacionais.
- Ceará, estado também de recursos limitados, com uma porcentagem relativamente alta de população rural pobre, onde as agências colaboradoras da USAID e outras instituições filantrópicas vinham implementando, durante vários anos, projetos destinados a melhorar o planejamento familiar.
- São Paulo, o estado mais rico da União, teoricamente com muitos recursos financeiros e humanos, de população predominantemente urbana, com uma rede pública de saúde que cobre todo o estado, onde as agências internacionais têm tido uma atividade limitada, mas em que havia uma grande participação dos movimentos de mulheres no governo.
- O Distrito Federal foi escolhido porque o Ministério da Saúde considerou muito importante mostrar a situação de um sistema teoricamente muito bem implementado, e porque, estando sob a influência direta do

governo federal, todos os achados teriam grande destaque, o que daria maior relevância e visibilidade ao programa.

5. *Preparação do cronograma e dos instrumentos de coleta de informação a serem utilizados*

   A equipe básica de pesquisadores preparou os instrumentos de coleta de dados e definiu o cronograma das atividades.

6. *Reunião da equipe de pesquisa*

   Embora os profissionais participantes tivessem experiência em pesquisa qualitativa, não tinham experiência com a estratégia, razão pela qual a reunião da equipe foi fundamental para esclarecer os objetivos e o método que seria utilizado, bem como para elaborar os instrumentos a serem utilizados.

   Nesta reunião também foi definido quem seriam as pessoas que coordenariam o trabalho de campo. Esse grupo coordenador foi formado por Ruth Simmons, da Universidade de Michigan, que liderou o trabalho de campo, Margarita Díaz, do Cemicamp e Peter Hall, da OMS. Essas pessoas tiveram a responsabilidade de coordenar as atividades, recopilar toda a informação recolhida pelos membros da equipe, coordenar reuniões periódicas durante o trabalho de campo, a fim de manter uma avaliação continua do processo e liderar a preparação do relatório final do trabalho.

7. *Trabalho de campo*

   - Toda a equipe visitou os estados escolhidos.
   - Em cada localidade visitada, a equipe dividiu-se em sub-equipes, para trabalhar com diversos setores (serviços, autoridades, comunidade, laboratórios, farmácias etc.).

- Ao fim de cada dia, a equipe reunia-se, para discutir e redigir as principais conclusões do dia.
- Cada subgrupo entregava um resumo das atividades do dia a um dos membros da coordenação.

8. *Preparação da primeira versão do relatório*

Uma vez finalizado o trabalho de campo, o grupo reuniu-se durante uma semana para discutir os achados e escrever a primeira versão do relatório. Depois dessa semana, Ruth Simmons e Margarita Díaz coordenaram a revisão, de que participou toda a equipe, e concluíram a primeira versão.

9. *Seminário/oficina de apresentação dos resultados*

O relatório foi apresentado num seminário/oficina de trabalho organizado pelo Ministério da Saúde, em Brasília, que contou com a participação de profissionais dos estados que participaram do trabalho de campo, representantes do Ministério da Saúde, grupos de mulheres e agências internacionais.

A discussão foi muito rica e foram feitas sugestões muito importantes que se incorporaram ao relatório final.

10. *Preparação e publicação do relatório final*

As duas pesquisadoras principais (Ruth Simmons e Margarita Díaz) prepararam o relatório final, incluindo as sugestões do seminário/oficina.

O relatório foi publicado pela Organização Mundial da Saúde.

Incorporando o Componente Educativo no Diagnóstico Estratégico

Desde a participação no primeiro diagnóstico estratégico até os dias de hoje, muito temos aprendido. A experiência de colegas de diversos países do mundo, minha participação na elaboração de um guia que permitisse facilitar a compreensão dessa nova metodologia, a facilitação de um seminário para compartilhar a experiência com outros países latino-americanos e o exercício de pensar com um grupo de profissionais a adaptação das perguntas estratégicas para realizar um diagnóstico sobre HIV/Aids nas fronteiras do Brasil, possibilitaram-me advogar no campo nacional e internacional pela incorporação de um componente educativo sistematizado como parte da Etapa I.

Nas experiências anteriores foi realizada uma reunião para reelaboração das perguntas estratégicas, definição dos instrumentos e organização do trabalho de campo. Entretanto, é natural que pessoas distintas que façam parte de uma equipe tenham diferentes concepções de sujeitos, de mundo, de educação, de pesquisa e de intencionalidade. É freqüente também as relações de poder entre membros de uma equipe, que precisam ser discutidas e refletidas, no sentido de se rever a maneira como se desenvolvem as relações entre eles, com as usuárias, o serviço etc.

Compreender um modelo teórico e a maneira como ele é aplicado na prática depende, em grande parte, do(a) pesquisador(a). Ou seja, olhar conjuntamente para as usuárias, os serviços e a tecnologia dentro de seu contexto cultural, social, político e econômico e trabalhar de maneira integrada vai além do conhecimento da metodologia, implicando um posicionamento realmente interessado e comprometido do(a) pesquisador(a) com as mudanças posteriores. Esta é a diferença com relação a pesquisas em que o papel do investigador termina ao apresentar os dados do diagnóstico.

Essa experiência nos levou a concluir que, antes de se iniciar o trabalho de campo, a equipe de pesquisa deve passar por um treinamento específico para realizar essa tarefa. Isso permite que a equipe entenda bem a metodologia e garante que seus diferentes componentes trabalharão usando os mesmos parâmetros.

3.1.3. Publicações

- World Health Organization. “An assessment of the need for contraceptive introduction in Brazil”. **Expanding Family Planning Options,** Geneva: WHO, 1994. 60 p.
- Simmons, R.; Hall, P.; Díaz, J.; Díaz, M.; Fajans, P.; Satia, J. “The Strategic Approach to Contraceptive Introduction”. **Studies in Family Planning,** v. 28, n. 2, p. 79-93, 1997.

EXPANDING FAMILY PLANNING OPTIONS

AN ASSESSMENT OF THE NEED FOR CONTRACEPTIVE INTRODUCTION IN BRAZIL

Report of an assessment undertaken by:

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Foreword

This document is the second of a series from the Special Programme of Research, Development and Research Training in Human Reproduction's Task Force on Research on the Introduction and Transfer of Technologies for Fertility Regulation.

The first document entitled "Contraceptive introduction reconsidered: a review and conceptual framework" described a three-stage strategy developed by the Task Force to assist family planning programmes in developing countries in decision-making on whether to introduce a new method of fertility regulation, reintroduce or improve utilization of currently available methods, or remove an existing method. This document is a report on an assessment of the need for contraceptive introduction in Brazil and represents the first application of the new strategy. The assessment was undertaken as a participatory exercise based on a national research institution, Centro de Pesquisas e Controle das Doenças Materno-Infantis (CEMICAMP), linked to the University of Campinas in the State of Sao Paulo. The participants in the assessment represented the Coordenadoria Materno-Infantil of the Ministry of Health, the WHO Task Force, CEMICAMP and two women's organizations, Colectivo Feminista Sexualidade e Saúde and União Brasileira de Mulheres.

The report gives the main findings from this Stage I Assessment, draws conclusions on the existing method mix, and makes recommendations for further research and dissemination of research findings. It is hoped that the report and subsequent activities will assist the Government of Brazil in expanding family planning options and in improving the quality of care of reproductive health services.

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List of Acronyms

ABEPF	Associação Brasileira de Entidades de Planejamento Familiar
AIDS	Acquired imuno-deficiency syndrome
BEMFAM	Sociedade Civil Bem-Estar Familiar no Brasil
CBD	Community based distribution
CEMICAMP	Centro de Pesquisas e Controle das Doenças Materno-Infantis
CEPARH	Centro de Pesquisas e Assistência em Reprodução Humana
COMI	Coordenadoria Materno-Infantil, MOH
DHS	Demographic and Health Survey
DIPROD	Divisão de Produtos, MOH
DMPA	Depot medroxyprogesterone acetate
FEBRASGO	Federação Brasileira de Sociedades de Ginecologia e Obstetrícia
HMO	Health maintenance organization
HRP	Special Programme for Research, Development and Research Training in Human Reproduction
IEC	Information, education and communication
IMIP	Instituto Materno Infantil de Pernambuco
INAMPS	Instituto Nacional de Assistência Médica e Previdência Social
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
MIS	Management and information system
MOH	Ministry of Health
NET-EN	Norethisterone enanthate
NGO	Non-governmental organization
PAISM	Programa de Assistência Integral à Saúde da Mulher
PAHO	Pan American Health Organization
PNAD	Pesquisa Nacional por Amostragem Domiciliar
SAS	Secretaria de Assistência à Saúde-MOH
SEADE	Sistema Estadual de Análise de Dados
STD	Sexually transmitted disease
SUS	Sistema Único de Saúde
TFR	Total fertility rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WB	World Bank

Introduction

This report presents results from a contraceptive introduction needs assessment for Brazil undertaken as part of the new strategy for contraceptive introduction developed by the World Health Organization's Task Force on the Introduction and Transfer of Technologies for Fertiltiy Regulation (Spicehandler and Simmons, 1994). This new approach is based on a three stage process that begins with an initial broad-based assessment of country needs (Stage I Assessments), and where appropriate is followed by a subsequent research phase (Stage II) and policy dialogues about the utilization of research findings for programme planning and implementation (Stage III).

The first Stage I Assessment was undertaken for Brazil in October and November of 1993 as a collaborative effort between the Ministry of Health of Brazil, WHO, Centro de Pesquisas e Controle das Doençcas Materno-Infantis (CEMICAMP) and representatives from two women's organizations. This report summarizes key findings from the assessment.

The purpose of this assessment was to answer three central questions: 1) Is there a need to introduce new contraceptive methods? 2) Is there a need to reintroduce or appropriately introduce existing methods? and 3) Is there a need to remove any existing methods from a given setting? We are aware that this report does not present new data, however, it does review available data as well as information obtained during field visits and identifies needs for action and research.

Objectives and Framework of the Stage I Assessment

Previous introductory efforts have typically focused on a single, new contraceptive method. A key step in this type of introductory process has been to explore the introduction of a method through research which is primarily intended to allow professionals, researchers and policy makers gain experience with the new technology. Such introductory studies tend to produce recommendations about how the new method could be introduced into a country programme, but may not provide an indication of the overall feasibility of the introduction or an indication of the likely impact of introduction on overall quality of care in the family planning system.

The new WHO strategy for contraceptive introduction is based on the principle that introductory research or decisions about using a new technology should be preceded by an assessment of a country's method mix, its service delivery capabilities, and user perspectives and needs. This approach has been adopted to assure that introductory efforts arise out of the real needs of countries for new methods, and are considered only in

those settings where service delivery capabilities exist to introduce new methods with appropriate levels of quality of care. Such contraceptive introduction needs assessments (Stage I Assessments), which are intended to provide answers to the three central questions referred to above.

When these three questions are emphasized, the focus of introductory efforts shifts from attention to one particular new method to the examination of the method mix as a whole. The method mix focus in this approach to contraceptive introduction derives from a concern for quality of care, especially for choice. The argument is that the goal of contraceptive introduction is to increase the meaningful rather than theoretical contraceptive options available to women. Methods should be available to "serve significant subgroups as defined by age, gender, contraceptive intention, lactation status, health profile and- where cost of method is a factor - income groups" (Bruce, 1990). In other words, the assessment should determine whether there are satisfactory choices for those men and women who wish to space, those who wish to limit, those who cannot tolerate hormonal contraceptives, and so forth. It is in this context that addition of new methods, strengthened delivery of available methods or elimination of outmoded or potentially unsafe methods should be considered.

Using this method mix approach, attention moves from an exclusive focus on the introduction of new methods to also including an examination of existing methods. This shift in focus is important for a number of reasons. There are many examples of programmes where methods which could meet identified needs are physically available within the service delivery system but which have never been properly introduced, or, for a variety of reasons, are inappropriately utilized or underused. In addition to providing information on ways to improve the utilization of currently available methods, examining the quality of care given for existing methods will help a programme to anticipate the impact of the introduction of a new method on the method mix and overall quality of care. To provide an example, WHO sponsored research on the introduction of Cyclofem in Indonesia highlighted the need for attention to the service delivery of existing injectables, depot medroxyprogesterone acetate (DMPA) and norethisterone enantate (NET-EN), and raised questions about the appropriateness of introduction of a new method before problems with the available injectables had been addressed (Simmons et al., 1994; Lubis et al., 1994).

When examining the method mix, it is also necessary to consider which methods, such as high dose oral contraceptives, may no longer be appropriate given advances in technology, or research which questions the safety of a previously accepted formulation. Thus, in examining the broader contraceptive method mix of a country, Stage I Assessments should ascertain whether a programme provides methods that should be withdrawn from a service delivery system in addition to addressing questions about the need

for contraceptive introduction or reintroduction.

The three central questions can be answered through an analysis of the method mix, the quality of care with which methods are provided, service delivery capabilities, and the needs and perspectives of actual or potential users.

The method mix: demand, availability and accessibility: The Stage I Assessment for Brazil studied method mix from the perspective of demand, availability, and accessibility. Need or demand for methods is reflected in patterns of use. This was examined through an analysis of available contraceptive prevalence surveys and direct observation and discussions with family planning managers and service providers. Availability refers to the physical presence of methods at various service delivery points, while accessibility focuses on the time, money and distance involved in gaining access to the method as described by users and providers. These issues were evaluated both in public sector and private/commercial settings.

Quality of care in contraceptive service delivery: In a general sense, quality of care can be defined as "the way individuals and clients are treated by the system providing services" (Jain and Bruce, 1989). Analysis of how people are treated by service delivery systems implies a judgement about the goodness of services or of their various dimensions (Donabedian, 1980). Bruce (1990) identified six elements of quality of care, namely: 1) choice of methods; 2) information given to clients; 3) technical competence; 4) interpersonal relations; 5) mechanisms to encourage continuity; and 6) appropriate constellation of services.

Service delivery capabilities: A focus on service delivery capabilities is unusual in most contraceptive introduction efforts. Previous efforts have assumed that service delivery capabilities would be adequate to provide the new technology or could be improved where necessary. However, many public sector programmes are severely constrained in their resource base, in the technical skills and competence of their staff, and in the availability of physical facilities, logistics and supplies systems, administrative and technical supervision, etc. It is increasingly recognized that introducing new contraceptive methods adds burdens and complexities to the service delivery, training, and administrative/ operational systems which may act to reduce rather than improve quality of care. If addition of new technology is to improve the quality of care, it is not adequate to focus only on training and guaranteeing supplies of the newly introduced method. There must be some certainty that the service delivery system has the necessary human and physical resources, and commitment to put in place the support systems which make it possible for new methods to be provided with an appropriate level of quality of care and for quality to be maintained for the full method mix.

User perspectives and perspectives of women's groups: Contraceptive use patterns are a necessary but not sufficient component in the analysis of user perspectives and needs. It is

equally important to understand users' attitudes towards, and experience with particular methods. Such examination of user perspectives, based on available research on and user knowledge of contraceptive practices, beliefs, and needs are an important component of Stage I Assessments. Additional valuable information can be obtained through dialogues with women's groups about their experiences with and perspectives on contraceptive technology.

Information obtained from an analysis of each of these areas was used to answer questions on the need for contraceptive introduction in Brazil. A further discussion of method mix, quality of care, service delivery capabilities and user perspectives are provided in the following chapters.

Government of Brazil and WHO collaboration in the Stage I Assessment

Brazil is a large country with a high contraceptive prevalence, a low total fertility rate (TFR), and a highly skewed method mix. The vast majority of women in Brazil rely on only two methods of fertility regulation: oral contraceptives and tubal ligation (BEMFAM/IRD, 1986; Demographic and Health Survey (DHS), 1992; World Bank, 1991). Indicators of underserved or unmet need include high levels of illegal abortion, rising adolescent pregnancy rates, and an increase in the frequency of post-sterilization regret and requests for reversal (Pinotti et al., 1986; Bahamondes et al., 1992).

Concern about these indicators and with the persistent levels of maternal mortality and morbidity led the WHO Task Force on Research on the Introduction and Transfer of Technologies for Fertility Regulation to conclude that Brazil would be an appropriate candidate country for a Stage I Assessment. Strong interest by the Ministry of Health (MOH) in the assessment process made the choice of Brazil both possible and desirable. It is hoped that the Stage I Assessment will be a step towards strengthening women's reproductive health services in the public sector.

The MOH has for many years recognized the need for attention to reproductive health as part of an integrated approach to women's health. This recognition continues even though institutional instabilities and resource scarcities weaken these efforts. The chief of the MOH Programa de Assistência Integral à Saúde da Mulher (PAISM) (integrated programme for women's health) participated in the assessment team, was instrumental in the selection of assessment sites, and facilitated the participation of other health authorities in the assessment. In each of the sites, the assessment was undertaken in collaboration with officials from the state and municipal secretariats of health.

Methodology

This assessment is based on information from field visits to sites in three states and the Federal District, and an analysis of the most recent data published on women's reproductive health, including the 1986 and 1991 DHS, other surveys, and reports

published by donor agencies, women's groups and researchers. Special acknowledgement must be made of the usefulness of the 1991 World Bank document, "Brazil. Women's Reproductive Health".

A number of sites were chosen that would provide some representation of the broad regional variation in socio-economic development, programme effort (both duration and degree of implementation) and access to external resources. With these in mind, the states of São Paulo, Mato Grosso, Ceará and the Federal District (DF) were selected. Within these states, activities were focused in São Paulo and Campinas, Cuiabá and Chapada dos Guimarães, Fortaleza and Maranguape, and Brasília.

The state of São Paulo in the southern region is an affluent state with a well established programme and moderate access to external resources. Mato Grosso, which is located in the west, is a state with a generally poor population, no formal family planning programme and no significant donor attention. Ceará, in the northeast, is a poor state with a newly created women's health programme, Viva Mulher, substantial family planning experience, and a significant donor focus. The Federal District is in the central region, with a wealthy capital and strong programme effort given its proximity to federal resources and donor access. These states were also selected on the basis of expressed willingness and interest to collaborate in the assessment process and follow-up activities.

As described above the unit of observation of this assessment was not Brazil but a sample of municipalities in four of the nine Brazilian States. The report is not intended to provide an exhaustive description of women's reproductive health in Brazil nor to produce new research findings. No effort was made to meet with all individuals or organizations conducting programmes or research in women's reproductive health. However, sufficient contacts were made to provide a picture of the state of the family planning programme within the context of reproductive health and women's health in general.

Women's Reproductive Health, Family Planning Policy and the Service Delivery System

Demographic factors

The total population figure for 1990 as indicated in World Population Prospects: 1990 (UN, 1990) was 150,368,000. The population figure from the 1991 census was 146,000,000 (Ministério da Economia, Fazenda e Planejamento, 1991). The population density is 18/km^2 and 75% of the population lives in urban areas. In 1985, the crude birth rate was 26.1 per thousand, and the crude death rate 7.5/1000. The current total fertility rate is estimated to be 2.5 (Berquó, 1994). The infant mortality rate is 57/1000. The life expectancy at birth is 66.3 (World Bank, 1991).

Women's reproductive health indicators

A recent World Bank report on women's reproductive health in Brazil indicates that although there has been progress in some areas over the past years, major problem areas continue to exist with regard to women's reproductive health. Key problem areas identified in the report are: severely limited choice of available contraceptive products and information, high rates of unsafe abortion, high rates of cervical cancer, large numbers of women with virtually no prenatal care, the world's highest rate of caesarean section deliveries, and a growing threat to women's and men's well-being from sexually transmitted diseases (STDs) and other reproductive tract infections (World Bank 1991). These six areas as well as maternal mortality are discussed below.

Choice of contraceptive methods: In Brazil, high contraceptive prevalence and a decreasing TFR have occurred despite the very narrow range of contraceptive options available to most women. Multiple factors including economic difficulties and increasing female participation in the work force have contributed to high rates of use of the oral contraceptives and sterilization even among women who express dissatisfaction with the method they have chosen. Decreasing age at first pregnancy and increasing adolescent fertility, related to societal changes, have not been supported by appropriate educational efforts or services tailored to the needs of adolescents.

Induced Abortion: According to the 1991 World Bank report, the lifetime induced abortion rate has been estimated at over two abortions per woman. The official 1992 MOH estimate places the total annual number of abortions between 800,000 and 1.2 million. This estimate is based on extrapolations from the number of abortion related hospitalizations treated under the Sistema Único de Saúde (SUS). Because abortion is illegal, there is no full information on the health impact of abortion in Brazil, and official figures may underestimate

the magnitude of the problem if a larger than expected number of women avoid seeking care or withhold information about their abortion experiences. The poor and the uneducated are exposed to the greatest risks of mortality and morbidity related to abortion. Instituto Nacional de Assistência Médica e Previdência Social (INAMPS) figures for 1988 indicated that admissions for complications of abortion were 2% of all hospital admissions (World Bank, 1991); MOH figures for 1992 show that 1.7% of the hospital admissions covered by SUS were for post-abortion complications. Rates of admission for abortion complications approached 40% in one hospital in the Northeast, and similar rates are found in other tertiary care centres.

Cervical cancer: Deaths from cervical cancer constitute the number one cause of cancer deaths among Brazilian women (World Bank, 1991). A great deal of attention has been given to the performance of Papanicolau smears for the early detection of cervical cancer, but coverage is still low and uneven (MOH, 1990).

Access to prenatal care: Although overall coverage for prenatal care is approximately 75%, almost half of rural and poor women are excluded from prenatal care and access to hospital deliveries (Ross, et al, 1992; World Bank, 1991; MOH, 1990). Much of the prenatal care delivered is limited in scope, and effective mechanisms for referral of women with complications are often lacking.

Caesarean section: Between 1970 and 1980, caesarean rates in Brazil increased from 15% to 31% of hospital births (Faúndes and Cecatti, 1991). In 1992, 32.7% of all hospital births covered by SUS were by caesarean section. In several states, the proportion of births delivered by caesarean has increased to over 50%. Rates in individual regions and in many private hospitals are substantially higher (Berquó, 1993).

According to the World Bank report, "More than half of these caesareans are unnecessary; this high rate of unnecessary surgery is largely a reflection of sociocultural factors, the way obstetrics is organized and practised, and in institutional, financial and legal factors, including the fact that multiple caesareans provide a justification for a sterilization under the present Medical Code of Ethics" (World Bank, 1991). The extreme medicalization of deliveries and the complete absence of midwives in Brazil exacerbates this situation. Because caesarean section is closely tied to access to tubal ligation, and physicians profit directly or indirectly from the performance of caesareans, there is little pressure from the public or medical community to reverse the trend towards increasing reliance on this procedure.

Sexually transmitted diseases: In 1991, 17,400 acquired imuno-deficiency syndrome (AIDS) cases had been reported (World Bank, 1991). By October 1993 this number had increased to 43,455. Although the ratio of male to female cases has been 6 to 1 over the entire period of reporting, data from 1993 show that this ratio has decreased to 4 to 1 (MOH, 1993). In the state of São

Paulo, where over 60% of all Brazilian AIDS cases have been reported, recent data released by Sistema Estadual de Análise de Dados (SEADE) identify AIDS as the 1st cause of death for women between 20 and 35 in the state of São Paulo (SEADE, 1994). AIDS is an increasingly important cause of female mortality particularly for women with lower educational achievement and income.

Maternal mortality: For a country with a low TFR and high contraceptive prevalence, maternal mortality is disproportionately high (United Nations Population Fund (UNFPA), 1991). The 1989 official MOH estimate of the maternal mortality rate in Brazil is 72/100,000 live births. Significant underreporting has led to consistent underestimation of the true values for maternal mortality. Research led Laurenti to conclude that in São Paulo maternal mortality was 2.4 times higher than initially reported, or approximately 100/100,000 live births (Laurenti, et al. 1986; Laurenti, 1988). The necessary adjustments for other areas of Brazil which were subsequently calculated by Laurenti vary significantly by region, and range from 3.5 in the Northeast to 1.5 in the South, with the national average adjustment being 2.4. The MOH has accepted and now uses the Laurenti corrections.

The poor attention pregnant women receive is also reflected in the statistics on maternal mortality recently published by the MOH. Of the four main causes of maternal death, abortion, haemorrhage, toxaemia and infection, 3 are related to the quality of care received during the prenatal period and delivery (Costa, 1992; MOH, 1990).

The policy environment of family planning

Population/family planning: A formal population policy for Brazil was prepared in connection with the 1984 World Population Conference, but has not been widely disseminated. The government does not have a policy to regulate or control population growth. The 1988 constitution states explicitly that based on the principle of human dignity and responsible parenthood, family planning is a free decision of each couple. Any form of coercion on the part of public or private institutions is forbidden. Within its broader commitment to the improvement of women's health and status, the PAISM programme supports family planning because of its contribution to the reduction in high risk pregnancy, maternal mortality, and infant mortality.

While government policy supports the use of contraception, the legal status of sterilization and abortion is complex. Surgical sterilization (male as well as female) is not included in the guidelines for family planning developed by the MOH, because of its ambiguous legal status. Despite this exclusion, tubal ligations are widely performed both in the public and private sector usually in association with caesarean section. Several proposed guidelines for liberalising surgical sterilization (particularly postpartum or interval tubal ligation) have been brought before the Brazilian Congress and are being debated, but no conclusion has been reached.

Abortion is illegal except in cases of rape and where the pregnancy threatens the life of the woman. Access to even legal abortion is often difficult.

National drug policy with regard to contraceptives: The Government of Brazil has made a long-standing commitment to stimulate local production of drugs and devices, including contraceptive products. Heavy import tariffs imposed on products not produced within the country have led in the past to high costs for some contraceptives, such as imported condoms, and intrauterine devices (IUDs). Many of these restrictions are currently being relaxed as part of the government's free market policies. Contraceptive donations must be authorized by or be reported to the MOH in order to avoid the sale or inappropriate distribution of donated supplies.

The Secretaria de Assistência à Saúde (SAS) division of the MOH has developed two drug lists: 1) the list of essential drugs that must be provided by the MOH and 2) the list of drugs that are approved for purchase but for which there is no government obligation to purchase or reimburse via SUS. In 1992 and 1994 respectively, spermicides and OCs were moved from list two to list one. This decision reflects increased emphasis on ensuring the availability of contraceptive supplies. Recent changes allow reimbursement by the SUS for IUD and diaphragm supplies as well as the consultations and insertion or fitting procedures. Condoms are provided through the STD/AIDS prevention programme.

Current research on new methods of family planning and national plans for contraceptive introduction: There is no national plan for introducing new contraceptive products, but some research is being conducted by Brazilian research institutions and pharmaceutical companies. Pharmaceutical companies in Brazil are actively involved in the introduction of new contraceptive products, particularly new oral contraceptive formulations, and regularly introduce their newest products into the private sector. Inclusion of these products into the public sector is dependent on cost and the incorporation of new formulations or methods into the MOH family planning norms.

Several research institutions with extensive capability and significant activity in the area of reproductive health (Centro de Pesquiasas e Controle das Doenças Materno-Infantis, CEMICAMP; Centro de Pesquisas e Assistência em Reprodução Humana, CEPARH; Instituto Materno Infantil de Pernambuco, IMIP; Maternidade Escola Assis, Chateaubriand) are involved in testing and introduction of contraceptive methods into the public and private sector. CEPARH is undertaking trials of Uniplant (a single rod implant containing nomegestrol), gossypol (a male method), vaginal use of oral contraceptives, 60%-dose Perlutan (a once-a-month injectable), and has plans for a study on a levonorgestrel-releasing IUD. CEMICAMP has recently conducted trials on different formulations of the CuT IUD and is coordinating the

recently initiated introductory trial of Cyclofem, a once-a-month injectable.

The role of donor agencies with regard to method choice: In previous years, the United States Agency for International Development (USAID) and the International Planned Parenthood Federation (IPPF) funded BEMFAM, a non-governmental organization (NGO) involved with community-based distribution of methods, emphasizing the oral contraceptive, but since 1985 there has been no strong donor agency influence on government policy for the purchase of specific methods. The government has strong relationships with UNFPA and the Pan American Health Organization (PAHO) which have supported PAISM, but neither UNFPA nor PAHO have had a particular focus on specific methods.

The influence of the Catholic church on family planning: Although the government has no official link to the Catholic church, the government has been influenced by the church's position on individual methods like the IUD and tubal ligation. This influence is not expressed as a clear opposition to family planning.

The family planning service delivery system

At the federal level, the MOH is responsible for family planning. The World Bank report on women's reproductive health summarized the role of the Ministry of Health as follows:

"The MOH is primarily responsible for providing basic health services for the rural poor and for disease control...., Recognizing the importance of basic reproductive health, the MOH in 1984 created the Integral Programme for Women's Health (PAISM), to be carried out in the basic public health network of the MOH and the State and Municipal Secretariats of Health. The PAISM programme is more comprehensive than the traditional, narrow maternal-child health framework; it includes family planning education and services, prenatal care, delivery and postpartum care, infertility services, breast and cervical cancer screening, sexually transmitted disease testing, and treatment of reproductive tract infections. The programme covers women of all ages, including adolescents." (World Bank, 1991)

The public sector in Brazil has had a limited role in the provision of family planning services, but is currently moving in the direction of accepting wider responsibility. Responsibility for family planning within the MOH rests with Coordenadoria Materno-Infantil (COMI), a unit within the programme division. Reimbursement for family planning services and supplies is provided through the Sistema Unico de Saúde (SUS) which is directly responsible to the Secretary of Health.

The Ministry of Health is responsible for the development and dissemination of family planning guidelines, referred to as norms, and for technical supervision and training. In connection with this responsibility the MOH provides materials and resources for family planning training to 70 reference centres that have been identified by it as centres with the potential or existing capacity to act as a training and

resource facility for public sector service delivery points.

State and municipal authorities in Brazil are autonomous and therefore not under the direct control and supervision of the MOH. Currently, a process of decentralization is underway that intends to shift responsibility and authority for the delivery of health services to the municipal level. It is expected that "municipalization" will allow the health system the flexibility to be responsive to local needs.

Family planning services are provided through a variety of service delivery points in the public sector that include municipal and state level primary and secondary health care centres and hospitals. The previous BEMFAM experience with community-based distribution (CBD) is still viewed with a considerable degree of criticism. This criticism is tied to a long-standing public debate over the objectives of the public sector's role in family planning. Religious groups and the women's movement have opposed particular methods of contraception as well any indication that family planning services might serve the objective of population control.

Public sector clinics provide oral contraceptives, condoms, IUDs, diaphragms, and contraceptive jellies, although actual service provision is severely constrained by limited supplies and frequent stock outs. The provision of IUDs and diaphragms is additionally constrained by the lack of personnel trained in the management of these methods. Tubal ligations are performed in public sector hospitals, many of which have independently developed age and parity criteria which women must meet in order to obtain approval for the procedure. Many women who meet these criteria have access to tubal ligation only during a caesarean section. Almost 80% of all tubal ligations in Brazil are performed during a caesarean section (Barros et al., 1991; Faúndes and Cecatti, 1991).

Family planning outside the public sector

Most contraceptive service delivery occurs outside the public sector, through: 1) the commercial sector; 2) NGOs; and 3) private providers.

Contraceptive service delivery in the commercial sector: The vast majority of all contraceptive supplies are provided through the commercial sector. The 1986 DHS reports that 90% of oral contraceptives are provided through pharmacies. Of these, approximately 85% are sold over-the-counter without prescription. In many, although by no means all of these cases, women have had some previous consultation with a physician. Condoms, spermicides, and once-a-month injectable contraceptives are widely available. Depo-provera is available in a limited number of pharmacies.

Non-governmental organizations: Several non-governmental organizations, ranging from smaller organizations including feminist health centres, to larger organizations that receive funds from international donor agencies (e.g. Sociedade Civil Bem-Estar Familiar no Brasil, BEMFAM; Associação Brasileira de Entidades de Planejamento Familiar, ABEPF) play a

role in contraceptive service provision. BEMFAM currently plays a role in the public sector in the Northeast where it provides not only all the methods approved by the MOH, but also technical assistance and training in the health posts in which it has contracted for these services with the municipality. Also, BEMFAM provides information, education and communication (IEC) materials used in these health posts during educational sessions. In addition to family planning services, BEMFAM offers infertility services, pre-natal care, early detection of cervical cancer and other educational activities related to sexual and reproductive health.

Health maintenance organizations (HMOs): HMOs or other group medical plans providing or reimbursing services to members on a prepaid monthly capitation fee are emerging as an important health care institution in the urban sector. In general, these organizations have not focused on family planning. One of these organizations, Promedica, has conducted a study demonstrating the cost effectiveness of including family planning as part of routine service delivery and is currently engaged in collaborative research with the Population Council on the provision of postpartum family planning services.

Private practice: Physicians in private practice are a main source of contraceptive services for the more privileged socio-economic classes. These physicians primarily provide tubal ligations in private hospitals, and prescribe oral contraceptives. Relatively few IUDs are provided by private physicians due to the widespread lack of training. This problem is compounded by the fact that training typically focuses on the CuT, while the Multiload is more readily available through the commercial sector. With few exceptions, barrier methods are not emphasized by private providers. The resulting private practice method mix is skewed similarly to that in the public sector.

Services for men

Very few public sector service delivery points provide family planning services to men. This situation is largely a function of the integration of family planning into the women's health programme (PAISM), and also due to the fact that family planning is considered a part of gynaecological care. Men rarely utilize public sector service delivery points to obtain contraceptive supplies. Condoms are primarily provided to women or are purchased by men or women in the pharmacies. In some of the more progressive health centres, men are encouraged to attend educational sessions with their wives, but sessions are not often provided at times that are convenient for working men.

Although access to vasectomy is still limited, it has become increasingly available over the past 10 years in the private sector. In São Paulo, the non-profit clinic Pro Pater has been instrumental in increasing awareness of and access to vasectomy, and has also been an important source of vasectomy training. Access in the public sector is extremely limited. Secondary health clinics in the public sector have a referral system for

vasectomy. However, with very few exceptions, such referral is not part of standard family planning service delivery.

Contraceptive Method Mix: Patterns of Use, Availability and Accessibility

Patterns of contraceptive use

Prevalence rates: Brazil is characterized by high levels of contraceptive use, variation in use patterns by region and socio-economic status, and considerable evidence of unwanted fertility, but relatively low levels of unmet need for contraception among married women. The total fertility rate in Brazil has declined rapidly and has fallen to 2.5 children per woman (Berquó, 1994).

A high level of contraceptive use is confirmed by several data sources, two national surveys, the 1986 BEMFAM/ IRD Demographic and Health Survey and the 1986 Pesquisa Nacional por Amostragem Domiciliar (PNAD), as well as the 1991 BEMFAM/DHS survey conducted only in the Northeast. The 1986 survey reports a contraceptive prevalence rate for women of reproductive age and living in union of 65.8% (BEMFAM/IRD, 1987). The somewhat lower rate of 59.8% reported by PNAD is largely a function of the fact that the latter sampled an older age group (PNAD, 1986). These prevalence rates place Brazil, together with Colombia, at the top of Latin American countries and are at a level that approaches patterns in countries of the North (DHS, 1993).

Regional variation is clearly apparent in Table 1 prepared from the 1986 DHS data, which shows the relatively wealthy state of São Paulo with a prevalence rate of 74% and the poorer Northeast at the lower end of 53%. By the time of the 1991 BEMFAM/DHS survey for the Northeast, this figure had increased to 59.2%. Contraceptive prevalence is higher in urban than in rural areas, and varies by education, although these differences are not as marked as they are in Latin American countries with lower prevalence rates such as Bolivia, Guatemala, Ecuador, and Peru (DHS, 1993).

Unwanted fertility and unmet need for contraception: The level of unwanted fertility for the year preceding the 1986 survey was 58%, with 32% of women who had a pregnancy during the previous year stating that the pregnancy was not wanted, and 26% stating they would have preferred to wait until later. Figures for unwanted pregnancy based on data of the 1991 survey of the Northeast indicate similarly high levels. Thirty percent of currently pregnant women did not want the pregnancy at all, and 34.6% felt their pregnancy was earlier than desired (BEMFAM/DHS, 1992). The level of unmet need for contraception, defined as women not using contraception, who are married and fecund, and do not want any more children, or do not want a child within the next two years was 13% in 1986 for the country as a whole (BEMFAM/IRD, 1987).

Education is related to unmet need. In the Northeast 78% of women of

Table 1. Contraceptive prevalence (for married women, or women living in union, age 15-44) in selected states or regions (Source: BEMFAM/IRD, 1987)

Area	Total CP	Oral contraceptive	Sterilization	Other
Brazil	65.8	25.2	26.9	13.7
Sao Paulo	73.5	24.3	31.4	17.8
Northeast	52.9	17.3	24.6	11.0
North-Central West	62.1	12.4	42.0	7.7
Central-East	63.7	23.5	25.7	14.5
South	74.4	41.0	18.3	15.1

reproductive age who do not want additional children but are not practising contraception have a primary school education or less (DHS 1992). The high level of unwanted fertility or pregnancy and underserved need for contraception are also suggestive of contraceptive failure.

Studies of special populations also provide evidence of unwanted fertility. Ferraz et al. (1992) report that 58% of single mothers aged 15-19 in three cities stated that their first pregnancy was unwanted. The decreased age at first birth reported between 1970 and 1986, and the fact that a large percentage of sexually active adolescents between 15-19 years of age do not use contraception at the time of first intercourse (Arruda et al., 1992) are also suggestive of unmet need for contraception. An additional indication of unmet need for contraception is the high rate of abortion discussed in the previous chapter.

Patterns of method use: Data from the DHS confirm the widely known pattern of limited method use for Brazil with its emphasis on two dominant methods, sterilization and the oral contraceptive. Forty-two percent of current by married users (representing 26.9% of all married women of reproductive age) were using sterilization according to the 1986 DHS (BEMFAM/DHS, 1987). In Latin America, only the Dominican Republic and Guatemala have higher sterilization rates. Moreover, Brazil is characterized by high oral contraceptive use, in fact by the highest percentage of oral contraceptive use among users reported for any country in Latin America (DHS, 1993). Use of other modern or traditional methods is extremely low. The 1986 DHS reports 1.7% for condoms, 1% for IUDs, 0.6% for injectables, 0.8% for male sterilization, 4% for rhythm and 5% for coitus interruptus (BEMFAM/IRD, 1987). Because of the attention given to the condom as part of AIDS campaigns, sales of condoms have increased in Brazil. There is some regional increase in the use of IUDs, reflecting the impact of special projects

focusing on contraceptive choice. In those clinics or regions where IUD services are implemented with a high level of quality of care, the prevalence of the IUD has increased, but there is no general trend towards an increased use of the IUD (CEMICAMP, 1991).

Evidence of sterilization regret and problems associated with method use: Data from the 1991 DHS for the Northeast indicate that 13.9% of all women who are sterilized or whose husbands had a vasectomy now regret the decision (BEMFAM/DHS, 1992). In a study conducted in 1986 in Campinas, sterilization regret amounted to 27% overall and was particularly high for women under 25 years of age (Pinotti et al., 1986). In the Northeast, problems associated with method use were most frequent for users of the oral contraceptive (23%), the condom (19%), and sterilization (13%). Side-effects and health problems were predominantly reported for the oral contraceptive and sterilization, and inconvenience or dislike for the condom (BEMFAM/DHS, 1992).

Availability of contraceptive technology in the public sector

In discussing the availability of contraceptive methods we refer to the presence of methods within either the public or the private sector. Within the public sector we distinguish between methods which are included in official policy guidelines and in that sense are "theoretically" available, and the actual, physical presence of methods at service delivery points.

Methods included in the official MOH guidelines: These include periodic abstinence, lactational amenorrhea, barrier methods, IUDs, combined and progestogen-only oral contraceptives. Tubal ligation, vasectomy, injectables and implants are not included in these guidelines. Formal norms for tubal ligation were prepared at one point, but were dropped due to the controversial nature of the issue and the ambiguous legal status of the procedure. Current bills before Congress request changes in the law for tubal ligation, and the establishment of formal guidelines for inclusion in the official norms for contraceptive service delivery (MOH, 1992).

Availability of methods at service delivery points: There is extensive variation in the availability of contraceptive methods at service delivery points within the public sector. An internal survey conducted by the MOH in part of Brazil established that 32% of public sector service delivery points offer no contraceptive methods, 49% offer some methods, and 19% offer the full range of methods approved by the MOH guidelines (MOH, 1990). A small number of service delivery points, particularly those involved in contraceptive research, also offer methods which are not included in the official guidelines.

At most public sector service delivery points which offer family planning, the supply of contraceptive methods is extremely limited, and available supplies are not adequate to meet the demand. Where methods are available, there usually is a limited and variable range of formulations in stock. IUDs

tend to be less widely available than oral contraceptives or condoms. Almost all services offer condoms only as a short-term method while users are waiting for another method. When supplies of a specific oral contraceptive are not available, physicians will give women prescriptions to purchase the oral contraceptives at a pharmacy or, when available, offer women a product of a different formulation. In 1993, international donations for the purchase of oral contraceptives were adequate to supply approximately 200,000 women for one year, which is approximately 2% of oral contraceptive users in Brazil.

The limited access to reversible contraceptive methods other than oral contraceptives is one of the most important factors explaining the increased incidence of tubal ligation. For example, many of the women health workers interviewed in connection with our visits had had a tubal ligation. They explained their decision to opt for this method in terms of the absence of adequate options for reversible contraception.

In the public sector, tubal ligations are provided in hospitals only. Because tubal ligation is generally performed with epidural or general anaesthesia, it is not provided on an outpatient basis. In response to the highly controversial status of this particular method, many hospitals have locally established restrictions for the performance of tubal ligations. These tend to be age and parity related. In many public sector settings, tubal ligation is available to women in connection with a gynaecological operation. In 80% of cases, tubal ligation is performed in association with caesarean section (Berquó, 1993); the limited number of interval or postpartum tubal ligations performed are disguised by other surgical procedures including hysteropexy and removal of ovarian cysts (J.N. Formiga Filho, personal communication, 1994). Vasectomy services, usually provided through urology departments, are extremely limited in the public sector.

There is significant regional variation in the availability of contraceptive methods. This variation depends on the history of political or individual commitment to women's health and family planning, the wealth of the region or the local and donor resources available for health, and the proximity of individual service delivery points to central, regional or state facilities.

Availability of contraceptive technology in the private sector

Private hospitals: In general, private hospitals in Brazil do not have outpatient clinics and do not offer family planning services as part of a formal family planning programme. Individual physicians working in these hospitals do provide family planning, particularly tubal ligation, and in a few cases vasectomy. Tubal ligations are mainly performed in connection with caesarean section deliveries, which are widely available to women and may be negotiated during pregnancy.

NGOs: Oral contraceptives, IUDs, condoms, diaphragms and spermicides are typically available through non-governmental organizations. A few NGOs offer tubal ligation. The only

major NGO providing vasectomy is Pro Pater which offers outpatient vasectomy with local anaesthesia.

Pharmacies: Oral contraceptives, condoms and spermicides are widely available through pharmacies. Smaller pharmacies stock only two or three main brands but most offer a wide range of oral contraceptive formulations and brands. Most pharmacies also sell once-a-month injectable contraceptives and provide the injections. It was observed that pharmacists had minimal knowledge of contraceptive methods and no written information for themselves or for users.

Four groups of products available in the commercial sector - some oral contraceptives, produced by small companies with inadequate quality control, sequential oral contraceptives, currently available once-a-month injectables which have not been adequately tested for safety and efficacy, and poor quality spermicides with inadequate spermicidal action - pose unacceptable health or pregnancy risks.

There is concern about certain oral contraceptives manufactured by certain small Brazilian companies. Products produced by these labs are not subjected to rigorous quality control, and may contain high or extremely variable doses of steroids (P. Hall, personal communication). Furthermore, sequential oral contraceptives are still available in many pharmacies. Responding to women's needs for low cost contraception and to some extent to the greater profit margins earned on these brands of oral contraceptives, despite price controls on pharmaceutical products, pharmacies sometimes offer these slightly less expensive oral contraceptives to women with prescriptions for other formulations. Although the market share for these oral contraceptives is generally low, women without a prescription, and those with limited financial resources may be particularly vulnerable to the risks implied in the use of these brands.

While the larger pharmaceutical companies are in the process of voluntarily withdrawing older, high dose formulations, the legal mechanism for forcing the removal of oral contraceptives produced by these smaller laboratories has not been effective. The market share of these oral contraceptives is kept small primarily by the limited price differentials between these and the low cost, low dose formulations produced by the major pharmaceutical companies.

The commercially available once-a-month injectables, Perlutan, Unicyclo and Unovular, are provided on a reinjection schedule which increases women's exposure to steroids. Following the companies' directions, these injectables are usually given at every bleeding episode rather than at monthly or regularly scheduled intervals. This may result in women receiving up to 16 injections per year. MOH efforts to block the production and sale of these injectables have been thwarted by legal action taken by the manufacturers. These injectables are not included in the MOH norms and are, with few exceptions, provided without prescription.

Several products advertised as contraceptive spermicides contain ineffective active ingredients or inadequate levels of spermicide. While these products do kill some sperm in vitro, no studies are available that demonstrate that the spermicidal action is adequate for contraceptive protection.

Private physicians: Oral contraceptives are widely prescribed by private physicians, injectables less frequently. Tubal ligations are performed in private and public sector hospitals. Only a small percentage of private providers insert IUDs or perform vasectomies. Most private physicians have had no formal training in family planning and receive information on family planning primarily from the pharmaceutical companies. Possibly as a result of such exposure, there is a tendency for private physicians to prescribe more expensive oral contraceptives containing third generation progestogens without any long term epidemiological evidence that these products are necessarily safer.

Accessibility of family planning services

Time: There are three elements to the question of how much time users must spend to get a method: 1) travel time; 2) waiting time; and 3) the number of visits before a woman receives a method. Data from the 1991 DHS from the Northeast show that more than 50% of rural women must travel more than one hour to reach a public sector service delivery point which offers family planning (DHS, 1992). Often women cannot attend the nearest health post because family planning services are either not available or doctors and nurses attend the clinic very infrequently and do not carry supplies. In urban areas, the majority of women are within half an hour of a family planning service delivery point. When non-users are asked why they are not using, a relatively small percentage indicate that distance to the clinic is a major problem (DHS, 1992).

Waiting times are often long and women must often make several visits to a service delivery point before obtaining a method. The first time a woman comes to the clinic, she is usually scheduled for an educational session, which may be available only once or twice a week. Attendance at educational sessions is typically a prerequisite for receiving a method, although there are exceptions to this rule. In some municipalities, more than one educational session is required and/or women are scheduled to see a social worker before their first medical consultation. After the educational session, women attend a consultation first with a nurse and then with a physician usually on the same day. During this visit, a gynaecological exam is performed and a Papanicolau smear is taken. Whether a woman receives a method on this day depends on the method selected.

A woman who has selected an IUD must wait for Papanicolau smear results prior to insertion, and is instructed to schedule an appointment for insertion during the first menses following the expected availability of results. Women who select the oral contraceptive may receive the method

during their consultation with the physician, but in some clinics they are required to be rescheduled for an appointment following the receipt of Papanicolau smear results. Women choosing the condom, spermicides or the diaphragm usually receive their method at the time of their visit with the physician. Having followed the prescribed steps women may be unable to receive the method of their choice because of a lack of supplies. If these women are unable to purchase the method in a pharmacy, they may be referred to another clinic where the process of waiting begins again.

Oral contraceptive users are generally given one, and occasionally two cycles when they initiate use in a clinic. On return visits, they receive two or three cycles and in exceptional cases more. If supplies are limited, women must return to the clinic more frequently. If the physician is not present on a day when women are scheduled, another appointment is scheduled, incurring lengthy delays during which women may be without a contraceptive method.

In the private, NGO and certainly in the commercial sector, much less time is involved in obtaining access to contraceptives. In the private sector, waiting time is reduced by a formal scheduling procedure. Access to pharmacies is generally good even in small towns, although in remote rural areas, access to contraceptive supplies through the commercial sector can also be difficult.

Costs to the user of obtaining contraceptives: The costs for time lost, child care, and transportation implied in the process of obtaining access to contraceptives in the public sector are considerable. To the extent that supplies are available in the public sector, they are free. Because supplies are often not available, women are given prescriptions to purchase supplies in the private sector. While the absolute cost of some oral contraceptives is not high, the relative cost of the method may be excessive for individual women.

Although 14 procedures covered by SUS are used to disguise interval or postpartum tubal ligation, the vast majority of tubal ligations continue to be performed in association with caesarean section. While SUS reimburses the costs of the caesarean, women pay varying levels of informal charges directly to the performing physicians. The exact amounts are, for obvious reasons, difficult to identify. The legal ambiguities associated with tubal ligation encourage and contribute to this practice of requesting informal payments. In part because of the profitability of this situation, there is little movement on the part of the obstetrics and gynaecology community to regularize tubal ligation and separate it from the practice of unnecessary caesarean section.

Thus, for women who seek contraceptive methods in the public sector, access is not easily obtained, and is often gained only after the significant expenditure of time and money. Because of the difficulties involved in obtaining public sector services, it may be cheaper for women to purchase supplies in the private sector than to pay the indirect costs of

multiple visits to a system which may in the end not have supplies.

In pharmacies, the older generation of oral contraceptives cost approximately US$2, although there is usually a small discount for products produced by small local companies. The new generation of oral contraceptives cost between US$7 and US$9 per cycle. Once-a-month injectables cost approximately US$4. There is an additional small charge for the needle and syringe. In many pharmacies injections are given free, in others a small (20-30 cent) fee is charged. The cost of condoms ranges from US$1-3 for 3 condoms depending on the brand, and product characteristics. Spermicides are generally available although access may be limited in very small pharmacies. IUDs are not sold through pharmacies.

Women are typically asked for a prescription when requesting oral contraception at a pharmacy, but approximately 40% of women obtain oral contraceptives without a medical prescription, and a larger percentage do not have a current prescription. Women frequently select, and pharmacy staff usually recommend, one of the least expensive brands when women come without a prescription or indicate that they cannot afford to pay for the formulation prescribed. Pharmacy prices are controlled and new price lists are issued twice monthly by the Brazilian Association of Pharmacists.

Costs are a major factor in limiting women's access to private sector services. The cost of consultations with obstetrics and gynaecology specialists range from US$25-100 depending upon region, size of the city and the prestige of the physician. Additional charges are made for a Papanicolau smear and colposcopy (US$25), and for insertion of the IUD (US$50-200 including the device). Some private physicians recommend removal and replacement of the IUD every 2 years; the more usual practice is four years. Official norms or guidelines recommend replacement of the CuT 380A every 8 years, and the Multiload 375 every 5 years. Earlier than necessary removal implies additional costs to the user, plus an increased risk of PID and other complications.

The cost of tubal ligation in the private sector is difficult to document because it is either embedded in the cost of other gynaecological surgery or is charged unofficially.

Quality of Care in Family Planning Service Delivery in the Public Sector

Mechanisms for assuring quality of care at the policy level

The 1992 MOH guidelines (norms) governing the delivery of family planning services in public sector service delivery points clearly affirm the importance of voluntarism and free choice in contraceptive service delivery. These norms also emphasize the value of providing culturally appropriate educational and clinical services which include understanding cultural beliefs and myths pertaining to contraceptive use.

The MOH guidelines identify two components of family planning service delivery: educational activities and clinical services. Educational activities are explicitly required and are intended to be focused on women's health as well as contraception. Clinical components are spelled out in considerable detail in the contraceptive guidelines. According to these guidelines, all contraceptive service delivery is to be initiated with an educational session and followed by a clinical consultation with a physician which includes a medical history, a gynaecological examination and a Papanicolau smear. Although focused more on the medical and technical dimensions of service delivery than interpersonal and counselling issues, these guidelines emphasize quality of care.

The interests of policy makers and managers are focused on the immediate need for human resources, training and supplies. Concern for the availability of services currently overshadows an emphasis on the quality of services provided. In a severely constrained system, this focus on the provision of services is to be expected. In some settings where resources and services are limited, technical and particularly educational requirements are consciously imposed as a way of restricting access to services which are inadequate to meet existing demand.

A lack of commitment to family planning is at times concealed in discussions of the importance of education, free choice and the broader context of women's health. In other cases, these same arguments may be used to make controversial services more acceptable to the groups who oppose increases in women's access to contraception. Acknowledging these situations does not diminish the importance of the genuine commitment to improving family planning and women's health that has emerged in some circles in the last decade.

Quality of care at service delivery points

Choice and information given: Although there is an official emphasis on free choice and individual provider

commitment to the concept, the limited availability of family planning services and the narrow range of methods available at most clinics severely limits choice. Educational sessions typically present the full range of methods approved under the MOH guidelines. In practice, however, choice is limited to the one or two methods available in most clinics. Incomplete information or provider bias may further reduce women's ability to make an informed choice among the methods available. Many providers are not adequately trained in family planning or have insufficient experience to dispel client fears or misconceptions and may directly or indirectly communicate their own biases. The medicalization of family planning, and power or gender imbalances between provider and client also contribute to a reduction in client choice when physician directed method choice is passively accepted by the client.

The emphasis on education in the public sector must be recognized as evidence of an increasing awareness of the importance of education in family planning services. It is also necessary to acknowledge that because of the structure of educational activities, this well intentioned service may act as a barrier rather than facilitate women's access to contraception. When women seeking a contraceptive method are assigned to educational sessions and cannot receive a method on their first visit, and when the information given in these sessions does not enable them to answer questions they may have about the characteristics of the different methods of contraception, education reduces rather than improves the quality of care. In addition, if educational sessions take the place of, rather than complementing, individual counselling, a woman or man who receives a method may not leave with adequate information on how to use that method properly.

Although it is important to continue providing education to women seeking contraceptive methods, it is necessary to ensure that these educational activities do not interfere or delay method choice and actual initiation of use. In some of the clinics visited, the requirement of participation in educational sessions prior to starting use of methods acts as a barrier to contraceptive use. Some potential users are unable to go through this whole process which sometimes lasts for three or four educational sessions. Some providers recognized that this system is maintained in part because it reduces the number of new acceptors, making the demand for contraception more adequate for the limited resources available.

Technical competence: Studies conducted at the University of Campinas (UNICAMP), and during a 1989 vaccination campaign, indicated that as many as 50% of the women interviewed were using oral contraceptives with contraindications regardless of whether they had obtained them with a physician's prescription or directly from pharmacies (Faúndes et al., 1986; Pinotti et al., 1990). The high percentage of women using oral contraceptives with contraindications is evidence of poor screening during initial and follow-up visits. It must be considered that this situation may also

reflect the limited range of reversible contraceptive options available. In this context, the compromise of use with contra-indications may be viewed as reasonable or necessary by physicians, women or both. Furthermore, in many services the list of contraindications has not been updated to reflect current medical knowledge. Because of this, the process of screening may be used to incorrectly exclude some eligible women.

The indirect evidence of high failure rates for oral contraception suggested by high rates of illegal abortion and unwanted fertility are a source of significant concern among providers, policy makers and women's groups. Frequent observations of incorrect oral contraceptive use, indicate that women do not have enough information about the appropriate use of oral contraceptives. Some women choose to use the oral contraceptive in a way they feel reduces the risk of unwanted side effects with the knowledge that it may increase their risk of pregnancy, but for many women incorrect use results from a lack of formal knowledge. Although this may result more from a lack of counselling than from the communication of incorrect information, there is evidence that some providers are unclear about how to use oral contraceptives correctly.

Attention to asepsis is generally good, and MOH norms for sterilization and high level disinfection are usually well followed. Awareness of the risk of AIDS transmission has increased provider attention to asepsis, and problems with inappropriate reuse of equipment or needles are very rarely reported. Basic supplies and equipment for conducting routine gynaecological exams are usually available, but shortages of equipment like speculums combined with appropriate attention to asepsis limit the number of women who can be seen for family planning in many clinics. Some misunderstandings of the proper asepsis procedures for IUD insertion have been encountered and may reflect the limited training that providers receive.

The very short consultation times observed in many clinics suggest that in many cases thorough gynaecological exams including breast examination are not conducted for family planning clients (or for women seeking other reproductive health care services). Time for individual counselling concerning method choice and instructions on method use is similarly limited when consultations are very brief. In many clinics physicians see 16 women in less than two hours rather than in the allotted four hours.

Limited provider ability or confidence in clinical diagnosis of STDs or other reproductive tract infections results in inappropriate reliance on Papanicolau smear results for the diagnosis of common infections. As a result many reproductive tract infections go untreated. In addition, many providers have misconceptions about the causes of vaginal discharge which they communicate to clients. Even though some regional and local variation in technical competence was observed, significant problems with technical competence exist even in places where training has been conducted.

Interpersonal relations: Although the PAISM programme has integrated interpersonal relations into its training for medical and non-medical personnel, the majority of family planning providers have received little or no formal training in communication and counselling skills. Gender, race and social imbalances act to further reduce the probability that providers engage in a meaningful and supportive counselling process and increase women's comfort with requesting information.

Communication skills are not incorporated into the curricula of medical and nursing faculties, and few providers have the opportunity to receive specialized training in these areas. The medicalization of family planning services makes physicians who are not trained to value listening and counselling skills, responsible for the majority of one-on-one discussions of method choice and use. Nurses are frequently observed to be interested in, and to the extent possible, involved in family planning counselling, but also expressed a need for formal training. Preserving family planning as part of a medical speciality may reduce interpersonal quality of care, particularly in those settings where provider time is limited.

It is currently being suggested by some women's groups and some health services that domestic violence be considered when women are being counselled on the choice of contraceptive methods. Once questions are asked, it becomes evident that many women have experienced violence surrounding the use of contraceptive methods. In general, it is thought that interpersonal relations and the overall quality of family planning services could be improved if providers were more aware of the reality lived by their clients.

Privacy during physical examinations is not always maintained. The lack of privacy in areas where medical histories are taken may inhibit women's discussions of reproductive intentions and sexual patterns which influence contraceptive choice.

Mechanisms for continuity: Most settings have no formal mechanism for ensuring continuity of family planning care. Established systems for contacting clients who do not return for follow-up visits are rare, and in many clinics the scheduling system itself is insufficient. Clients with scheduled appointments may not be guaranteed attention, and there is little ability or willingness to schedule emergency consultations for clients with complaints. Women who attend emergency room services for contraceptive complaints often receive instruction to discontinue the method rather than counselling or discussion of alternative method choices. If these women are unable to receive family planning attention within a reasonable time, their risk of unintended pregnancy is increased.

Weak or absent record keeping systems do not allow continuity of attention to women's reproductive health or family planning histories. The high turnover of providers decreases the continuity of care for women and increases the demands on individual providers to solicit the information necessary to maintain appropriate quality of care.

In addition, because of a lack of a comprehensive approach to women's health, family planning is not usually discussed when women attend for other medical reasons. Apart from the need to consider potential drug interactions or other medical issues which could affect a woman's use of family planning or the effectiveness of her chosen method, the opportunity to provide family planning support, counselling or supplies is lost.

For centres that lack the ability to provide contraceptive services or supplies, appropriate referral mechanisms are important to assure access to a choice of contraceptive methods. In many areas, however, there are no centres within a reasonable distance which provide the services or methods unavailable locally. Because tubal ligation is not included in the MOH guidelines, formal referral criteria for the majority of women seeking access to tubal ligation do not exist.

Appropriate constellation of services: While situating contraceptive service delivery within the women's health programme establishes a service delivery context that is convenient and acceptable to women, this location does not make services readily available to men. In some of the more progressive programmes, men are allowed and encouraged to attend educational sessions, but in most locations these sessions are not tailored to men or couples, and are not provided at times when men employed in the formal sector are willing or able to attend.

Even though family planning services are included in the integrated women's health care system, women looking for contraception do not have wide access to other reproductive health services. Cervical cancer screening through Papanicolau smears reaches a small proportion of users and cases needing follow-up usually do not receive adequate treatment. Breast cancer screening is almost non-existent and services for the prevention of reproductive tract infections are either not available or poorly implemented. Attention to sexuality is completely neglected. Other preventive activities are not implemented and the referral system is very weak.

Service Delivery Capabilities

Previous chapters have noted that the family planning situation in Brazil is characterized by a high level of demand for contraceptives, as well as by considerable evidence of unmet need, unwanted pregnancy and fertility (DHS, 1992). Availability and accessibility of methods in the public sector is limited, and major weaknesses in the quality of contraceptive care have been observed. In this chapter we identify some of the broader characteristics of the public sector family planning programme in Brazil that shape the conditions of service delivery.

Weak political commitment and resource constraints: A long-standing history of controversy over the objectives of contraceptive service delivery has left the public sector in a weak position to focus on family planning even when presented in the context of women's reproductive health. Moreover, while there is some evidence of increasing commitment to contraceptive service delivery within the public sector, resource scarcities resulting from the country's economic crisis constitute major constraints in the public sector's capacity to provide such services, and reduce the priority given to family planning. Strong linkages between the women's movement and public health institutions are a source of strength in the system and have helped to focus attention on women's health.

Collaborative efforts between representatives of women's groups and public sector institutions have produced innovative attempts to address a variety of dimensions of women's reproductive health. However, these links are not institutionalized, vary with local political and social conditions, and do not necessarily survive changes in political administration.

Medical orientation in contraceptive service delivery: The public sector family planning effort in Brazil is characterized by a strong medical orientation to contraceptive service delivery, and limited consciousness of the broader social implications of family planning. The lack of non-medical personnel, such as nurses or nurses' aids, seriously restricts access to family planning because of the limited availability of physician time in many clinics.

There also is unwillingness to delegate service delivery functions to those non-medical professionals who are available. The provision of relatively routine and uncomplicated services, such as IUD insertions, have been treated as a medical speciality within obstetrical and gynaecological care rather than as part of primary care. This fact removes services from the context in which most women's needs arise and limits access to care. Integration of family planning into obstetrics and gynaecology care allows

their absence to be ignored if other gynaecological services are being provided.

Furthermore, the majority of health centres do not have gynaecologists, but are staffed by general practitioners who are unprepared to provide family planning. PAISM has attempted to change this orientation, supporting the training of a broad range of professionals in family planning. These efforts have met with strong resistance on the part of the medical profession.

Although contraceptive services are considered a medical function, the medical profession in Brazil does not place a priority on the provision of these services. When resources are scarce, family planning is often the first service to be eliminated or the last to be implemented. Prenatal care, cancer prevention and general gynaecological care take priority both on a practical and a philosophical basis, although the quality of care with which these services are provided is also often poor. Doctors who provide a limited number of consultations in the public sector, may see family planning as secondary to treatment of routine or emergency obstetrical and gynaecological problems. Together these situations point to an important lack of commitment to family planning within the medical community.

Insufficient or weak family planning training: Information on family planning does not form a significant part of training for medical and nursing students. Although a family planning curriculum has been developed by Federação Brasileira de Sociedades de Ginecologia e Obstetrícia (FEBRASGO), there is no information on the extent to which it has been implemented in schools of medicine and nursing. The virtual exclusion of family planning from most medical and nursing curricula is a strong indicator of the low priority given to these services by the medical profession. As a result, technical competence in the area of contraception is weak, and the importance of choice, information and counselling is not communicated to medical and nursing students.

Specific training in family planning is provided by COMI as part of the PAISM programme. The MOH budget for training in family planning is allocated to states and municipalities. Reference centres for family planning were created in an effort to standardize training and to maintain family planning and PAISM norms. Although trainers from the reference centres are uniformly prepared, there is no evaluation or monitoring of the training as it is replicated in the centres, and little communication between reference centres on the type and content of training provided by other centres.

Beyond this effort to provide these reference centres for training, COMI does not coordinate family planning training among states and regions. The decentralized approach to training, with responsibilities resting largely with the state and the municipal level, implies that training is variable in quality and scope, depending upon the priorities and resources of the state, or region. States with strong commitment to PAISM (like São Paulo) have stronger training programmes. Trained

professionals interviewed confirmed that they were trained mainly on methods including medical intervention, leaving in a secondary level interpersonal communication techniques, counselling and user controlled methods, such as periodic abstinence and barriers. This partly explains the lack of emphasis given to users perspectives, especially choice of methods.

Problems with training are exacerbated by the high turnover of physicians and nurses within the public sector. Although large numbers of providers have been trained through the PAISM or other programmes, many have subsequently left the public sector for the private sector, or have been moved to administrative positions. For example, in the clinic Grande Terceiro, a reference centre in Cuiabá, there are no physicians trained for IUD insertion. This situation was also observed in Ceará which has received strong external support for a considerable period of time.

Good physical facilities - limits in human resources: Physical facilities are generally well maintained and clean and in no sense restrict the ability to provide family planning services. A major constraint, however, exists in the area of human resources. In addition to the already mentioned shortage of trained personnel, there are problems with the overall number of staff, the types of staff, and in the management of human resources.

São Paulo lost 25,000 health workers as a result of reductions in salaries and deterioration of conditions following a change in administration. Human resource shortages may be exacerbated by the process of municipalization, because poorer or less committed municipalities may allocate insufficient resources to hold trained providers in the public sector. Moreover, the unusually high physician to nurse ratio of 8-10 physicians per nurse makes it unlikely that nurses will play a major role in contraceptive service delivery in the near future. Overall morale among public sector staff is low due to changes in political commitment to public health, resource scarcities, and low salaries.

Supervision and monitoring of family planning services are weak. Technical supervision tends to be resisted by the medical community. Even the organization of a special commission of maternal mortality to address high rates of mortality faced significant resistance. Administrative supervision in turn focuses on quantity rather than on quality of care. The orientation of the management and information system (MIS) towards recording services provided for reimbursement by SUS rather than facilitating the management of services restricts its usefulness for improving logistics or the provision of care.

Complex reimbursement mechanisms and underdeveloped public sector procurement, logistics and supply systems: Two funding mechanisms have in the past covered the cost of contraceptive service delivery. The social security system (INAMPS) allowed reimbursement of services for those employed in the formal sector of the economy. The second mechanism was a separate public health budget at the federal

level. With the recent integration of the social security system into the Ministry of Health to form the SUS the ultimate aim is to cover all expenses through reimbursement mechanisms. However, at the present time, states and municipalities continue to receive budget allocations for public health on a per capita basis.

The earlier social security system, and now the SUS are strongly curative in their orientation. In the past only 2% of the INAMPS budget was available for preventive services including vaccination, training and education. This amount has increased under SUS to 5% at present, but is not expected to grow significantly. While the 1988 constitution calls for more emphasis on preventive services, this orientation is not reflected in the current pattern of resource allocation.

There has been a gradual expansion in the availability of reimbursement mechanisms for family planning. However, these mechanisms are not widely understood, and therefore remain largely underutilized. The resulting shortage of resources to purchase even basic contraceptive supplies reduces the ability or inclination of many service delivery points to focus on contraceptive service delivery. Mechanisms like the inclusion of contraceptive methods in the list of essential drugs, or approval of SUS reimbursement for contraceptive devices like the IUD and the diaphragm have only recently been implemented. In the past, municipalities received a budget for health through the state. A portion of these funds could be used to request essential drugs and to purchase drugs not on this list. These budgets, which were separate from reimbursement payments, were not determined objectively and were subject to political bargaining.

As of the end of 1993, municipal health budgets will be calculated on a per capita basis. Each municipality will be allocated a total of US$42 per capita including reimbursement payments. It is anticipated that a new system will be operational in 1994 whereby all essential drugs (including contraceptive products) will be purchased by the MOH with moneys outside the municipal budgets. Based on estimated needs, municipalities will receive an initial shipment of essential drugs, which will be replaced according to use.

Once implemented, this system of essential drug provision and the complementary reimbursement of devices through SUS should allow municipalities to ensure more regular supplies of contraceptive methods. Logistics and procurement systems will have to be strengthened at the federal, state and municipal levels. Weak or non-existent systems for tracking and ordering contraceptive supplies at the clinic and municipality level will, however, need to be implemented before available supplies can be efficiently and effectively channelled to the points of need. Simply increasing the opportunities for obtaining supplies will not alone address the inadequacy of family planning. Training of administrators to encourage efficient use of these mechanisms, the development of logistics and supply procurement systems, and employment of sufficient numbers of adequately

trained staff will be necessary if these changes are to have significant impact on contraceptive choice.

User Perspectives and the Social Context of Method Choice

Previous sections of the report have presented evidence on patterns of method use and on the service delivery context within which contraceptives are provided. We now turn to a discussion of user perspectives on method choice and of the broader social context of contraceptive decision making including the positions of women's groups.

User perspectives and the social context of method choice

As Hardy (1993) has recently documented, little research has been undertaken on user perspectives of method choice in Brazil. Even less is known about how method choice and contraceptive use more generally have affected women's lives. The few research studies that exist are limited, and often linked to special introductory efforts (Díaz, 1990). Only a few studies assess the attitudes and orientation of both users and non-users. Moreover, available studies tend to focus on women and not on men, and to concentrate on single methods rather than on the method mix (Araújo et al., 1993; Hardy et al., 1991). Finally, whatever research on user perspectives exists tends to be quantitative in orientation, missing the rich contextual data and insight that can be derived from more qualitatively oriented work. Nonetheless, there is sufficient evidence from demographic surveys, user perspective research and from the experience of professionals in the field to arrive at some very general conclusions.

Oral Contraceptives: Findings from the major national and regional surveys indicate that almost all women in Brazil know about the oral contraceptive and many use it in the course of their lives, obtaining it in the large majority of cases through the commercial sector. For many women, the oral contraceptive appears to be synonymous with contraceptive use - that is to say it is viewed as the one option available to women who wish to avoid pregnancy - until they are ready for tubal ligation.

Oral contraceptives are not only widely used, they are also often incorrectly used (Pinotti et al., 1990; Petta, 1992). Incorrect use puts women's health at risk, leads to contraceptive failure, and undoubtedly contributes to the high rate of abortion in Brazil. Based on clinical experiences discussed during the assessment, interviews with users, and on research conducted by Centro de Pesquisas de Assistência Intregrada a Mulher e a Criança, CPAIMC, in favelas in Rio de Janeiro, there is evidence that a significant percentage of women who classify themselves as using the oral contraceptive are not using the method according to recommended regimes (Costa et al., 1990).

A study undertaken by Costa and Chaloub (1992) in three cities reveals that a large number of women, both users and non-users, attribute negative characteristics to oral contraceptives. More than half believe that the oral contraceptive is annoying and difficult to take on a daily basis, that it is harmful, causes weight gain, headaches and dizziness, and is not an effective method. It was further stated that oral contraceptives cause cancer and are expensive.

Interviews with family planning users during our assessment visits also indicated that women have concerns about using the oral contraceptive for long periods of time and that side-effects are a significant worry. While there are also positive views about the oral contraceptive, these findings give the impression that on the whole, women believe that use of the oral contraceptive implies hardship and damage them. Given the living conditions of most Brazilian women, the expense is indeed significant, and side-effects are made more troublesome by limited access to health services. Some of the negative attitudes towards the oral contraceptive are likely to be related to the fact that many women purchase the oral contraceptive from the pharmacy without a prescription, and generally do not receive instruction on the use and characteristics of this method. Similar problems are experienced by women who attend some public and private sector services where complete information or counselling are not provided.

Other temporary modern methods: These methods of contraception are less widely known, and women are less likely to be familiar with sources of access to these methods. This is particularly true for the IUD, and vaginal methods. The IUD was known by about half of married women in the 1991 DHS survey in the Northeast, but only 20% knew where they might obtain this method. Vaginal methods were known by 39% but only 21% knew where they could obtain these methods. Injectable methods were known by 85% of women and 59% knew of a location where they could obtain the method.

A set of focus group discussions undertaken by CEMICAMP found that women have a wide range of concerns about IUDs and injectables. They were concerned about the IUD's position and possible mobility within the body, and the strangeness of having a foreign object inside them. It was also mentioned during our visits that women fear the IUD. For example, a community health agent in Fortaleza pointed out that many women do not have the "courage" to use the IUD, because they think it is not good for them. Concerns about injectables included menstrual irregularities, weight gain, irritability, headaches, changes in libido, and other undesirable effects.

While there is evidence of fear and concern about many temporary methods, carefully conducted introductory studies have shown that when methods are properly introduced, there is demand and many women tend to be satisfied with the method (Costa Paiva, 1993; Díaz et al., 1992). This has been shown to be true even for those methods which are widely

believed to be unacceptable to women. In an introductory study of the diaphragm in Brazil (Araújo et al., 1993), it was shown that the diaphragm can be an effective and acceptable method for some women when provided by trained personnel, with appropriate attention to counselling. Other clinical studies have shown that whenever a broader range of methods is made available with adequate quality of care, there is considerable demand for these methods. However, for most women in Brazil, temporary methods other than the oral contraceptive do not figure prominently in their decisions about contraceptive use.

Even the widely known condom is not frequently used. Condoms are thought to reduce sexual pleasure, and according to the findings from a study by Berquó and DeSouza (1991), they are not utilized because, as respondents put it "we are not in the habit of using them". This statement reflects the reality that condoms are not considered an important method of contraception. Condoms are used almost only as a transient method while waiting for the method chosen. More importantly still, this statement also suggests that many women are not in a position to negotiate shared responsibility in the burdens of fertility control.

A recent action research project with poor urban women also found that women's attitudes towards condoms are predominantly negative (Goldstein, undated). Women feared interference with sexual pleasure, breakage, the association of condom use with prostitution, and infection resulting from pieces of the condom remaining inside the vagina. Men's attitudes were similarly negative. Another recent study of low-income female adolescents found that non-use of condoms was explained by the fact that respondents did not know how to obtain them, thought condoms an insecure method and did not know how to use them (Vasconcelos et al., 1993).

Prejudice about certain methods is shared by providers, and may be communicated intentionally or unintentionally to women during the course of educational or counselling sessions. It has also been argued by Araújo et al. (1993) that medical schools and providers associate contraception with hormonal methods only, and are not familiar with, or supportive of, other methods. Negative opinions about some contraceptive methods are reinforced by the Catholic church, and opposition to all methods is expressed by some of the more fundamental Protestant organizations. Such negative opinions increase the difficulty of informed and comfortable contraceptive choice for women.

Sterilization: The prevalence of sterilization has increased markedly over the past years and is associated with lower ages than in the past. An increasing percentage of women under the age of 25 are sterilized and the median age of sterilization has decreased by seven years in both São Paulo municipality and the Northeast between 1986 and 1991/92 (Berquó, 1993a). While demand for sterilization is high across all educational groups, much of the demand may be poverty driven, responding to the cost of childbearing and rearing, the expense

of oral contraceptives, the need for employment, and the fact that in some settings employment is tied to sterilization. A "culture" of sterilization has developed from necessity and lack of choice. In a recent article comparing data from the Northeast and from São Paulo, Berquó writes:

> "the process of sterilization in Brazil has followed its course as if it were part of a culture, leading cohorts of women every year to put an end to their ability to reproduce ..... In São Paulo, 52% of sterilized women are daughters or sisters of other sterilized women, and there are cases of families where the mother and two or three of her daughters have had tubal ligations." (Berquó, 1993b)

Sixty-five percent of respondents in São Paulo who had undergone tubal ligation would recommend the method to others, and justified this position in terms of the financial difficulties of raising many children and the safety of the method. Confidence in tubal ligation as a secure method of contraception was frequently expressed by the women we interviewed during our visits to the four regions.

While there is strong evidence that there is real demand for sterilization, including the fact that some women refer to it as "liberation", sterilization regret and desire for reversal is an increasingly important problem, and may become more important as the large numbers of relatively young women who have been sterilized in recent years grow older. Sterilization regret reported for the Northeast in 1991 was 13%, and 11% for São Paulo, where such regret was associated with "death of children, new marriages, wanting to have more children, and health problems"(Berquó, 1993b).

A case control study undertaken at CEMICAMP (Hardy et al., 1993) found that the request for reversal of tubal ligation came frequently from women who had chosen sterilization because of difficult marital relations, husbands' drinking problems or wife beating. Women who did not regret the decision had opted for tubal ligation more frequently because of health related problems. Moreover, sterilization regret was associated with the operation being performed in women under 25 years of age, with a lack of knowledge that the procedure was being performed, with a change in partners, with death of a child, and with a lack of discussion about the permanence of the procedure (Hardy et al., 1993). These findings raise concerns about the conditions under which tubal ligations were performed, and about the extent to which women had the opportunity to consider the implications of this choice.

There is evidence that good counselling prior to tubal ligation dramatically reduces the incidence of post-sterilization regret (Bahamondes et al., 1992). The fact that 10% or more of all sterilized women regret the decision also reflects the reality that for those who want to limit childbearing and do not want the oral contraceptive, tubal ligation is not a choice, but an inevitability. This is particularly true for the poorer Northeast where the prevalence of tubal ligations has increased from 47.2% of users in 1986 to 62.9% in 1991 (Berquó, 1993b).

An appreciation of the broader context of sterilization must also take into account that, in Brazil, the culture of sterilization is closely linked to a culture of caesarean sections. Large numbers of women and physicians believe that caesarean sections are indicated and desirable in cases where medical evidence suggests that they are not (Faúndes and Cecatti, 1991; World Bank 1991).

Moreover, given the legal ambiguities of surgical sterilization, and the lack of straightforward reimbursement mechanisms for this procedure, both women and physicians believe that caesarean sections are necessary to justify a tubal ligation. The costs of tubal ligation are much higher than indicated by the informal payments women must make. There are significant infant and maternal morbidity and mortality risks associated with the performance of unnecessary caesarean sections (Faúndes and Cecatti, 1991; World Bank, 1991).

The social and financial costs implied in unwanted childbearing must also be considered. Women who already have their desired number of children may 'choose' to become pregnant again and to negotiate a caesarean delivery in order to obtain access to surgical sterilization (Faúndes and Cecatti, 1991). Finally, there are the social and political costs and the risks of manipulation implied when women must approach their employers or candidates for political office to gain access to free surgical sterilization.

Position of women's groups on contraceptive introduction

Given the fact that women's groups in Brazil have for a long time expressed their concern for the broader context of reproductive choice, we include a brief reference to positions from women's groups related to contraceptive introduction. The intent here is not to summarize the position of the women's groups in Brazil on the subject of women's reproductive health. These positions are stated in the Carta de Itapecerica (1993), the Carta de Brasília (1993) and an unpublished paper by Araújo and Diniz (1993). The objective is merely to identify key points that are particularly relevant to an assessment of the need for the introduction or reintroduction of contraceptive technology. The following principles appear most relevant:

"Considerations of the need for contraceptive technology must be anchored in the concern for women's reproductive health, as well as their general health and well-being." This focus leads to a general desire for contraceptive methods that minimize interference with the menstrual cycle. Concern exists for the longer health effects of hormonal methods. From within this perspective there also arises an emphasis on linking the prevention of AIDS and STDs with family planning, and a focus on methods that protect both against AIDS/STDs and unwanted pregnancy (Araújo and Diniz, 1993). This perspective leads members of women's group to be concerned about the fact that currently available, very effective, "high tech"

methods do not protect women against HIV, and may instead lead them to ignore the need to protect themselves against such infections.

This broad focus on women's health has led to extensive involvement with, and support for PAISM (the integrated programme for women's health), as well as to a position of opposition to demographically oriented policies, and patriarchal institutions of service delivery that are not committed to the goals of enhancing women's health. This position also suggests a preference for methods such as condoms and the diaphragm which can be discontinued without the aid of a physician or other service providers.

"Considerations about the need for contraceptive introduction must be woman centred rather than medically oriented or technology centred." This principle leads to a priority for the proper introduction of existing methods through education, information and counselling within a context of quality of care. New methods are evaluated from the perspective of women's needs and concerns rather than from an exclusive focus on the technology itself. It also suggests a preference for methods and modalities of introduction that empower women to gain better understanding of, and control over their bodies.

"Considerations of the need for contraceptive technology must be placed into the context of gender relations." Here, the critical concern is with the imbalance in gender relations in society, and with the unequal sharing of the burden of fertility regulation. Because of their low status in society, women have difficulties negotiating sexual relationships and the use of contraceptive technology with their partners. Although many women know that condoms protect them from HIV and other STDs, given the prevailing gender relations they are not in a position to negotiate their use. While women have always lacked the ability to negotiate sexual relations and contraceptive use, the AIDS crisis means that this inability significantly increases their health risks. This has led to an increasing emphasis on the importance of providing education and counselling that is focused on self-protection and the ability to negotiate. Focusing on the need for new contraceptive technology from a gender perspective thus implies that one should ask more questions than whether or not a method is effective. It clearly leads to a focus on male methods to assure a fairer balance in the burdens of contraceptive use; and on mechanisms for empowering women to negotiate a situation where they can use contraceptive methods that protect their health. A gender perspective also implies attention to men's responsibility in contraceptive use.

"Considerations of contraceptive technology must be placed within the context of women's rights as citizens." The right to fertility control and free choice of methods without coercion is guaranteed by the 1988 Constitution. Beyond the rights guaranteed in the Constitution there is a belief that women should have the right to abortion, the right to sexuality in whatever expression or form they choose, freedom from sterilization abuse, and freedom from undue interference on the part of the medical

profession or other providers in the exercise of reproductive choice.

"Considerations of contraceptive technology must be placed within the context of class, race and ethnicity." There is great concern that the poor, and racial or ethnic minorities suffer disproportionately from demographically oriented population policies. In terms of contraceptive technology, this concern leads to uneasiness about high technology and medicalized approaches to contraception. This perspective on the relationship between social structure and contraceptive use also produces an emphasis on linking access to contraception to other social rights, such as the right to education, health, and employment.

Sexuality and gender relations in the social context of method choice

Although providers are increasingly aware of the influence of sexuality and gender relations on women's contraceptive choices, very few have received formal sensitization or training in these areas. Adopting a focus on sexuality and gender may require a physician or other provider to go against their own socialization. For this reason, changes in the service delivery environment which strengthen women's ability to take an active and positive role in contraceptive decision making may be slow even when providers have been trained.

Sexuality: Issues of sexuality influence women's choice, continuation and proper use of contraceptive methods. In a study conducted in Campinas, 50% of women having sexual complaints believed that these problems were related to the contraceptive method that they were using. After a sex education programme, only 5% of these women attributed sexual problems to the contraceptive method (Díaz, 1992).

Women who do not receive counselling which addresses sexuality may be potential discontinuers if sexual problems coincide with the use of contraceptives. Providers who have not had adequate training may be unable to dispel women's misconceptions about the influence of different methods on their sexuality, and may hold many of these beliefs themselves. Furthermore, provider discomfort with discussions of sexuality may lead them to intentionally or unintentionally constrain women's choice of methods which require a discussion of sexuality (particularly coitus dependent methods) and to focus on technological solutions to women's complaints (e.g. switching methods rather than discussing the range of factors which influence libido).

Gender relations: Gender relations exert a strong influence on women's decision making about contraception and family planning. The imbalances in decision making power between men and women, and often between provider and client may seriously limit women's ability to exercise their right to free choice unless education and counselling are focused on empowering women to make contraceptive decisions. Providers may need sensitization and training to allow them to break out of their own position in the gender and power hierarchy before

they can provide women with the full information and support they need to select and negotiate use of a contraceptive method.

Stereotypical, domestic images of women are perpetuated in IEC materials, and are reflected in the organization of family planning services. The limited number of clinics which offer evening hours are an important sign of the influence of gender stereotypes on women's access to family planning services. Although an increasing number of women are employed in the formal sector and cannot attend normal clinic hours without significant sacrifice, clinics have not adapted to meet the needs of these women. This failure to acknowledge or respond to the changes in women's realities increases women's difficulty in accessing important services.

Increasing provider sensitivity to and confidence in the areas of sexuality and gender perspectives is an important component of improving quality of care in family planning services. Training and dissemination of information on these issues may be necessary to support the changes that will allow services to provide more balanced attention to women's contraceptive needs.

Conclusions and Recommendations

This report has presented findings from an assessment of the need for contraceptive introduction in Brazil, undertaken in collaboration with the MOH and CEMICAMP utilizing WHO'S new strategy for contraceptive introduction. The objective of this assessment was to identify relevant areas for introductory research that would broaden contraceptive options within a context of quality of care. The assessment has been guided by three central questions: 1) Is there a need to introduce new contraceptive technology? 2) Is there a need to reintroduce or appropriately introduce existing methods? and 3) Is there a need to remove any existing methods?

Conclusions

This assessment has confirmed the widely noted pattern of contraceptive use in Brazil, whereby the high demand for spacing and limitation is predominantly channelled into the use of either the oral contraceptive or tubal ligation. Despite widespread use, there are major constraints on the availability and accessibility of these two major methods particularly in the public sector. These limitations are more severe for the other methods that have been approved as part of official policy guidelines. This assessment also identified weaknesses in quality of care and significant public sector service delivery constraints. A limited number of centres were observed which provide a broad range of methods with excellent quality of care, however, a strong, socially oriented family planning programme is not widely implemented. While family planning is considered a basic human right by the Brazilian Constitution, the overall conclusion was that the necessary political commitment to implement this right does not currently exist.

There is a critical need for public sector family planning services which can provide women with a broader range of contraceptive options, and that encourage greater use of male methods. Research on contraceptive introduction or reintroduction as defined in the WHO strategy has the potential to play a catalytic role by stimulating related research on strategies for broadening contraceptive options in constrained public sector settings. Increased donor support for such public sector research will be necessary to realize this goal. In the following sections of the report, research priorities are defined and specific recommendations made for the type of projects to be undertaken.

Priority must be accorded to better and more appropriate utilization of existing methods

Given the constraints within the public sector programme, priority should be given to research related to improved utilization of existing methods rather than to introduction of new technology.

This will require: 1) the introduction (or "reintroduction") of underutilized methods, such as the IUD, barrier methods, the lactational amenorrhea method (LAM) and periodic abstinence; and 2) the appropriate utilization of methods for which there is extensive demand, such as the oral contraceptive and tubal ligation. In light of the AIDS epidemic condom use requires special attention; strengthening services for men is essential to attaining such an objective.

Programme officials and service providers interviewed in connection with this assessment emphasized the need for adequate supplies of existing methods, and for training to increase their ability to provide education and services for methods which at present are only theoretically available. It was generally considered that if the full range of methods approved by the MOH could be effectively provided within the public sector, many of the client population's needs would be met. We concur with these views and conclude that introductory research should focus on the question of how methods currently approved for use within the public sector can be more appropriately and widely introduced.

Research must also be undertaken on the two methods which currently dominate the method mix, the oral contraceptive and tubal ligation. The public sector programme has an important role in promoting the appropriate use of the oral contraceptive and assuring the availability of trained providers who can deliver oral contraceptives with adequate quality of care. With appropriate mechanisms for and a basic commitment to the provision of regular supplies of oral contraceptives, women's options for safe contraception would be enhanced.

Moreover, the public sector programme can play an important role in designing educational strategies that reach out to those women who purchase the oral contraceptive through the commercial sector and use it without appropriate information and guidance. Applied research studies, designed to test public sector strategies for assuring the appropriate utilization of oral contraceptives are an important focus for introductory research.
Research on tubal ligation has contributed much towards understanding of the social and service delivery context within which utilization of this method occurs. Continued research attention to these issues could strengthen the case for clarification of the legal status of tubal ligation and inclusion of this method in the family planning norms. The appropriate reintroduction of tubal ligation in Brazil would make an important contribution towards improving the quality of care with which this method is delivered. Similar research should be undertaken on vasectomy.

Removal of some methods from the commercial sector is desirable

All methods currently provided in the public sector meet recognized safety standards. There are, however, four types of contraceptive methods on the commercial market which should be subject to greater control. Sequential oral contraceptives, oral contraceptives produced by small laboratories with

inadequate quality control, currently available once-a-month injectables which have not been adequately tested for safety and efficacy, and some products inaccurately advertised as spermicides, should be removed from the commercial market until their safety and efficacy are assessed according to internationally recognized standards.

Removal should be accompanied by appropriate information to users and recommendations about appropriate substitutes. Although the government has made an effort to remove some of these products from the market, there is no effective legal mechanism for prohibiting their production and distribution, and the MOH has little control over the availability of these products. Nonetheless it is recommended that continued attention be given to alternative mechanisms for removal of these methods including strengthening of the regulatory process. Broader provision of safe oral contraceptives within the public sector, and eventual introduction of new, low-dose injectables has great potential for directing women toward safer alternatives.

Limited introduction of new methods should await MOH inclusion into the family planning norms and the development of greater service delivery capabilities

If appropriately introduced, a method like Depo-provera has the potential to meet identified needs for reversible, highly effective, long-acting methods which may be used during the postpartum period. However, unless consistent availability and quality of care in service delivery can be assured, the addition of such a method would not increase contraceptive choice or improve women's options, and should not be considered.

The appropriate introduction of one of the appropriately tested, low-dose, once-a-month injectables could have a positive impact on contraception and health by increasing women's options and reducing demand for the available once-a-month injectables that are of unknown safety. Market competition may be successful in removing less safe products where legal action has not succeeded. This supports the recommendation that introduction of alternative once-a-month injectables be considered for the private and commercial sector as soon as these products have received MOH approval.

While introduction of once-a-month injectables should be considered a priority for the private and commercial sectors, it is our conclusion that widespread introduction of these or other injectables into the public sector cannot be recommended at this point in time. It is essential that overall service delivery capabilities be improved before the public sector programme assumes the additional burden of introducing new methods.

However, as once-a-month injectables receive MOH approval, and as Depo-provera is approved by Divisão de Produtos-MOH (DIPROD) for contraceptive use, it would be appropriate to conduct introductory research to assess the service delivery implications of adding these new methods to the public sector. In fact, such research may be helpful in

identifying concrete, operational strategies for introducing new methods in ways that maximize the limited resources within the public sector programme.

Recommendations

It is recommended that the WHO Task Force on Research on the Introduction and Transfer of Technologies for Fertility Regulation support research endeavours in Brazil which are consistent with the priorities identified by this assessment. Such research should have two main objectives: 1) to produce evidence on whether and how contraceptive options for both women and men can be broadened; and 2) to determine the extent to which research institutions with experience in providing a broad range of contraceptive methods can help to stimulate the process of contraceptive introduction and reintroduction within the public sector.

Multiple research approaches are suggested whose results would become available at different points in time. For this reason, we suggest that a process of simultaneous research and dissemination of research findings be initiated. This approach is particularly important since what is suggested is not only dissemination of research findings for operational and policy development, but also dissemination of information on a research process which can be used to encourage new approaches to contraceptive introduction. It is anticipated that dissemination will encourage collaborations between innovative research or service institutions and public sector programmes.

The WHO framework for contraceptive introduction proposes a three stage process whereby an assessment of the need for contraceptive introduction is followed, where appropriate, by a research stage (Stage II), and by a subsequent series of policy dialogues that focus on the utilization and dissemination of research findings (Stage III). What follows are specific recommendations for research, and for processes that are intended to ensure the dissemination and utilization of research findings on a larger scale.

Recommendations for research

A variety of research strategies will be required for the study of how currently underutilized or poorly utilized methods can be more widely and appropriately introduced into public sector delivery settings in Brazil. In the broadest sense, research should be undertaken to understand 1): user perspectives on contraceptive methods and users' attitudes towards and experience with the institutions of service delivery; and 2) the service delivery environment, with a focus on how the management of services, client-provider interactions, and larger operational factors influence the method mix and the quality of care with which methods are provided.

Both qualitative and quantitative research methods are necessary for the research suggested below. We recommend that qualitative approaches be given emphasis because of the value of such research for understanding the process of service delivery and the user perspective. Research drawing upon ethnographic approaches makes it possible to provide in-depth and

contextual understandings of contraceptive use and the service delivery setting.

The following specific recommendations for research have the potential for rapid impact on the provision of family planning services.

Demonstration projects: There is a need to explore how currently underutilized methods, such as the IUD and barrier methods, can be more broadly introduced in the public sector while at the same time assuring that the quality of care for the two most widely used methods, oral contraceptives and tubal ligation, is improved. Moreover, as other methods, specifically injectables, are approved it will be appropriate to conduct research directed at assessing the service delivery implications of the addition of these new methods to the public sector programme. Since the introduction of additional methods imposes managerial and service delivery burdens, differentiated approaches to introduction should be researched. Such strategies might imply full introduction of new or underutilized methods in some settings, and an emphasis on education and referral in others.

We recommend that research be undertaken as collaborative demonstration projects between research centres with successful experience in the delivery of a broad range of contraceptive options and municipal secretariats of health. The collaboration of community groups, especially members of relevant women's organizations should be actively pursued.

Demonstration projects should utilize a process of diagnostic assessments, interventions and evaluations with the objectives of broadening the method mix, assuring regular supplies, and increasing focus on the quality of services. Such projects must operate within the existing institutional arrangements for service delivery at the municipal level in order to provide information on the requirements for broadening contraceptive choice within the public sector.

Collaboration with research centres with relevant service delivery experience is intended to encourage the transfer of knowledge to the public sector, while at the same time assuring appropriate attention to the research component of such projects. Research from Bangladesh has shown that collaborative action research projects between established research institutions and the public sector programme can make significant contributions to improvements in service delivery and facilitate programme and policy development (Simmons et al; 1987).

The proposed demonstration projects should have research, intervention, and information dissemination components. Research should consist of: 1) diagnostic studies to guide activities including baseline assessments where necessary; 2) studies documenting the experience of specific interventions undertaken; and 3) overall evaluation of project impacts. Research undertaken within the demonstration project would be expected to include some of the issues and approaches which are discussed below as separate research activities.

User perspective research: We recommend a series of studies on user perspectives related to contraceptive choice and experience with service delivery systems. Recommended areas for research include: user attitudes about contraceptive methods, perceptions of health and other concerns relevant for method use, and experience with service providers and health care facilities and its impact on method choice. Special emphasis should be given to user attitudes towards male methods especially condoms and to research exploring attitudes of young people might be emphasized. Such research is essential for the design of service delivery and educational approaches that would increase confidence in, and provide more appropriate information about currently underutilized methods. When new methods are introduced in demonstration projects, user perspective research can provide insights into users' experience with the method and with the service delivery institutions which subsequently can be used to improve services.

Studies of client provider interactions and quality of care: Documentation and analysis of client-provider interactions should be undertaken to improve understanding of the existing conditions of service delivery. Studies should focus on indicators pertaining to the quantitative dimension of the interaction (service coverage, frequency and duration of the exchange), indicators pertaining to quality of care (choice, technical quality of care, interpersonal quality of care) and indicators measuring the nature of the services provided. Some attention should also be devoted to provider attitudes and perspectives and to questions of how differences in status, power and culture between providers and clients affect the process of service delivery. This area could also include research on the appropriateness of family planning service provision by medical and non-medical personnel. Research on client-provider exchanges under conditions of routine service delivery can identify training needs and can identify opportunities for introducing a broader focus on method choice. Such observational studies can also be a helpful tool in evaluating change in service delivery and quality of care over time.

Studies of IEC strategies: An important area of work concerns research on how educational and informational materials can best be disseminated within and beyond the clinic setting to assure that easily understandable and user friendly materials on method choice, appropriate use, sources of access etc. reach a broad range of actual and potential users. One specific area which will require research is how to effectively incorporate information on the need to protect against STDs/AIDS as well as pregnancy. Research on IEC should also include attention to the question of how appropriate educational materials can reduce provider bias against underutilized methods.

Service delivery research: Research should be undertaken on the organizational, management and policy context within which services are provided to assess how these could be

utilized to support broader method choice and quality of care. For example, projects might assess mechanisms through which municipalities can utilize new opportunities to obtain contraceptive supplies for the public sector. Operational research might also be undertaken on how municipalities can maximize their limited resources by broadening method choice in some of their service delivery points, while assuring appropriate referral mechanisms in the remaining clinics. Greater attention to service delivery strategies for men must also be investigated.

It is important to document the constraints on the ability of the system to deliver currently available methods and identify factors such as staffing, provider morale, and supply systems which would need to be modified or strengthened to assure broader method choice and quality of care. Documentation and analysis of success stories within the public sector would also be relevant.

Studies should also focus on how the highly medical and curative focus of contraceptive service delivery could be shifted towards a greater emphasis on a preventive and social focus that includes attention to sexuality and gender. In addition, research should explore how the clinic-based focus of current public sector services could be expanded to incorporate closer links with the community.

Recommendations for Dissemination of Information

Dissemination of research findings to local communities, policy makers, political leaders, service providers, managers, donor agencies and the media. Broad dissemination of research findings is an essential element of the proposed collaborative demonstration projects. This will require new approaches to the presentation of data with a strong emphasis on effective and efficient communication with diverse audiences. Dissemination should include the development of short briefing papers on specific findings written in a style and language that are easily understood by lay audiences. Press releases intended for utilization by the media are another important mechanism for dissemination of accurate information. Workshops should be arranged for presentation and review of findings. Broad-based participation of programme officials, providers and community representatives should be encouraged.

Development of a support and dissemination network. A network consisting of programme officials, providers, researchers, university professors, members of women's groups or other relevant community organizations including state and municipal councils from various regions and states in Brazil should be stimulated. The purpose of such a network would be to assist in the development of a group of professionals with common goals of broadening contraceptive options and assuring quality of care. Members of this network would learn from each other through: 1) sharing of written

documents including scientific papers, briefing papers, and reports; 2) participation in special workshops focused on the review of relevant experience among members of the network; 3) collaborative projects; and 4) first hand observations of innovative projects in other regions. It is hoped that this group will facilitate the utilization of findings from the demonstration projects in other municipalities.

Dissemination of research findings to the scientific community. Presentation of papers at conferences and seminars should be encouraged. While such dissemination is important, these mechanism have limited influence on the utilization of research for policy and programme development, and must therefore be supplemented by a variety of other approaches, some of which have been discussed above.

Concurrent information dissemination activities are intended to initiate Stage III discussions for the utilization of research findings for programme planning and implementation. It is hoped that simultaneous research and information dissemination will reduce the time between the start of project activities and the application of findings within and beyond the chosen municipalities. On completion of Stage II research, formal Stage III activities should be conducted, including the preparation of a strategic plan for the broader utilization of research findings.

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References

Arruda J, Rutemberg N, Morris L, Ferraz EA. Pesquisa sobre saúde e sexualidade do jovem: Rio de Janeiro, Curitiba e Recife em 1989-1990. Rio de Janeiro: BEMFAM and U.S. Department of Health and Human Services, 1992.*

Araújo M and Diniz S. (unpublished). Mulher, Sexualidade e AIDS: a epidemia e as novas responsabilidades dos programas de planejamento familiar, 1993.*

Araújo M, Ferreira A, Regina C, Díaz M, Grillo C, Faúndes A. Avaliação clínica do diafragma vaginal em três contextos brasileiros. Femina, 21:463-72, 1993.*

Bahamondes L, Petta C, Faúndes A, Bedone A. Significado do recente aumento do número de solicitantes de reversão de laqueadura em um serviço de esterilidade. Femina, 20:360-362, 1992.*

Barros FC, Vaughan I, Victoria C, Hutthy S. Epidemic of caesarean sections in Brazil. Lancet, 338:167-169, 1991.*

BEMFAM and Demographic and Health Surveys/Macro International Inc., Pesquisa Sobre Saude Familiar No. Nordeste Brasil, 1991. BEMFAM, Rio de Janeiro, 1992.*

BEMFAM/IRD. Pesquisa Nacional Sobre Saude Materno - Infantil e Planejamento Familiar Brasil 1986. Rio de Janeiro, 1987.*

Berquó E, De Souza M. Conhecimento e uso de condom: Anticoncepção e prevenção de doenças sexualmente transmissíveis. NEPO/UNICAMP texto Nº 20, 1991.*

Berquó E. Brasil um caso exemplar. Anticoncepção e partos cirúrgicos a espera de uma ação exemplar. Seminário "A situação da mulher e o desenvolvimento". NEPO/UNICAMP, 1993a.*

Berquó E. Brasil um caso exemplar. Anticoncepção e partos cirúrgicos a espera de uma ação exemplar. Seminário "A situação da mulher e o desenvolvimento". Estudos Feministas, CIEC/ECO/UFRJ/Vol.1, Nº 2, 1993b.*

Brasil. Constituição da República Federativa do Brasil, 1988.*

Bruce J. Fundamental elements of the quality of care: A simple framework. Studies in Family Planning 21,2:61-91, 1990.

Carta de Brasília. Encontro Nacional de Mulher e População. Nossos Direitos para Cairo. Brasília, DF, Setembro 1993.*

Carta de Itapecirica. Encontro Nacional de Mulher Negra e População. Itapecirica, São Paulo, Agosto 1993.*

CEMICAMP. Reavaliação do Programa de Assistência Integral à Saúde da Mulher no Estado de São Paulo. Relatório I, 1991.*

Costa A. O PAISM: uma política de assistência integral à saúde da mulher a ser resgatada. Comissão de cidadania e reprodução. São Paulo, 1992.*

Costa M, Chaloub R.. Anticoncepção oral. Uso e rumores. Fortaleza, Recife, Salvador. CEPPD, Rio de Janeiro, 1992.*

Costa Paiva L. Avaliação da performance do acetato de Medroxiprogesterona injetável como anticoncepcional e efeitos sobre o peso corporal, pressão arterial, ciclo menstrual e histologia endometrial. Dissertação de Mestrado, UNICAMP, 1993.*

Costa S, Martins I, Freitas S, Pinto C. Family planning among low income women in Rio de Janeiro: 1984-1985. International Family Planning Perspectives, 16:16-22, 1990.

Demographic and Health Surveys/Macro International, Inc. Population and Health Data for Latin America. USAID, Washington, D.C., 1993.

Díaz J, Bahamondes L, Díaz M, Marchi N, Faúndes A, Marini M. Evaluation of the performance of the Copper T380A IUD up to ten years. Is this IUD a reversible but potentially permanent method? Advances in Contraception, 8:275-280, 1992

Díaz M. Return for removal of NORPLANT after five years of use. Assessment of the spontaneous rate and strategies for its improvement. Technical Report. The Population Council, New York, 1990.

Díaz M. Implementation of a sex education programme in a family planning clinic: its contribution to quality of care. Presentation at a Meeting on "Family Planning Counseling: The International Experience", Turkey, 1992.*

Donabedian A. The definition of quality and approaches to its assessment. Health Administration Press, Ann Arbor. 1980.

Faúndes A, Díaz J, Díaz M, Pinotti J. Frequência e adequação no uso nos métodos contraceptivos por mulheres de Campinas. Revista Paulista de Medicina, 104:44-46, 1986.*

Faúndes A and Cecatti J. A operação cesárea no Brasil. Incidência, tendências, causas, consequências e propostas de ação. Cadernos de Saúde Pública, RJ, 7:150-173, 1991.*

Ferraz E, Ferreira J, Soares M, Morris L. Pesquisa sobre saúde reprodutiva e sexualidade do jovem: Rio de Janeiro, Curitiba e Recife em 1989-1990. Rio de Janeiro: BEMFAM and U.S. Department of Health and Human Services, 1992.*

Goldstein D. The cultural, class, and gender politics of a modern disease: Women and AIDS in Brazil. Report-in-Brief. Women and AIDS Research Programme. Undated.*

Hardy E, Coutinho M, Goodson P, Andrade R, Bonfim S. Percepção das usuárias de NORPLANT a respeito da informação recebida sobre o método. Reprodução, 6:38, 1991.*

Hardy E, Bahamondes L, Osis M, Rodrigues T, Alves G, Pádua K, Vera S. Arrependimento após esterilização cirúrgica. Estudo caso-controle. Relatório apresentado à Fundação Carlos Chagas, 1993.*

Hardy E. Users perceptions of different contraceptives. The Brazilian experience. The International Council of Scientific Unions. November, 1993.*

Jain, AK., and Bruce, J. Quality: the key to success. People, 16,4:6-8, 1989.

Laurenti R et al. Mortalidade materna: causas basicas e associades de morte em quatro municipios do Estado de São Paulo, 1983. Analise de atestados de obitos. Relatório final, 1986 (Mimeo). OMS, Sao Paulo, 1986.*

Laurenti R. Marcos referenciais para estudos e investigações em mortalidade materna. Revista de Saúde Pública 22:507-12, 1988.*

Lubis F, Fajans P, Simmons R. Maintaining technical quality of care in the introduction of CYCLOFEM® in a national family planning programme: findings from Indonesia. Contraception, 49(5):527-541, 1994.

Ministério da Economia, Fazenda e Planejamento. Instituto Brasileiro de Geografia e Estatística. Censo Demográfico, 1991. Rio de Janeiro, 1992.*

Ministério da Saúde. Divisão Nacional de Saúde Materno-Infantil. Relatório de atividades. Brasília, 1990.*

Ministério da Saúde. Secretaria Nacional de Assistência à Saúde. Departamento de Programas de Saúde. Coordenação de Saúde Materno Infantil. Assistência ao Planejamento Familiar. Brasília, 1992.*

Ministério da Saúde. Boletim mensal sobre epidemiologia da AIDS. Brasília, Outubro, 1993.*

Ministério da Saúde. Programa de Assistência Integral à Saúde da Mulher. Bases para uma ação programática. Brasília, 1983.*

Pesquisa Nacional por Amostra de Domicílios. Supplement on contraceptive use. Secretaria de Planejamento da Presidência da República. Fundação Instituto Brasileiro de Geografia e Estatística (IBGE), 1986.*

Petta CA. Associação entre o uso do anticoncepcional combinado oral e prevalência de fatores que contribuem para o risco de complicação durante seu uso. Dissertação de Mestrado, UNICAMP, 1992.*

Pinotti J, Díaz A, Díaz M, Hardy E, Faúndes A. A identificação de fatores associados à insatisfação após esterilização cirúrgica. Revista de Ginecologia e Obstetrícia Brasileira, 9:304-309, 1986.*

Pinotti J, Petta C, Pastene L, Faúndes A. Avaliação da adequação de uso de anticoncepcionais orais pela população feminina do Estado de São Paulo. Revista de Ginecologia e Obstetrícia, 2:110-116, 1990.*

Ross J, Mauldin W, Green S, Cooke R. Family Planning and Child Survival programs as assessed in 1991. The Population Council, New York, 1992.

SEADE. AIDS primeira causa de morte entre as mulheres. Ano 1; N° 2, Janeiro, 1994.*

Simmons R, Phillips J, Koenig M, Huque A. Implementation based policy development in Bangladesh. Paper prepared for the annual meeting of the Population Association of America. Chicago, April 30-May 2, 1987.

Simmons R, Fajans P, Lubis F. Contraceptive introduction and the management of choice: the role of CYCLOFEM® in Indonesia. Contraception, 1994, 49(5):509-525.

Spicehandler J, Simmons R. Contraceptive introduction reconsidered: A review and conceptual framework. WHO, Geneva, 1994. (Document no: WHO/HRP/ITT/94.1 available from HRP, World Health Organization, 1211 Geneva 27, Switzerland.)

UNFPA. Brazil. Programme review and strategy development report. UNFPA, New York, 1991.

United Nations Population Division. World population prospects. UNDP, New York, 1990.

Vasconcelos A, Acioli N, Valença A, Braga C, Pacheco M, Dantas S, Simonetti V, Garcia V. AIDS and sexuality among low income adolescent women in Recife, Brazil. Report-in-Brief, Women and AIDS Research Programme. September 1993.*

World Bank. Brazil. Woman's Reproductive Health. Report no. 8215 - BR. World Bank, Washington D.C., 1991.

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The Strategic Approach to Contraceptive Introduction

Ruth Simmons, Peter Hall, Juan Díaz, Margarita Díaz, Peter Fajans, and Jay Satia

The introduction of new contraceptive technologies has great potential for expanding contraceptive choice, but in practice, benefits have not always materialized as new methods have been added to public-sector programs. In response to lessons from the past, the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development, and Research Training in Human Reproduction (HRP) has taken major steps to develop a new approach and to support governments interested in its implementation. After reviewing previous experience with contraceptive introduction, the article outlines the strategic approach and discusses lessons from eight countries. This new approach shifts attention from promotion of a particular technology to an emphasis on the method mix, the capacity to provide services with quality of care, reproductive choice, and users' perspectives and needs. It also suggests that technology choice should be undertaken through a participatory process that begins with an assessment of the need for contraceptive introduction and is followed by research and policy and program development. Initial results from Bolivia, Brazil, Burkina Faso, Chile, Myanmar, South Africa, Vietnam, and Zambia confirm the value of the new approach. (STUDIES IN FAMILY PLANNING 1997; 28, 2: 79–94)

Over the past several decades, new methods of contraception have made essential contributions to couples' well-being by allowing them to avoid unwanted pregnancy and abortions and by permitting improvements in the timing of childbirth. The oral contraceptive, which became widely available in the 1960s, was the first of the modern reversible methods, followed by the intrauterine device (IUD). Shortly thereafter, injectable preparations entered the market, and subdermal implants were introduced beginning in 1983. Without doubt, health and social problems resulting from unwanted fertility could be alleviated if the contraceptive technologies that now exist were more broadly available, accessible, and affordable to a wider range of people than those who currently benefit from them. Introduction of new technologies has long been seen as one important way of expanding contraceptive use and addressing unmet need. More recently, introduction of new methods has also been regarded as a means of improving quality of care by making available a wider choice of contraceptives.

Although the introduction of new contraceptive technologies into service systems has great potential, three decades of experience have also shown that in practice, the benefits of technology have not always materialized. Close examination of contraceptive introduction in the public sector of Southern countries suggests that the availability of new contraceptives alone will not expand use or broaden choice unless the existing constraints faced by programs in delivering adequate services are addressed (Simmons, 1971; Soni, 1984; Ward et al., 1990; Simmons et al., 1994; Lubis et al., 1994; Snow and Chen, 1991). Even when users are

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satisfied with methods, a program's inability to attend to the technical requirements of a method, for example, the necessity to remove Norplant® implants after five years of use, is problematic (Hull, 1996). The issues to be considered in policy choices related to technology introduction are complex. Above all, they require greater systematic attention to the social and institutional context of method choice and broader input from relevant stakeholders than they have received so far.

In response to these lessons from the past, the UNDP/UNFPA/WHO/World Bank[1] Special Programme of Research, Development, and Research Training in Human Reproduction (HRP) has taken major steps to reframe its strategy for contraceptive introduction and to support governments interested in implementing new approaches. This process of redefinition was initiated at a strategic planning meeting in December 1991, organized by the Task Force on Research on the Introduction and Transfer of Technologies for Fertility Regulation within HRP. Experts from the World Health Organization and other institutions revised the existing concept of introduction to avoid focusing on single technologies, to advocate instead an examination of what can be learned about services and users that will better inform the decisionmaking process for selection of methods (Spicehandler and Simmons, 1994). This new model, referred to as "the strategic approach to contraceptive introduction," also suggests that new technologies must be introduced within a quality-of-care and reproductive-health framework and must incorporate the perspectives of a broad range of stakeholders, including those of users, providers, managers, policymakers, and women's health advocates.[2]

Since the end of 1993, WHO has been providing support to public-sector programs in Bolivia, Brazil, Burkina Faso, Chile, Myanmar, South Africa, Vietnam, and Zambia, in order to implement this strategic approach. Experience has confirmed that this new way of proceeding can be a means of enhancing the capacity to provide quality services. This article provides an overview of the strategic approach and presents lessons from the implementation experience in eight countries. Although many illustrations in this paper refer predominantly to the introduction of contraceptive methods, the strategy addresses fertility-regulation technologies broadly defined to include menstrual regulation and abortion.

Previous Approaches

Approaches to contraceptive introduction have evolved considerably over the past three decades, progressing from simplistic and mechanical assumptions to much broader understandings. Widespread introduction of the IUD in the 1960s, especially in India, proceeded on the notion that the provision of new contraceptive technology on a large scale was a routine matter. The device itself was widely considered to offer the solution to India's population problem. The importance of the social impact of method use and of the new service-delivery requirements involved in providing the IUD with an appropriate level of quality were ignored (Soni, 1984), as was the need for early evaluation (Simmons, 1971). As a consequence, the Indian program was unable to ensure appropriate levels of technical competence and counseling; it did not provide adequate logistics and supplies; and it did not support women as they experienced the physical and social consequences of IUD use. After an initially favorable response to the method, the IUD soon became discredited, depriving Indian women of the benefits that could have been provided if introduction had proceeded more cautiously and with greater attention to both the social and institutional contexts of method use.

Bridging Clinical Testing and Introduction with Applied Research

The Indian IUD experience shaped subsequent approaches to contraceptive introduction in public-sector settings. Research on experience with and acceptability of new methods within routine service-delivery settings served as a bridge between clinical testing and broad introduction of the methods. This approach consisted initially of two components: introductory or field trials and acceptability studies. In the late 1980s and early 1990s, several projects with a focus on service-delivery research were added.

Introductory trials are organized after the safety and effectiveness of methods have been established, at least provisionally, through a series of clinical trials conducted to examine methods under rigorously controlled conditions, according to clinic-based research protocols. Introductory trials continue to examine safety and effectiveness, but their focus shifts to introducing program providers to the requirements of the new method and to examining patterns of, and reasons for, discontinuation. Acceptability studies document the user's perspective on the new method and typically are conducted through individual or group interviews with users or potential users. Service-delivery research is undertaken to study the organizational and operational adaptations necessary to ensure quality of care if and when delivery of new methods is scaled up for routine provision in national programs.

Such a bridging approach has characterized the Norplant introduction undertaken by the Population Council (Beattie and Brown, 1994). Clinical and introductory trials were organized in more than a dozen countries, including Chile, the Dominican Republic, and Indonesia. Acceptability studies were undertaken in Colombia (Vollmer, 1985), the Dominican Republic, Egypt, Indonesia, and Thailand (PIACT, 1987), and service-delivery research was initiated in the late 1980s and early 1990s in Colombia, Indonesia, and Peru (Ward et al., 1988 and 1990; Simmons and Ward, 1991). Family Health International also conducted Norplant introductory trials in several countries, including Bangladesh, Nepal, Pakistan, the Philippines, Senegal, and Singapore, as well as acceptability studies in Bangladesh, Nepal, Haiti, and Nigeria, among others (Kane et al., 1990; Grubb et al., 1995).

WHO followed a similar approach in its introduction of a monthly injectable, Cyclofem™. Introductory trials were initially undertaken in five countries (Indonesia, Jamaica, Mexico, Thailand, and Tunisia), and subsequently in Brazil, Chile, Colombia, and Peru (Hall, 1994). Service-delivery research was conducted in Indonesia.

The main objective of Norplant and Cyclofem introductory trials was to provide data for national regulatory approvals, develop national training capabilities, and offer first-hand experience to leading health-care providers. Systematic feedback from service providers and users was channeled into the preparation of technical and counseling guidelines and training activities (Spicehandler, 1989). Findings from service-delivery studies underlined the importance of identifying management and program parameters required to integrate new methods into service-delivery systems.

Evidence from Research in Indonesia

These applied introductory research efforts produced the knowledge that induced WHO to question this approach and to undertake a strategic shift in introduction initiatives. Two service-delivery studies in Indonesia were most influential in this transition. One of these, the Population Council-supported Norplant study (Ward et al., 1990), was conducted at the time of the transition from field studies to large-scale expansion within the national program. It demonstrated that the national program was inadequately prepared at that time to provide Norplant with appropriate quality of care. For example, method choice was not guaranteed, removal on demand was not routinely available, side-effect counseling was minimal or absent, and the pace of training in removal was inadequate. While some of these quality-of-care and operational inadequacies were subsequently remedied (Beattie and Brown, 1994), the existence of these problems at the time of scaled-up introduction demonstrated that earlier detection of these potential weaknesses would have been important. The second study examined the implications of adding Cyclofem to the Indonesian national family planning program while focusing both on quality of care and quality in management of the delivery system (Simmons et al., 1994; Lubis et al., 1994). The major conclusions from that study are reviewed here because discussion of that research provided the impetus for the formulation of the new strategy for introduction.

The study showed that although Cyclofem's introduction into six trial clinics had broadened women's choice to some extent, conditions of routine service delivery included a range of weaknesses likely to counteract the potential contribution of this new method to the national program (Simmons et al., 1994). Evidence from observation of nontrial service settings showed that the availability of two injectable formulations—DMPA (depot medroxyprogesterone acetate) and NET-EN (norethisterone enanthate)—in the Indonesian program did not broaden women's choices. Providers did not emphasize the difference between the two injectables to prospective clients, and routinely substituted NET-EN for DMPA when stock depletion or logistic bottlenecks occurred. Typically, women were not informed of this substitution. Providers' understanding of the differences in the hormonal preparations or the management of side effects was poor, and reinjection time frames (three months for DMPA and, initially, two months for NET-EN) were not followed rigorously. The record-keeping system made provision for injectables, but did not allow for differentiation between the two types, and the logistics system did not ensure the availability of needles appropriate for each formulation. These findings raised doubts about the wisdom of adding yet another injectable to this service-delivery setting.

Policy commitment to making major changes in counseling, information giving, record keeping, logistics, and training would have been required for Cyclofem introduction to expand contraceptive options. Commitment to such major operational change, however, was unlikely in light of the government's interest in cost reduction. Thus, although introduction of Cyclofem in the context of an introductory trial, with its associated special training, monitoring, and supply inputs, was beneficial for women enrolled in the study, the potential addition of this method to routine service settings would have been problematic.

The service-delivery study on Cyclofem introduction in Indonesia raised a central question that had not been routinely considered in advance of an introduc-

tory trial: Is it appropriate to introduce the method? The decision to proceed with the Cyclofem introduction in Indonesia had been based largely on biomedical criteria; Cyclofem was viewed as an improvement over other injectables because it generally causes fewer disruptions in women's vaginal bleeding patterns. Findings from the service-delivery study, however, revealed that the intrinsic characteristics of new methods, by themselves, do not enhance women's choices.

The December 1991 planning meeting at WHO concluded, therefore, that although the prevailing approach to contraceptive introduction constituted a clear advance over earlier patterns, the overall paradigm remained flawed. It had been technology driven and had relied on decontextualized assumptions about method introduction. The addition of technology, ipso facto, had been assumed to increase reproductive choice, and the relationship between technology and choice had been considered largely in a social and institutional vacuum. Attention to the social context of method choice had been limited, the fit of the new method into the range of existing methods within a country remained unexplored, and questions about the capability of service-delivery systems to provide quality of care in the process of introduction and beyond was only beginning to be examined. Moreover, concerns for the perspectives of users, as well as service capability, had been viewed as essential only with regard to facilitating the process of introduction, not as a set of questions to be raised prior to the decision to introduce a method.

The Strategic Approach

The 1991 WHO meeting led to the development of a new approach that views contraceptive introduction not as a narrow operational issue, but places it in the context of overall program strategy. This strategic approach shifts attention from promotion of a particular technology to an emphasis on quality of care, reproductive choice, and users' perspectives and needs. It recognizes the implications of technology introduction for changes in program management systems. When policy choice and research are guided by a systems framework that allows for the integration of technologies, programmatic capabilities, and the social context of method use, outcomes are likely to serve users' needs. Figure 1 represents the user/technology/service system that serves as a foundation for the strategic approach.

Technology

The technology point in the triangle within the figure refers to the characteristics of contraceptive methods, including their safety, efficacy, administration, side effects, reversibility, and duration. Here, the basic questions identified by Bruce (1990: 63) as the defining elements of method choice should be raised:

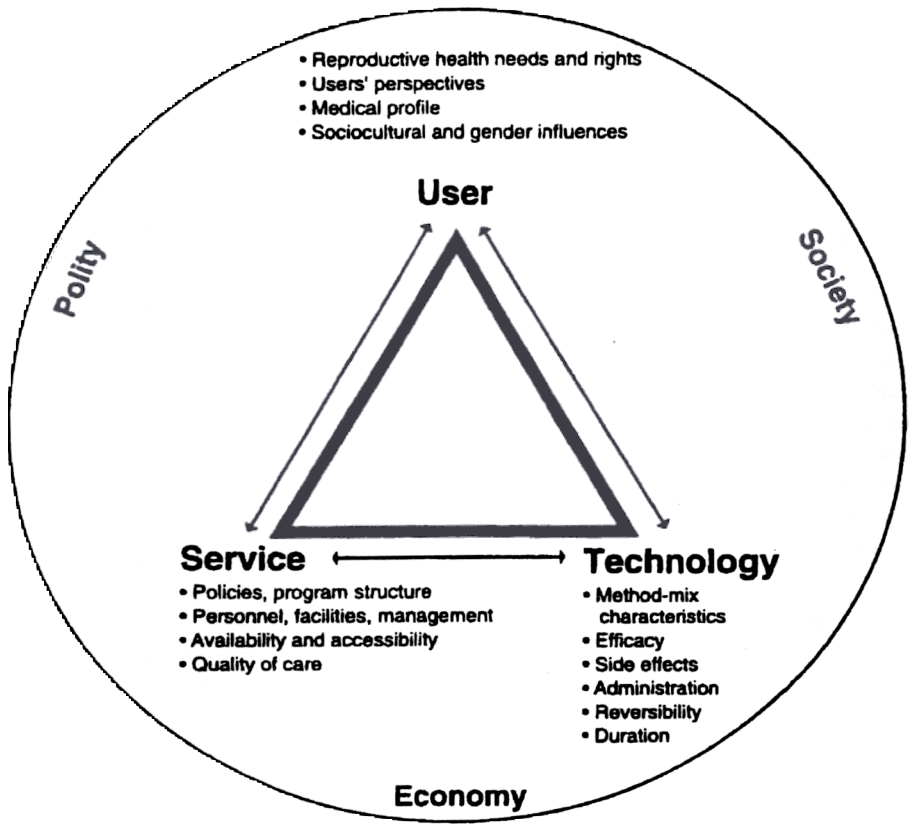
> Which methods are offered to serve significant subgroups as defined by age, gender, contraceptive intention, lactation status, health profile, and—where cost of the method is a factor—income groups? To what degree will these methods meet current or emerging need (for example, adolescents)? Are there satisfactory choices for those men and women who wish to space, those who wish to limit, those who cannot tolerate hormonal contraceptives, and so forth?

Characteristics of methods provided within a service-delivery system, as well as attributes of those with potential for introduction, should be considered. This emphasis shifts attention from an exclusive focus on methods considered for introduction to the characteristics of the actual or potential method mix. When introduction activities are focused on increasing variability in the characteristics of available methods, reproductive choice is enhanced.

Users' Perspectives and Needs

Technology must be appropriate to the reproductive health needs of potential users and to the sociocultural context into which they are introduced. Reproductive health needs and people's perspectives on technology and on the service-delivery system should be considered when decisions are made about which contraceptives to offer. Attention to women and men in various stages of the life cycle is essential. In the framework described in the figure, users' perspectives and needs are placed at the apex of the triangle to reflect the preeminence they deserve. The user–technology interface suggests such questions as these: Do users find that the advantages of a particular method outweigh its disadvantages? Do they have specific health-related concerns or fears about the method? Do they experience side effects, and if they do, what is their significance within the cultural and social context of the women's lives? Are pressures brought to bear by partners, family members, or others in the community to use or reject specific methods for personal, political, religious, or cultural reasons? In populations where the incidence of reproductive tract infections (RTIs) is high, consideration of IUD services should be linked to the capacity for RTI diagnosis and management; where the threat of HIV/AIDS is high,

Figure 1 Systems framework guiding the strategic approach to contraceptive introduction



the need for dual protection must be a priority. Where maternal mortality from illegal abortion is high, consideration of methods and services must focus on how such deaths can be avoided.

The user–service interface, in turn, suggests the following questions: Do users find the health center easily accessible in terms of distance and travel cost? Are waiting times acceptable? Are users' rights to adequate levels of information and their voluntarism in contraceptive use and method choice respected? Are people treated respectfully by staff? Are women with incomplete abortions provided with adequate care? Are contraceptive methods affordable? Where clinic-based services are widely used and service providers are trusted by the local people, introduction of new methods is likely to have important payoffs. Where the opposite is true, addition of new technology may have no effect or may possibly increase social distance, distrust, and suspicion. When women's power to negotiate contraceptive use is limited, methods requiring male cooperation or consent are of limited value; so are contraceptive services offered in distant clinics in cultures where women's limited status restricts their mobility.

Program/Service Capacity

Policy choice related to technology introduction must also be guided by the capabilities of service-delivery systems. Central questions are: Does the service-delivery system have the necessary managerial capacity in terms of human resource development, planning, logistics, and monitoring? Does it have the technical capacity to provide new methods with appropriate levels of quality of care? Do existing policies support voluntarism in contraceptive use and method choice? Does this capacity exist in both the public and the private sector? Is it feasible to provide the method within a large network of clinics or health posts or should it be restricted to special settings? Are the costs of new methods affordable within the limitations of existing resources? Are some methods too expensive to warrant introduction?

Where service-delivery systems do not have the capac-

ity to provide methods with appropriate levels of quality of care, addition of new methods may not be warranted. In such circumstances, focusing on building the capacity to increase availability, management support, and quality of service in provision of the methods that are already within a program may be more important.

In the figure, the user/technology/service triangle is embedded in a circle that draws attention to the broad social, economic, environmental, and political context within which relationships occur. Users' perspectives and needs are anchored within a social structure and a set of gender relations. Religious and cultural norms, as well as the power relations between men and women, shape views about contraceptive methods and affect the legitimacy of formally organized efforts to address reproductive health needs. Economic conditions and political ideologies, in turn, determine the resource pool available to address health needs and to build institutional capacities for organizing provision of contraceptive methods with attention to quality of care.

A Participatory Process

The strategic approach to contraceptive introduction involves a change in the process of policy choice, emphasizing country ownership, broad-based participation, and transparency of decisionmaking. Although international agencies make essential contributions to facilitate and support the strategic approach, the process must be led and implemented by key decisionmakers from all relevant sectors of the country. Moreover, broad-based participation implies expansion from a relatively narrow group of decisionmakers toward inclusion of other stakeholders from governmental and nongovernmental institutions representing multidisciplinary perspectives. Transparency in decisionmaking necessitates a commitment to an open process and widespread dissemination of information. Such a participatory process increases the likelihood that contraceptive introduction abides by ethical principles and enhances reproductive choice.

A participatory process and a systems framework guide the following three stages of work within the strategic approach: assessment, research, and use of research for policy and planning. Each of these phases also corresponds to a funding category within which WHO has supported these activities with increasing involvement from other agencies. The three stages of work are described below.

Stage I: Strategic Assessment of Need

Stage I is an assessment of national family planning services focused on the method mix, the extent of coverage, and the capability of the service-delivery system to provide quality services, to assure voluntarism, and to respond to the needs and perspectives of actual or potential users. A systematic assessment with input from a broad range of stakeholders conducted prior to making decisions about introduction constitutes a major departure from previous approaches.

The central purpose of these assessments is to answer the following three questions: (1) Does a need exist for the improved provision of existing methods? (2) Is there a need to remove methods from a service-delivery setting in cases where the safety or efficacy of these methods has not been systematically established or in cases where they have been replaced by improved formulations or devices? (3) Does a need exist for the introduction of new contraceptive methods, and if so, for what level of service delivery are they appropriate? These questions shift attention from considering exclusively methods that are new to a program to a concern for the improved provision of currently available methods or to the potential removal of methods from a service system. Thus, within this context, the very concept of introduction assumes a broadened meaning.

The assessment is not envisaged as an extensive analysis or as a baseline research study. Assessment reports make recommendations for policy and research with regard to the strategic questions of contraceptive introduction and related policy, programmatic, or operational issues. The strategic assessment is a first step in a larger process, as well as a valuable tool in its own right. The data-collection component of these assessments comprises: existing secondary data; a number of key informant interviews with policymakers, program managers, service providers, community people (including young people), users, and women's health advocates; as well as selective observations of service-delivery practices. Prior to field observations, the interdisciplinary team summarizes secondary data and available literature in a background document to ensure that the assessment addresses areas where information is lacking.

Overall, the extent of primary data collection in these assessments is limited. However, the methodology emphasizes evaluation of existing field conditions through qualitative interviews and observations of service conditions in major regions of a country. Although the main emphasis has been on an examination of public-sector services, assessments have also included some attention to the private sector, in particular in those settings where government services are limited and the private sector is the sole provider in large parts of the country.

Assessments are government led, involving rel-

evant national decisionmakers in all aspects of the process including in the development of instruments, site selection, conduct of field visits, analysis of findings and recommendations, preparation of the assessment report, and the dissemination of results. The team also includes women's health advocates, local researchers, and representatives from national NGOs. Technical support has been provided by WHO and by the agencies that have collaborated in the development and implementation of the strategic approach. Following the strategic assessment, a national workshop is organized at which key findings are presented. The workshop provides a critical forum for ensuring the ongoing involvement and input of local, national, and international institutions.

Whereas the core strategic questions related to contraceptive introduction provide the guiding framework, the flexibility of the Stage I methodology allows other reproductive health issues to be included, reflecting the country's interests and needs.

Stage II: Research

Assessments of the need for contraceptive introduction may lead to a variety of policy changes, to research initiatives related to contraceptive introduction, and to improvements in quality of care. Among policymakers and other relevant stakeholders, they also produce greater awareness of the relationship between contraceptive technology, quality of care, and reproductive health.

Stage II entails the design and implementation of applied research focused on country priorities as established by the strategic assessment. This stage may entail research on the improved provision of methods already offered within a service-delivery setting, or on the introduction of a new method or methods, with attention to the technical, operational, and managerial changes required to ensure that these methods are provided with an adequate level of quality. Service-delivery settings are studied in order to evaluate what adaptations are needed when innovations are introduced on a broader scale. Such research has included as main components demonstration or pilot projects and user-perspective and service-delivery research within public-sector settings. Both quantitative and qualitative methods are used; because of the need for in-depth understanding of program functioning, however, qualitative methods are particularly important. To guarantee research relevance and policy use, the broadly participatory process initiated during the strategic assessment is continued. Research is undertaken either by researchers from government institutions or it is conducted by local research institutions in collaboration with the public-sector program. WHO and its collaborating institutions have provided technical assistance for this research.

Stage III : Use of Research for Policy and Planning

The primary objective of Stage III is the use of research results for policy and program development. Past experience has shown that the application of lessons learned is not assured by good assessments and research findings alone but must be carefully fostered. Although attention to the use of assessment and research findings is an ongoing process, the third stage of the strategic approach focuses on initiatives intended to ensure that Stage I and Stage II are heeded as service innovations are introduced and method introduction expands.

Moving from Stage II to Stage III involves a review of the three strategic questions related to contraceptive introduction. In examining the bigger picture, policymakers must then determine how to scale up the quality of services elsewhere and decide which service-delivery points are most appropriate. Additional changes and adaptations required for scaling up from a pilot phase to regional or national implementation may require testing and refinement. If a new method is to be incorporated on a larger scale, plans for gradual expansion must be made in order to retain the emphasis on quality of care as the process unfolds. The central focus of these efforts must remain the overall improvement of quality of care and the provision of contraceptive options, not the physical availability of a particular method. If contraceptive expansion is recommended, a strategic plan is required for developing and upgrading training curricula and courses; information, education, and communication materials; infrastructure; logistics; and supply systems.

Specific activities undertaken at this stage vary and must arise out of country and program needs. They may entail additional research for scaling up from demonstration or pilot projects to a larger number of program sites, technical assistance, dissemination of results, and continued evaluation. In order to ensure that innovations from research are sustainable, Stage III activities must continue to address questions related to costs, the longer-term availability of funding, and other activities initiated during Stage II.

Continuation of the participatory and community-oriented approaches that guided the earlier phases of the strategic approach are essential. Program managers, in particular, must be part of the process of sharing results, because ultimately they will implement the recommendations that arise from research. An important element

of Stage III is, therefore, the organization of workshops and the promotion of dialogue to ensure that the implications of findings are fully understood and that consensus is reached. In addition, results from these initiatives should be disseminated through professional or policy seminars and publication of papers and newsletters.

Experience with Implementation

The strategic approach to contraceptive introduction is currently being implemented in eight countries: Bolivia (Camacho et al., 1996); Brazil (Formiga et al., 1994); Burkina Faso (CRESAR, 1997); Chile (Ministerio de Salud, 1997); Myanmar (Government of Myanmar, 1997); South Africa (Reproductive Health Task Force et al., 1994); Vietnam (Hieu et al., 1995); and Zambia (WHO, 1995). Choice of countries for this exercise has depended upon country interest in pursuing this approach and a request directed to WHO to support the process. The potential contribution of the exercise in light of the particular historical moment at which a country or program finds itself, or the extent of previous work, has also been important. For example, in South Africa, the exercise was supported in large measure because the country was in a major transition where such input would be of particular value. In Myanmar, the exercise was especially relevant because contraceptive services are extremely limited, but the government is planning major program expansion. Zambia, by contrast, faced implementation of significant bilateral funding support for its family planning program, a situation where a strategic assessment could provide critical guidance to the program-development process. Vietnam was concerned about its skewed method mix and wished to expand contraceptive options. The choice of countries has also been guided by desire for a wide geographic spread and diversity in social and economic development, in program settings, in contraceptive prevalence, and in methods currently available.

As Table 1 indicates, the process of implementation extends over several years, which is, in part, a reflection of the exigencies involved in working on systems improvements using participatory approaches. Length of implementation has also depended on WHO procedures related to ethical and scientific reviews and the funding process. As experience with the strategic approach accumulates, implementation time may decrease. The table indicates the countries in which Stage I assessments have been held and the dates for the dissemination workshop that precedes the initiation of research activities. In general, Stage II research projects are designed to last for as long as two years. The length of time between steps varies depending on the circumstances of the countries involved. Because most of the implementation experience to date covers the assessment stage and the development of subsequent research, the lessons discussed below refer primarily to these first phases of the strategic approach.

Table 1 Implementation of the strategic approach to contraceptive introduction, by country, according to stage in the process, 1993–97

Country	Stage I (Assessment)	Dissemination workshop	Stage II (Research underway)	Stage III (Initiated)
Brazil	November 1993	February 1994	✓	✓
South Africa	July 1994	September 1994	✓	—
Vietnam	November 1994	February 1995	✓	—
Zambia	March 1995	May 1995	✓	—
Bolivia	November 1995	September 1996	✓	—
Chile	July 1996	August 1996	—	—
Myanmar	September 1996	January 1997	—	—
Burkina Faso	October 1996	December 1996	—	—

Validating the Method-mix Focus

Experience has validated the importance of analyzing the need for introducing a contraceptive within the context of methods currently available in a particular setting. In Brazil, the assessment led to the conclusion that introduction of new methods should await improvements in the provision of currently approved methods of family planning (Formiga et al., 1994). Significant demand for family-size limitation in Brazil is reflected in the widespread use of oral contraceptives and tubal ligation. However, the current provision of these methods does not reflect a commitment to quality of care or to reproductive choice. The incorrect use of oral contraceptives is widespread (Pinotti et al., 1990; Costa et al., 1990) and, in large measure, is linked to inadequate provision of information to clients who obtain the method through pharmacies. The ambiguous legal status of tubal ligation, physicians' financial exploitation of women's demand for this method, and the frequent insistence upon sterilization as a prerequisite for employment have made women vulnerable. By contrast, IUDs, condoms and other barrier methods, lactational amenorrhea, and periodic abstinence—all of which are approved for public-sector services within the existing policy context—are little used. Therefore, instead of introducing additional methods, attention to improving access, quality of care, and provision of all approved methods is required in Brazil.

The other country assessments also revealed that reproductive choice is limited because of major method-

mix imbalances and serious shortcomings in all dimensions of quality of care. In Vietnam, providers tend to emphasize use of the IUD and discourage use of the pill, which is considered too difficult for rural women to remember to take regularly and potentially dangerous. In South Africa, most users, particularly black South Africans, are essentially limited to injectables. Access to IUDs, sterilization, and barrier methods is greatly constrained. In Bolivia, by contrast, use of periodic abstinence is widespread, yet women and providers lack accurate information about how to identify the fertile period. Unplanned pregnancies and a high rate of clandestine abortion are the results. In Zambia, where use of modern methods is low, the pill accounts for almost half of contraceptive use among married women of reproductive age, while about one-fifth use condoms and tubal ligation. According to the assessment, these methods were little used because of limitations in the service-delivery system, client and provider misinformation, and weaknesses in the management-support system.

In some settings, method cost is a major factor constraining contraceptive options, a condition that is rarely solved by introducing new methods. Cost issues manifest themselves both at the program and the individual level. For example, in Bolivia, where clients must pay for public-sector contraceptive services and supplies, the IUD is selected often as the cheapest method, rather than as the preferred method (Camacho et al., 1996). Moreover, many service settings do not even stock condoms or oral contraceptives because of limited finances. Cost constraints reinforce providers' belief that the cheapest method is the best for all women. Frequently, as a consequence, women's only option of a modern method is the IUD. In such settings, the broadening of choice among theoretically available methods or the introduction of new ones through Stage II research can only succeed if cost issues are appropriately addressed. In the private sector, cost is less problematic.

In Bolivia, South Africa, Vietnam, and Zambia, assessments have recommended that introduction of methods that were previously unavailable or not officially available can serve as a useful vehicle for increasing quality of care in the provision of all methods. Stage II research in South Africa and Zambia is particularly instructive in that it focuses on the addition of methods that have previously been neglected in introduction efforts—emergency contraception and barrier methods. The South African project focuses on barrier methods, including both male and female condoms, and on emergency contraception as backup. In Zambia, emergency contraception and barrier methods are introduced in conjunction with the reintroduction of Depo-provera. Characteristically, assessments have recommended that introduction research and policy change focus on improving quality in the provision of all methods. Thus, broadened attention to the method mix and the local program context enhances the potential for increasing reproductive choice.

Although the experience of implementation of Stage II research is still limited, emphasis on the method mix has characterized all projects and is producing important results. In Brazil, the Stage II project organized in one municipality has drawn attention to the contraceptive needs of populations that were previously ignored by the service system, namely, adolescents and men. With limited municipal resources, a referral center for family planning was created in which vasectomy, attention to adolescent needs, and distribution of condoms are all provided. Moreover, increased availability of and access to gynecological services and improvement in the collection of pap smears became possible for the total municipal service system (Diaz et al., 1997).

Removing Methods from Distribution

In all countries where an assessment has been completed, removal of methods from general distribution has been identified as important, especially with regard to hormonal methods, particularly oral contraceptives. Oral contraceptives containing 50 milligrams of estrogen were found to be used routinely in Brazil, Bolivia, South Africa, Vietnam, and Zambia. WHO has recently recommended that the use of oral contraceptives containing more than 35 milligrams of ethinyl estradiol be strongly discouraged. Triphasic preparations were encountered in Brazil, South Africa, and Zambia, and removal of these from the public sector was suggested, because service providers were unable to explain what they were or to ensure that they were taken correctly.

In Zambia, confusion prevailed about the numerous brands of oral contraceptives available in the public sector. Neither providers nor clients understood the differences among the formulations and brands. In Brazil, pills and injectables were produced by local companies in which quality control was inadequate. In both Brazil and Bolivia, the assessment team expressed concern about high-dose injectables available in the commercial market. In Vietnam, the use of quinacrine for sterilization, the safety of which has not been established through internationally accepted scientific procedures, created a major concern (Pies et al., 1994; Berer, 1995). The assessment team endorsed the Ministry of Health's decision to halt this method's introduction.

Many developing countries do not have strong drug regulatory mechanisms and, therefore, have limited influence over methods available from the private sector.

When methods are deemed no longer appropriate for distribution, ministries of health are in a position to withdraw these methods from supply. However, when methods are commercially available or available by means of highly decentralized systems where commodity purchases are made locally, method removal is difficult to accomplish. In such settings, introduction of a new method into the public sector can encourage withdrawal of inappropriate formulations from the commercial sector. For example, in Brazil and Bolivia, where high-dose once-a-month injectables are widely available through the commercial sector, public introduction of low-dose injectables has the potential to encourage a general shift to these formulations. Similarly, in Myanmar, commercial provision of a monthly injectable, which has a complex treatment regimen and low efficacy, argues for the public-sector introduction of newer products.

Linking Introduction to Quality of Care

Implementation of the strategic approach has demonstrated in several countries the value of linking the introduction of contraceptive methods to quality-of-care improvements. A concern for quality of care and the need to improve the provision of currently approved methods led to the conclusion in Brazil that the introduction of additional methods had low priority. In Vietnam, the emphasis on quality of care produced a government decision to reconsider the widespread introduction of Norplant. Extensive field observations and analysis carried out during the strategic assessment led to the conclusion that the Vietnamese program (with its target-driven, promotional approach and its weaknesses in technical quality of care and counseling) did not have the capacity to provide this method in a manner that would increase contraceptive choice. Decisions concerning future introduction have been delayed pending a retrospective analysis of earlier limited introductory trials of Norplant.

A similarly motivated, though less dramatic, shift occurred regarding the introduction of Depo-provera in Vietnam. Prior to the strategic assessment, the government and several major donors were interested in a quick, wide-scale introduction of Depo-provera throughout the national program. However, previous limited experience with provision of Depo-provera showed high drop-out rates and lack of attention to counseling. In light of these and other observed weaknesses in quality of care, the assessment recommended that an incremental and research-based approach to injectable introduction was needed. The introduction of Depo-provera is currently being supported within the context of voluntarism, broad method choice, and general quality-of-care improvements in the delivery of all methods through a Stage II research project in two provinces.

The important point of comparison with previous introductory studies is the deliberate attempt to use method introduction as an entry point for general quality-of-care improvements. In Vietnam, training has emphasized counseling and the provision of balanced and technically accurate information on all available contraceptives. Moreover, all staff providing family planning services—including community-based workers and volunteers—are being trained, not just a small subset of people addressing the special needs for a Depo-provera protocol. Stage II projects under way in Bolivia, South Africa, and Zambia will also introduce additional methods of family planning. While the specifics of these projects vary considerably, they all function within a broad quality-of-care paradigm that emphasizes voluntarism and choice, technical quality of care, counseling, and information-giving in all methods.

Managerial, Structural, and Philosophical Barriers

All of the assessments conducted so far have revealed major structural, managerial, and philosophical barriers to quality of care in services for reproductive health in general and family planning in particular. As noted, these weaknesses have been so significant in several settings that the assessments concluded that introduction of additional methods was unwarranted. Where assessments have recommended introduction of new methods, this has been done through a carefully phased and research-based process intended to encourage the development of the appropriate managerial capacity and to engender a humanistic philosophy of care.

Results from Stage II projects reinforce the importance of giving attention to management support systems and the philosophy of care. In Brazil, the Stage II project succeeded in reorganizing the service systems substantially to increase both access and quality of care. However, critical leadership and supervisory impetus for this change relied heavily on the institutional support provided by CEMICAMP. The challenge of institutionalizing such management capacity within the public sector remains unaddressed. In Vietnam, initial project results show that change in training alone has a limited and short-lived impact unless extensive supervision is provided. Without related changes in management and in the general philosophy of caregiving, providers quickly revert to old patterns of behavior. These results re-emphasize a point made earlier with regard to the introduction of injectable contraceptives in Bangladesh, that "[s]ystematic changes are needed that address critical structural and opera-

tional barriers to improving quality of care" if new contraceptive technologies are to make a contribution (Phillips et al., 1989: 243). These issues remain major challenges in the organization of Stage II research and in the subsequent use of research findings for program and policy development.

Social and Institutional Contexts

The significance of anchoring the strategic approach in social and institutional contexts of contraceptive use is well illustrated by several of the findings from strategic assessments and subsequent research. Race, ethnicity, class, religion, and sex are central forces that shape not only social attitudes and norms about contraception but also policies and programs and the power relations within which they are implemented.

In South Africa, the influence of a racially motivated and often coercive family planning program during the apartheid regime translated into an emphasis on the provision of injectables to black women, neglecting entirely their need for meaningful options and informed choice. The racially based political and administrative organization of the country produced highly differential access to services, leaving black women in rural areas with few options. In Bolivia, differences in ethnicity and class background between providers and clients explain low usage of services in the public sector, while the strong influence of the Catholic Church and political ideologies have limited government involvement with family planning. Traditional beliefs have impeded the use of modern services and specific methods. All assessments undertaken so far have provided ample evidence of the effect of gender imbalances on contraceptive choice. Viewing contraceptive introduction within a broader institutional context also raises the question of whether method introduction enhances reproductive choice or subjects people to coercive institutions of the state. Such ethical issues are particularly relevant in cases where provider-dependent, long-acting methods are considered.

Stage II research projects have been designed with a concern for the larger institutional context. In Bolivia, Stage II research will institute a process of dialogues between community representatives and service providers and managers to reduce the social distance between the two groups and to enhance opportunities for adapting services to local needs. The proposed training program will devote attention to gender dynamics. However, a single research project is limited in the extent to which it can respond to general social needs and address institutional constraints. The full benefits of framing introduction issues within a larger context will be accrued when multiple actors and institutions are able to use assessment findings.

The Participatory, Field-oriented Process

The power of a participatory process in assessments, policy development, and research has been demonstrated unmistakably in the implementation experience. The strategic approach emphasizes country ownership of the three-stage process of introduction. With one exception, assessments that have been conducted were led by senior ministry-of-health officials. In one case, the process was directed by a member of a research institution. Sustained governmental and nongovernmental participation in all stages of the fieldwork was accomplished in all assessments. WHO and its collaborating institutions provided extensive technical support and facilitated the process, but were not in charge of organizing and leading the process. The development of assessment instruments, the conduct of visits to the field, the analysis and interpretation of collected data, as well as the organization of workshops and subsequent research, were a team effort. A variety of governmental and nongovernmental institutions participated in workshops both prior to and after the assessment. Stage II research is undertaken by a government or involves a government agency in collaboration with national research institutions.

Involving senior government officials in the conduct of clinic observations and interviews with community members or providers at service-delivery points at all levels is of significant value, especially when such visits go beyond the ceremonial encounters typical of official field visits. Government authorities rarely have the opportunity of seeing the realities of program implementation at the local level. They are even less likely to converse with ordinary people in their homes, or to participate in discussion groups with community leaders in a frank exchange about the conditions of service delivery. In addition, they seldom have the opportunity to conduct a strategic analysis of policy choices regarding contraceptive introduction, using a systems framework focused on quality of care.

Expanding participation in the strategic process to other stakeholders, especially those typically not included at this level of decisionmaking, has proved to be both feasible and valuable. Collaboration of representatives from nongovernmental organizations and women's health advocates was secured for all Stage I assessments. In some settings, such participation was easily accomplished. Because close collaboration between the Women's Health Secretariat, NGOs, and wom-

en's health advocates existed prior to the initiation of the three-stage process in Bolivia, soliciting participation and establishing constructive working relationships was easy. In Zambia, team members were chosen from a group of individuals representing more than a dozen organizations, including Planned Parenthood Association of Zambia and the Young Women's Christian Association. Although some of the representatives were from women's organizations, women were also represented through legal, health, and development organizations.

Addressing women's concerns is more difficult when few or even no nongovernmental organizations exist that represent women's interests. In Vietnam, the Vietnam Women's Union (VWU) was a partner in the assessment. Although it is a governmental organization, the Union does not necessarily represent the same point of view as the Ministry of Health or the National Committee on Population and Family Planning. The participation of the VWU in the strategic process served to legitimize the perspectives of the organization and include women's voices, to encourage a client-oriented approach to services, and to strengthen the ability of the VWU to influence governmental health policy. In Myanmar, participation of the Myanmar Maternal and Child Welfare Association, an NGO working closely with the government, has provided women from that organization the opportunity to become aware of how their village-level membership could play a more active role in promoting birth-spacing services in rural areas. The assessment gave them a chance to learn not only from discussions with their own members during field visits, but also from interviews with nonmembers—that is, with villagers and local providers. Participants gained new insights into what their organization was and was not accomplishing at the village level.

In Brazil, where controversy existed between family planning providers and women's health groups in the past, collaboration in the assessment and extensive participation of women's health groups in the subsequent workshop provided an opportunity for some rapprochement of divergent perspectives, as well as for continued expression of diverse points of view. A unique result of the Stage II research project in Brazil was the creation of a community-based women's organization that has supported the action research project organized within a municipality. In preparation for the third phase of work, the project organizers are placing considerable value on the contribution of such groups in assuring replication of lessons from research.

The three principles of country ownership, participation of all stakeholders, and an open, transparent process are essential to the three-stage process. Bringing together policymakers, program managers, and researchers with community and district-based providers, women's health groups, and young people is both informative and provocative. These alliances are not necessarily natural ones, nor is working across such constituencies in a collegial manner effortless.

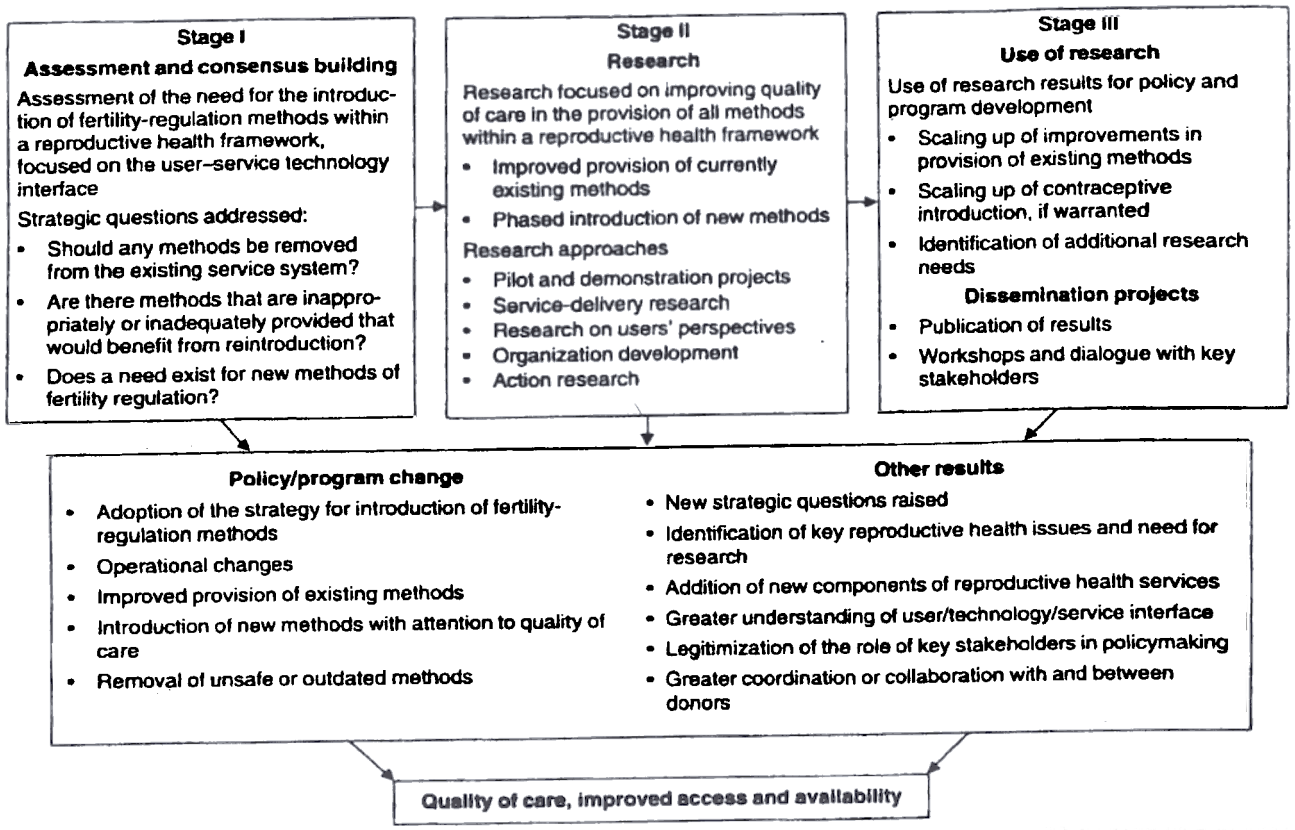
The Importance of Flexibility

The strategic approach suggests a logical process that may follow a number of paths. Flexibility is essential in assuring its participatory nature. Broad-based participation of a range of stakeholders leads to adaptations that reflect both national priorities and local concerns. Several countries broadened their approach to an assessment of reproductive health services, while maintaining an emphasis on contraception. In South Africa, doing so implied attention to sexually transmitted diseases (STDs), reproductive-system cancer screening, infertility, and abortion. In Bolivia, obstetric care was included, and in Brazil, attention to the diagnosis and early treatment of cervical cancer was added to the assessment. In all countries, the contraceptive introduction strategy has allowed significant input for identifying and addressing broader reproductive health needs. In Zambia, recommendations for policy and program changes from the strategic assessment were adopted as part of the national reproductive health agenda.

Implementation has shown that the strategic approach produces a more complex set of outcomes than originally had been anticipated and that these can occur earlier than expected. Policy, programmatic, or operational outcomes can result from Stage I assessments immediately, rather than later from Stage II research. An example is the Vietnamese government's decision to change its plans for widespread introduction of Norplant in favor of a more cautious process. The government and international agencies accepted the Stage I assessment as the national strategy for contraceptive introduction. As a result, several donor agencies wishing to introduce injectables have decided to wait until results from the introductory research in two provinces are available.

Similarly, useful research findings were expected to emerge at the completion of research. Experience has shown that dissemination and replication of such findings can occur earlier. Findings from the Stage II research project in the municipality of Santa Barbara d'Oeste in Brazil have been shared with other municipalities and with state and federal officials midway through the project. In Vietnam, the Stage II project produced a large workshop nine months after project initiation that shared preliminary results with agencies supporting reproductive health activities. The

Figure 2 Anticipated outcomes of the strategic approach to contraceptive introduction



closely interactive process of assessment, research, and policy and program development is illustrated in Figure 2.

Issues and Concerns

Although those who have participated in, or seen the results of, the strategic approach have been persuaded of its underlying value, the following four issues require attention as this approach becomes more widely implemented: (1) selection of research for Stage II ; (2) consequences of flexibility; (3) implications of undertaking the relatively lengthy process required to implement the strategic approach; and (4) assurance of sustainability.

First, the transition from assessment to research involves critical choices related to the selection of Stage II projects. Stage I assessments typically conclude with a range of recommendations about what type of introductory research is desirable. Only one project has been funded in each country from the range of research suggestions contained in the assessment report. Therefore, questions of what project to undertake and what method(s) to focus on are critical. Unless a number of researchers and funding agencies are willing to pursue the broad research agenda suggested in Stage I assessments, introductory research must be chosen to ensure that projects most critical for policy and program development are undertaken.

A second issue arises from the flexibility of the strategic approach that allows broadening of the assessment to include other areas of reproductive health. Although the rationale for such an expanded scope of work can be extremely persuasive, such broadening must be pursued with caution, to make sure that attention to strategic introduction questions is not compromised. Moreover, doing justice to several of the elements of reproductive health within the context of a single assessment is not easy. Use of sequential assessments may be an appropriate approach for some settings. For example, the Vietnamese government decided to pursue a second strategic assessment, this time addressing abortion and menstrual regulation, rather than focusing on contraceptive services. Although these issues were identi-

fied in the contraceptive method-mix assessment, they have such central significance for reproductive health in Vietnam that three years later an additional assessment is scheduled to take place. The overall framework and process remain the same, but the topic and strategic questions change.

Third, the amount of time required to implement technology introduction using a participatory approach focused on quality of care is considerable. Senior government officials, representatives of women's groups, and other participants in the process are limited in the amount of time they can dedicate to such a process. A related limitation concerns continuity and stability in government. Implementation of the strategic approach requires an ongoing rational process of policy choice and program development. Where ministries and political process are unstable, the strategic approach may not succeed fully, but the approach still has value, and the process may not need to extend over several years. In fact, the flexibility of the approach allows it to be adapted to the constraints inherent in such situations. Finally, because many countries are still dependent upon donor agencies for supply of contraceptive commodities, multilateral partners such as UNFPA and relevant bilateral donors must be involved from the outset of the strategic process. However, because assessments are country-owned exercises, it is essential that donor agencies support the process but do not influence it unduly. Such collaboration has been achieved in many of the countries where assessments have been conducted. In some of them, UNFPA and certain bilateral agencies have provided financial support for the assessment and continuing support for the Stage II research activities.

The underlying logic and philosophy of the strategic approach argue that method introduction should only proceed where a system's ability to provide services of high quality exists or can be generated. Such strengthening of quality, however, takes time. Does this emphasis on the quality of care deprive women and men of the benefits of new technology for too long? As Bruce suggests "[T]he ill-prepared introduction of a technology does not constitute the expansion of choice" (Bruce, 1990: 98). Taking the time necessary to move toward greater quality of care when introducing a method, therefore, is a worthwhile investment. Moreover, given the emphasis of the strategic approach on method mix, the results that are achieved, although they require time and effort, have an impact on all available methods, not merely on a newly introduced technology. The potential exists for ensuring that the benefits of currently available technology, of which women may have been deprived for a long time, are finally coming within reach.

A final concern is the sustainability of the strategic approach. Whereas the emphasis on country ownership, participation, and capacity building certainly has the potential for contributing to an enduring process, the issue of sustainability remains problematic. As Stage II research and Stage III activities unfold, the salience of this issue is likely to increase. Many of the changes proposed through the application of the strategic approach require strengthening the management infrastructure of public-sector programs as well as reorienting the overall philosophy and ethics of care. Such institutional change is not easily attained or maintained when results from pilot projects are transferred to larger settings. Outside support from institutions with credibility and technical skills is essential to ensure that the process is transparent and inclusive. Such support should continue as the strategic approach is more widely implemented.

Conclusion

The strategic approach to contraceptive introduction represents an important shift in perspective. It emphasizes quality of care and a reproductive-health focus as central elements in the process of improving provision of existing methods and adding new technology into the service system. In contrast to previous practice, it encourages a participatory approach that values responsiveness to a country's needs and collaboration among governments, women's health groups, community groups, nongovernmental providers, researchers, international donors, and technical assistance agencies. Implementation to date indicates that, in general, service-delivery settings are not well equipped to introduce new methods widely with adequate quality of care without significant change and adaptation in management and the philosophy of care. Improved provision of existing methods has been shown to be just as important as—at times more important than—the introduction of new ones. The strategic approach produces not only longer-term benefits with regard to improved quality of care and method choice but also has immediate policy, programmatic, and operational results that can transcend the narrow confines of existing contraceptive services to extend broader benefits in reproductive health. Although it should not be viewed as a panacea providing instant relief from the many institutional problems that afflict public-sector programs, the strategic approach is a participatory policy-development process of relevance for all countries.

Notes

1 United Nations Development Program/United Nations Population Fund/World Health Organization/World Bank.

2 Formulation and implementation of the strategic approach has involved extensive collaboration between WHO and the following institutions: the Center for Maternal and Child Health Research (CEMICAMP), a nongovernmental organization linked to the University of Campinas, Brazil; the University of Michigan; the Population Council; and the International Council on Management of Population Programmes (ICOMP). These institutions have provided major support to WHO through their participation in consultations and planning meetings of the Scientific Review Committee on Technology, Introduction and Transfer, HRP, and through their role in the design and implementation of the various stages involved in the new approach.

References

Beattie, Karen J. and George F. Brown. 1994. "Expanding contraceptive choice: Norplant." In *Contraceptive Research and Development 1984–1994*. Van Look P.F.A. and G. Pérez-Palacios. Delhi: Oxford University Press.

Berer, Marge. 1995. "The Quinacrine controversy continues." *Reproductive Health Matters* 6, 142–144.

Bruce, Judith. 1990. "Fundamental elements of the quality of care: A simple framework." *Studies in Family Planning* 21,2: 61–91.

Camacho, Hubner V. et al. 1996. *Diagnóstico Cualitativo de la Atención en Salud Reproductiva en Bolivia*. Geneva: World Health Organization. WHO/HRP/ITT/96.1 .

Cellule de Recherche en Santé de la Reproduction (CRESAR). 1997. "Evaluation des besoins en santé de la reproduction au Burkina Faso: Enquête qualitative." CRESAR. Forthcoming.

Costa, Sarah, Ignez Martin, Sylvia Freitas, and C. Pinto. 1990. "Family planning among low income women in Rio de Janeiro: 1984–85." *International Family Planning Perspectives* 16,1: 16–22.

Díaz, Margarita et al. 1997. "Expanding contraceptive choice: Findings from an action research project in Brazil." Unpublished.

Formiga, José Noble et al. 1994. *An Assessment of the Need for Contraceptive Introduction in Brazil*. Geneva: World Health Organization. WHO/HRP/ITT/94.2.

Grubb, Gary S., Deborah Moore, and N. Gustav Anderson. 1995. "Pre-introductory clinical trials of Norplant® implants: A comparison of seventeen countries' experience." *Contraception* 52,5: 287–296.

Hall, Peter E. 1994. "The Introduction of Cyclofem™ into National Family Planning Programmes: Experience from Studies in Indonesia, Jamaica, Mexico, Thailand and Tunisia." *Contraception* 49: 489–507.

Hieu, Do Trong et al. 1995. *An Assessment of the Need for Contraceptive Introduction in Viet Nam*. Geneva: World Health Organization. WHO/HRP/ITT 95.3.

Hull, Terence H. 1996. *The Dilemma of Norplant Removals in East Nusa Tenggara, Indonesia*. Report to the Annual Research Meeting, Mataram, Lombok, 1–3 May.

Kane, Thomas T., Gaston Farr, and Barbara Janowitz. 1990. "Initial acceptability of contraceptive implants in four developing countries." *International Family Planning Perspectives* 16,2: 49–54.

Lubis, Firman, Peter Fajans, and Ruth Simmons. 1994. "Maintaining technical quality of care in the introduction of Cyclofem™ in a national family planning program—Findings from Indonesia." *Contraception* 49,5: 527–40.

Ministerio de Salud de Chile et al. 1997. "Assessment of reproductive health and family planning services in Santiago, Chile." Unpublished.

Ministry of Health, Republic of Zambia and WHO's Task Force on Research on the Introduction and Transfer of Technologies for Fertility Regulation. 1995. *An Assessment of the Need for Contraceptive Introduction in Zambia*. Geneva: World Health Organization. WHO/HRP/ITT/95.4.

Phillips, James F., Mian Bazle Hossain, A.A. Zahidul Huque, and Jalaluddin Akbar. 1989. "A case study of contraceptive introduction: Domiciliary Depot-Medroxy Progesterone Acetate services in rural Bangladesh." In *Demographic and Programmatic Consequences of Contraceptive Innovations*. Eds. S.J. Segal, Amy O. Tsui, and S.M. Rogers. New York: Plenum Press.

PIACT. 1987. "Use of focus group discussion research: Looking at the acceptability of NORPLANT® implants in four countries to improve product introduction efforts." New York: Population Council. Unpublished.

Pies, Cheri, Malcolm Potts, and Bethany Young. 1994. "Quinacrine pellets: An examination of nonsurgical sterilization." *International Family Planning Perspectives* 20,4: 137–141.

Pinotti, J., A. Díaz, M. Díaz, E. Hardy, and Anibal Faúndes. 1990. "A identificação de use de anticoncepcionais orais pela população feminina do Estado de São Paulo." *Revista de Ginecologia e Obstetrícia* 2: 110–116.

Reproductive Health Task Force, South African Ministry of Health et al. 1994. "Assessment of reproductive health services in South Africa focusing on family planning." Report submitted to the World Health Organization, Geneva.

Simmons, George B. 1971. "The Indian Investment in Family Planning." *An Occasional Paper of the Population Council*. New York: Population Council.

Simmons, Ruth and S. Ward. 1991. "Service delivery systems and quality of care in the implementation of NORPLANT® in Peru." Report submitted to the Population Council, New York.

Simmons, Ruth, Peter Fajans, and Firman Lubis. 1994. "Contraceptive introduction and choice: The role of Cyclofem™ in Indonesia." *Contraception* 49,5: 509–526.

Snow, Rachel and Lincoln Chen. 1991. "Towards an Appropriate Contraceptive Method Mix: Policy Analyses of Three Asian Countries." *Working Paper Series*. No. 5. Cambridge, MA: Harvard Center for Population and Development Studies.

Soni, V. 1984. "The development and current organization of the family planning programme." In *India's Demography: Essays on the Contemporary Population*. Eds. T. Dyson and N. Crook. New Delhi: South Asian Publishers.

Spicehandler, Joanne. 1989. "NORPLANT® introduction: A management perspective." In *Demographic and Programmatic Consequences of Contraceptive Innovations*. Eds. S.J. Segal, Amy O. Tsui, and S.M. Rogers. New York: Plenum Publishing Corporation.

Spicehandler, Joanne and Ruth Simmons. 1994. *Contraceptive Introduction Reconsidered: A Review and Conceptual Framework.* Geneva: World Health Organization. WHO/HRP/ITT/94.1.

Union of Myanmar. 1997. "An assessment of the contraceptive method mix in Myanmar." Unpublished.

Vollmer, L. 1985. "Women's perspectives on the NORPLANT® contraceptive implants: Colombia." New York: Population Council. Unpublished.

Ward, Sheila, Ruth Simmons, and George Simmons. 1988. "Service delivery systems and quality of care in the implementation of NORPLANT® in Colombia." Report submitted to the Population Council, New York.

Ward, Sheila et al. 1990. "Service delivery systems and quality of care in the implementation of NORPLANT® in Indonesia." Report submitted to the Population Council, New York.

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3.2. Etapa II

Baseados nas recomendações do diagnóstico, era necessário que a Etapa II fosse um projeto piloto, de pesquisa participativa, voltado para o estudo da possibilidade de se melhorar o acesso e a qualidade de atenção em planejamento familiar num serviço público de saúde, com os recursos existentes no município. Para isso escolheu-se a cidade de Santa Bárbara d'Oeste município com aproximadamente 170 000 habitantes. A cidade foi escolhida devido ao interesse e compromisso manifestado pelas autoridades políticas e de saúde em melhorar a saúde sexual e reprodutiva da população local. Outro critério de escolha foi sua proximidade da cidade de Campinas, o que facilitaria a assistência técnica por parte do Cemicamp.

A Etapa II iniciou-se em fins de 1994, e a avaliação dos resultados foi realizada um e dois anos depois de iniciado o projeto.

3.2.1. Objetivos

1. Identificar as condições necessárias para a introdução de novos métodos anticoncepcionais nos serviços de saúde municipais.

2. Avaliar que intervenções poderiam facilitar a adequada introdução de novos métodos anticoncepcionais, de maneira a aumentar realmente as opções disponíveis no serviço público municipal.

3. Avaliar quais seriam as melhores estratégias para integrar da maneira mais eficiente, em todo o município, todos os serviços e programas de atenção à saúde reprodutiva.

4. Estudar o efeito das intervenções sobre a capacidade das autoridades municipais de mobilizar recursos para a adequada introdução dos métodos e a melhoria da qualidade dos serviços.

5. Estudar a aceitabilidade dos métodos anticoncepcionais quando oferecidos dentro de um contexto de livre escolha baseada em informações em serviços que ofereçam boa qualidade de atenção.

6. Avaliar o efeito das intervenções sobre a qualidade de atenção nos serviços municipais.

7. Estudar a opinião das/os usuárias/os dos serviços sobre os métodos anticoncepcionais, a qualidade dos serviços e a saúde reprodutiva em geral, e de que modo o projeto as havia modificado.

8. Avaliar o impacto do projeto sobre as políticas e normas oficiais sobre o planejamento familiar e a saúde sexual e reprodutiva em geral.

3.2.2. Método

Esta etapa foi um projeto de pesquisa participativa realizado no município de Santa Bárbara d'Oeste que incorporou três componentes: Diagnóstico, Intervenção/Ação e Avaliação.

Outro aspecto metodológico utilizado foi o desenvolvimento organizacional, que é uma estratégia de melhoria de organizações surgida no final da década de 50 e início dos anos 60. Refere-se à maneira como as pessoas e organizações trabalham e àquilo que se deve fazer para que elas trabalhem melhor.

A literatura guarda numerosas definições, e embora não haja consenso sobre uma única definição, há concordância sobre algumas de suas características principais.

Uma definição delas diz:

> Desenvolvimento organizacional é um esforço a longo prazo, conduzido e apoiado pelas chefias, para melhorar a visão de uma organização, num processo de empoderamento, aprendizagem e de solução de problemas, através de um gerenciamento de cultura de organizações, colaborativo e contínuo, com especial ênfase na cultura de equipes de trabalho, usando um consultor-facilitador e a teoria e tecnologia aplicadas às ciências de comportamento, incluindo a pesquisa-ação. (French e Bell, 1999, p. 25)

a) *Diagnóstico*

Para esse diagnóstico, foi elaborado e/ou adaptado um conjunto de doze instrumentos destinados a proporcionar informações sobre os recursos existentes e as potencialidades das unidades de saúde, o fluxo e o tempo gasto pelas mulheres na unidade, as relações interpessoais entre provedores e usuárias/os, a competência técnica ou capacitação dos provedores, e a percepção de provedores e da comunidade (homens e mulheres) sobre o planejamento familiar, os métodos anticoncepcionais e os serviços de saúde.

Esses instrumentos foram:

1. Inventário
2. Roteiro de Observação da Competência Técnica
3. Roteiro de Observação da Recepção
4. Folha de Registro do Tempo Gasto na Consulta
5. Fluxo das Usuárias na Unidade[4] (distribuído às/aos usuárias/os e preenchido pelos/as profissionais)
6. Guia de Observação do Fluxo
7. Questionário para Entrevista de Saída (destinado a mulheres que se consultaram com o ginecologista)
8. Entrevista com Usuárias da Unidade

[4] Adaptada da Cope (AVSC, 1995)

9. Roteiro para Grupo Focal com Mulheres da Comunidade
10. Roteiro para Grupo Focal com Homens da Comunidade
11. Roteiro para Entrevista ou Grupo Focal com Provedores
12. Roteiro para entrevista com autoridades

O diagnóstico foi realizado em todas as Unidades de Saúde do Município, nove Postos de Saúde e dois Centros de Saúde.

Quanto à análise, as entrevistas em profundidade e os grupos focais foram transcritos e analisados mediante o uso de técnicas de análise qualitativa, desenvolvida pela equipe de pesquisa que aplicou os instrumentos, liderada pela autora. As entrevistas de saída e de usuárias foram digitadas e analisadas com o programa SPSS para microcomputadores.

Um dos objetivos do diagnóstico na pesquisa participativa é fazer que as pessoas conheçam sua própria realidade, que participem da produção desse conhecimento e se apropriem dele.

Esse processo de aprendizagem se deu em todos os sentidos. Nós, pesquisadores, além de aprendermos a conhecer a situação das unidades de saúde, a opinião e perspectiva da comunidade etc., tivemos que aprender a trabalhar conjuntamente, ou seja, aprendemos a coletar dados com pessoas da comunidade e provedores de saúde que não eram “pesquisadores” e, nas discussões, a simplificar a linguagem para a devolução dos resultados e identificação das ações necessárias.

b) *Intervenção/Ação*

Para garantir o processo participativo, a primeira intervenção realizada foi a criação de um comitê executivo, que era uma instância de representação e

decisão criada para dar apoio ao projeto. Ele é constituído por representantes de autoridades, provedores de serviços, comunidade e equipe do Cemicamp.

A implementação desse comitê foi uma das primeiras ações realizadas e talvez a mais difícil de conseguir, se a analisarmos sob a ótica do real significado de participação.

O principal objetivo do Comitê era garantir a representação e a participação dos diversos segmentos envolvidos, principalmente da comunidade, no processo de tomada de decisões do Programa de Saúde Sexual e Reprodutiva. Foi decidido pelo próprio comitê que ele deveria colaborar também na busca de apoio e recursos, disseminar o programa na comunidade e integrar outros setores e instituições para discutir assuntos de interesse comum. Por exemplo, para as ações com adolescentes, a integração de educação e saúde.

A dificuldade não surgiu na formação do comitê, mas sim na real participação das pessoas, especialmente das mulheres da comunidade. Participar com opiniões, idéias ou votando junto com outras pessoas que na sociedade têm mais poder, como os médicos, secretário de saúde e nós mesmos, pesquisadores, não foi tarefa fácil, mesmo porque culturalmente essas pessoas também nunca participaram da elaboração de projetos, definição de ações de saúde etc.

Nesse aspecto nosso papel foi de fundamental importância, principalmente nossa atuação como educadores, incorporando as mulheres da comunidade nos cursos de capacitação junto com médicos, enfermeiras etc., facilitando o processo de participação nas reuniões, possibilitando o diálogo e fortalecendo principalmente os grupos com menor poder, como as mulheres e os adolescentes, as atendentes e recepcionistas.

Os resultados do diagnóstico foram apresentados a esse comitê, que identificou ações e intervenções que seriam prioritárias para resolver os problemas

detectados. Esse comitê reunia-se uma vez por mês durante todo o projeto para avaliar os resultados e definir novas ações.

As principais intervenções realizadas nesta etapa foram:

- Criação do SOS Mulher, para aumentar a participação comunitária.
- Instituição do PAISM, com a criação de um centro de referência em saúde sexual e reprodutiva, priorizando as ações de planejamento familiar e de detecção precoce do câncer de colo e de mama.
- Aumento das opções anticoncepcionais disponíveis nos serviços.
- Elaboração de materiais educativos e implementação de ações educativas sobre anticoncepção em todas as unidades de saúde.
- Redistribuição de funções entre a equipe, por exemplo, designando ao pessoal de enfermagem algumas atividades que eram realizadas pelos médicos, como a coleta de citologia oncótica (CO), exame de mama, consultas de seguimento a usuárias de métodos anticoncepcionais etc.
- Implementação de um sistema de registro de informações (folha do PAISM), que permitiu o cálculo de necessidades de anticoncepcionais, a obtenção de dados quantitativos para avaliar os resultados do projeto e otimizar o reembolso, pelo SUS, das atividades desenvolvidas.
- Implementação de um programa de adolescentes que incluiu a criação de um Centro de Referência para Adolescentes, um Grupo de Apoio para Adolescentes Grávidas e um grupo de Adolescentes Voluntários Agentes de Saúde (Grupo IRSSA – Instrutores de Referência à Saúde Sexual do Adolescente) – (ver anexos 1 e 2: Boletins Informativos).
- Implementação de um programa de vasectomia para aumentar a participação do homem.
- Formação de líderes comunitárias para atuar como promotoras voluntárias de saúde.

Para realizar todas as intervenções listadas, a Educação foi o elemento fundamental, presente ao longo de todo o processo, em oficinas e cursos de capacitação, com a participação de toda a equipe de saúde, líderes comunitárias, adolescentes etc.

Cabe assinalar que as denominações usadas para as atividades educativas que visam ao preparo e à formação dos profissionais estão atualmente em discussão. No campo da educação, tem-se avançado bastante nessa questão, no sentido de não somente mudar os paradigmas do que se entende por formação de professores, mas também de discutir muito sobre a terminologia usada nesse campo.

Numa análise de termos e concepções realizada por Alda Junqueira Marin (1995), revisam-se os diferentes termos usados e faz-se uma crítica no sentido de facilitar a compreensão de que muitas das decisões e ações tomadas no campo da educação são feitas com base nesses conceitos. Entre os termos mais usados que ela analisa estão: reciclagem, treinamento, aperfeiçoamento, capacitação, educação permanente, formação e educação continuadas. Os quatro primeiros são os mais usados na área da saúde, quando o objetivo é realizar atividades educativas com os profissionais de saúde depois da graduação. Nesse sentido, esse repensar crítico também nos ajuda a rever a terminologia usada em nossa área de atuação.

Segundo Marin (1995, p. 14), o termo “reciclagem” usado como *“*atualização pedagógica, cultural, para se obterem melhores resultados”, não deveria ser usado para pessoas, já que vem sendo usado para os processos de modificação de objetos ou materiais, os quais podem ser desmanchados e refabricados, ou ainda moídos, para que sua matéria-prima se transforme em novos objetos, ou seja, esse material está sujeito a alterações radicais incompatíveis com a idéia de atualização pedagógica.

Ela também questiona a obtenção de melhores resultados, afirmando que isso não depende só de atualização, mas sim de outros fatores. Compartilho sua opinião quando diz que a adoção desse termo resultou na implementação de cursos rápidos e descontextualizados, palestras e encontros esporádicos, nos quais se focaliza só uma parte, e de maneira superficial, o amplo universo que envolve o ensino.

O termo “treinamento”, que significa tornar destro, apto, capaz de realizar determinada tarefa, de ter habilidades, não é rejeitado completamente pela autora, no sentido de que em algumas situações é possível e necessário o desenvolvimento de determinadas habilidades. Entretanto, questiona-o, quando ele implica ações com finalidades meramente mecânicas, já que a educação considera que as pessoas exercem funções pautadas pelo uso da inteligência.

Se aplicarmos essa crítica ao campo da saúde, também diríamos que em alguns casos as pessoas precisam ser “treinadas”, ou seja, desenvolver algumas habilidades quase mecânicas, como por exemplo colocar a camisinha.

Entretanto, penso que, mesmo para essa ação mecânica, é preciso que a pessoa use sua inteligência, mobilize alguns sentimentos que lhe permitam se motivar para aprender. Além disso, também rejeito a idéia de modelação de comportamentos, como sugere o próprio termo.

Paulo Freire também critica a palavra “treinamento”, preferindo o termo “formação”. Para ele, a prática educativa envolve um profundo respeito à figura, o gosto e a formação do educando (Freire, 2000).

Alda Marin (1995) também analisa o termo “capacitação”, considerando que há mais de uma forma de conceber as ações de capacitação. Por um lado, significa tornar capaz, habilitar e, por outro, significa convencer, persuadir. Ela concorda com o primeiro enunciado e discorda do segundo, já que em sua opinião, se bem

seja importante que os educadores tornem-se capazes para o desempenho de sua profissão, não devem ser persuadidos ou convencidos de idéias. Eles devem conhecê-las, analisá-las, criticá-las e até mesmo aceitá-las, porém usando a razão.

Em sua análise, os termos “educação permanente”, “formação continuada” e “educação continuada” estão colocados no mesmo bloco, já que eles guardam semelhanças entre si. Tais termos colocam o conhecimento como eixo da formação inicial ou básica e incorporam as pesquisas que valorizem o conhecimento dos profissionais da educação e tudo aquilo que eles podem auxiliar a construir.

Ela reconhece que essa temática ainda precisa de mais estudos, contudo refere que a terminologia “educação continuada” pode ser uma abordagem mais ampla que incorpora as noções anteriores de treinamento, capacitação, aperfeiçoamento, dependendo da perspectiva, do objetivo específico ou dos aspectos a serem focalizados no processo educativo.

Em nosso projeto, optamos por escolher o termo “capacitação”, considerando o primeiro significado, já que em nosso modo de ver os provedores de saúde precisam desenvolver algumas habilidades e competências que os tornem realmente “profissionais” no desempenho de suas funções. Por exemplo, muitas enfermeiras são designadas para realizar ações educativas, sem nunca terem aprendido a lidar com grupos, a usar o apoio visual, a se comunicar com as usuárias etc.

E no que se refere às ações desenvolvidas com as usuárias, optamos por mudar o termo mais usado, “palestra”, por “ações educativas”, já que este último exprime mais a idéia do que realmente se faz, ou seja, um processo participativo de troca, de reflexão, de ensino-aprendizagem.

O componente educativo tinha uma intencionalidade que era colocar em prática o modelo teórico, ou seja, tornar as usuárias sujeitos participantes e trazê-las para o sistema, não somente com voz passiva (opinião nas pesquisas), mas como pessoas que com informação e espaço de diálogo pudessem ser integradas ao sistema de saúde e transformá-lo para seu benefício.

A ferramenta para se conseguir isso era o processo educativo. Mas, ao mesmo tempo, tínhamos que trazer, para participar, toda a equipe de saúde, além do secretário de saúde e os coordenadores, porque embora a organização dos serviços de saúde atendesse prioritariamente às necessidades dos médicos (horários de atenção, por exemplo), em geral toda a equipe também se sentia explorada pelo sistema. Estavam insatisfeitos e desmotivados.

Se considerássemos o entorno político, social, cultural e econômico, aparecia com mais clareza o papel da educação nesse processo de mudança de um sistema de saúde e de uma sociedade que, no final, em vez de contribuir para o bem-estar das pessoas estava ajudando a manter o mal-estar geral da população, dos provedores de saúde e das autoridades, além do descrédito em relação aos serviços de saúde pública.

O processo educativo que visava despertar o interesse e a consciência do papel que cada um podia ter na transformação não só do sistema de saúde mas do estilo de vida esteve presente em cada interação da autora com as diferentes pessoas, e a seguir serão listados alguns aspectos considerados nos cursos de capacitação.

De acordo com as reflexões acima, o sistema de capacitação utilizado foi diferente de outros programas desse tipo já utilizados previamente na América Latina, e seu impacto na qualidade de atenção tem sido muito limitado.

1. Capacitação planejada de acordo com as necessidades detectadas na etapa de diagnóstico. Nesse estágio foram detectadas as habilidades que cada membro da equipe deve ter, os conhecimentos e habilidades com que já contam e as principais deficiências. O diagnóstico também permitiu detectar as necessidades e potencialidades do pessoal para assumir outras funções além das que vinham sendo desenvolvidas.

2. Elaboração de diferentes programas de capacitação. Com base no diagnóstico e considerando os objetivos do projeto, desenvolveram-se diferentes programas de capacitação, com variada duração, orientados a cobrir as necessidades de todos os profissionais e das pessoas da comunidade. Alguns deles:

    - Curso básico de capacitação em planejamento familiar. Melhoria da qualidade dos serviços. Para médicos, enfermeiras, psicólogos, trabalhadoras sociais, auxiliares etc. (40 horas)
    - Curso de técnicas de comunicação interpessoal para recepcionistas (16 horas)
    - Oficina de sexualidade, gênero e DST/Aids (8 horas)
    - Curso de coleta de citologia oncótica para auxiliares e técnicas de enfermagem (16 horas)
    - Curso de formação de Agentes Voluntárias de Saúde, para líderes comunitárias (36 horas)
    - Curso de formação de Agentes Voluntários de Saúde para adolescentes (56 horas)
    - Curso para profissionais da saúde. Melhorando a qualidade da atenção de adolescentes grávidas (20 horas)

A seguir listam-se os conteúdos comuns a todos os cursos de capacitação, tratados com diferentes graus de complexidade, dependendo da categoria profissional dos capacitados:

I. Saúde sexual e reprodutiva
II. Sexualidade
III. Gênero
IV. Direitos sexuais e reprodutivos
V. Conceito de atenção integral
VI. Métodos anticoncepcionais
VII. Comunicação interpessoal
VIII. Qualidade de atenção
IX. Vulnerabilidade

3. Marcos de referência. Todas as atividades educativas tiveram como marcos referenciais o enfoque estratégico da OMS, os direitos sexuais e reprodutivos, levando em conta o plano de ações das Conferências do Cairo e Beijim, a sexualidade e a perspectiva de gênero, a qualidade de atenção e o modelo de desenvolvimento organizacional (DO).

4. As capacitações foram realizadas no local/cidade onde foi implantado o projeto. Na Etapa II, em Santa Bárbara d'Oeste, e nas três cidades que replicaram o projeto na Etapa III, Anápolis, GO, Ituiutaba, MG, e Sumaré, SP. Além dos cursos nas próprias cidades, alguns profissionais fizeram um estágio no Ambulatório de Reprodução Humana da UNICAMP. Para a implementação do programa de vasectomia, os profissionais foram capacitados na UNICAMP e na Profamilia, na Colômbia. Na Etapa III, algumas atividades práticas de capacitação foram realizadas em Santa Bárbara d'Oeste, por exemplo a capacitação do médico para implementar o projeto de vasectomia em Sumaré.

5. Todas as atividades educativas foram realizadas segundo uma metodologia participativa, com o uso de técnicas que possibilitassem partir sempre do conhecimento dos/as participantes, abrindo caminho para a reflexão, a incorporação de nova informação e a construção de novos significados. A

capacitação focalizava os aspectos cognitivos, afetivos, emocionais e o desenvolvimento de aptidões ou habilidades. Visava também, além de habilidades técnicas, aprender por exemplo a técnica de inserção do DIU, o desenvolvimento da capacidade de questionar, criticar, buscar soluções, ou seja, a intencionalidade do processo educativo era trazer essas pessoas para serem sujeitos de seu processo de aprendizagem e autores do processo de mudança.

6. Supervisão como uma etapa da capacitação. A equipe encarregada dessa tarefa, composta de duas pessoas, uma delas a autora, realizava visitas de supervisão que visavam reforçar a capacitação. A intenção era auxiliar as pessoas a pôr em prática o que haviam aprendido nessa matéria, ajudando a superar as dificuldades e fortalecendo o trabalho em equipe. A supervisão também foi útil para detectar novas necessidades relacionadas com os objetivos do programa. Estes eram também momentos de coleta de informação e revisão de registros.

7. Elaboração de materiais educativos. Foram elaborados folhetos para as/os usuários/as dos diferentes métodos anticoncepcionais, para servir de apoio às ações educativas. Dessa atividade também participaram usuárias e trabalhadores da equipe de saúde. Também foram doados e utilizados outros materiais desenvolvidos previamente pelo Cemicamp, tais como o álbum seriado dos métodos anticoncepcionais.

c) *Avaliação*

Na avaliação foram utilizados os mesmos instrumentos do diagnóstico, além dos dados coletados por meio do formulário do PAISM (anexo 3), que proporcionou os dados quantitativos.

Os resultados da avaliação são apresentados nas publicações correspondentes.

O programa de adolescentes e o programa de vasectomia foram avaliados separadamente, com instrumentos especialmente desenvolvidos para esse fim. Os resultados estão incluídos no relatório da avaliação da Etapa III.

3.2.3. Publicações

- Díaz, M. *et al*. “Expanding contraceptive choice: findings form Brazil”. **Studies in Family Planning**, v. 30, n. 1, p. 1-16, 1999.
- Díaz, M. e Simmons, R. “When is research participatory? Reflections on a reproductive health project in Brazil”. **Journal of Women’s Health**, v. 8, n. 2, p. 175-184, 1999.

Expanding Contraceptive Choice: Findings from Brazil

Margarita Díaz, Ruth Simmons, Juan Díaz, Carlos Gonzalez, Maria Yolanda Makuch, and Debora Bossemeyer

This article presents findings from a participatory action research project in a municipality in southern Brazil that models a new and holistic approach to broadening women's contraceptive choices. The project encourages a collaborative process between researchers, community members, and public health managers to diagnose service-delivery problems, to design and implement interventions, and to evaluate their effectiveness. Findings from the baseline evaluation revealed major constraints in availability of and access to family planning and reproductive health services for women, as well as severe deficiencies in quality of care. Interventions designed to address these weaknesses, bound by the limited resources of the public sector, focused on training, restructuring of providers' roles and service-delivery patterns, the management process, the creation of a referral center, and the introduction of injectables, vasectomy services, and a program for adolescents. Evaluation results show the project's considerable impact in broadening reproductive options, although not all issues, especially those related to sustainability, have been resolved. (STUDIES IN FAMILY PLANNING 30[1]: 1–16)

Contraceptive choice is a central element of quality of care in the provision of family planning services. It is also an important dimension of women's reproductive rights. Consequently, the introduction of new fertility-regulation technology into family planning programs often is advocated as a means of expanding women's options. The history of introducing contraceptive methods, however, has proved that a narrow focus on technology is not beneficial to women. Although in recent years considerable progress has been made in understanding the complexities involved in expanding method choice (Snow and Chen 1991; Bruce 1987; Hull 1996), the importance of placing contraceptive introduction within a social and organizational context is still not widely appreciated. The aim of this article is twofold: first, to demonstrate the need for improving reproductive health services in a municipality in southern Brazil and second, to present results from a project that has sought to address these needs by modeling a new approach to contraceptive introduction and the broadening of reproductive choice.

The project is part of an effort initiated by the World Health Organization and currently being carried out in nine countries to implement a participatory strategy based on quality of care for the introduction of fertility-regulation methods (Spicehandler and Simmons 1994; Simmons et al. 1997). This approach shifts attention from an exclusive emphasis on new technology to a holistic view of factors relevant for method introduction, including a concern for the social context of method choice, the currently available method mix, and the organizational capability of programs to ensure quality of care. Within this framework, the central policy issue is not only whether or not a new contraceptive method should be introduced within a given setting, but on how reproductive choice can be ensured.

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The strategic approach suggests three stages of work, beginning with a nationwide assessment of the need for contraceptive introduction and followed by introductory research and by deliberate efforts to foster the use of assessment and research results for policy and program development. In Brazil, the nationwide assessment showed that public-sector availability and access to contraceptive services were highly constrained (Formiga et al. 1994). Few public-sector health facilities provided the range of government-approved contraceptive methods, which included the pill, the intrauterine device (IUD), barrier methods, lactational amenorrhea, and periodic abstinence, or attended to all elements of quality of care. Provider bias against such underused methods as the IUD was found to be widespread, and technical competence and counseling were weak. Rather than increasing options and access, clinic-level education for users often served to control demand for scarce supplies and for appointments. In some service settings, women were required to schedule a series of appointments—for an educational session, a Pap smear, receipt of the Pap-smear result, and a consultation with a specialist—before they finally obtained an IUD. Tubal ligation, for which demand is high, was provided in a limited number of public facilities and only under special circumstances. Vasectomy services were similarly constrained.

Overall, the assessment showed that implementation of family planning services, a component of Brazil's Program for Integrated Assistance to Women's Health (PAISM), was weak. Therefore, adding new technology was not a priority (Formiga et al. 1994). Instead, improvement in access, availability, and the quality of services for methods already approved was urgently needed, and managerial conditions that would make these improvements possible had to be created. The assessment also noted considerable demand for injectables, reflected in the use of a high-dose once-a-month brand, Perlutan®,[1] which women obtain primarily through pharmacies. Because Perlutan is of unknown safety, the assessment recommended that after injectables receive Ministry of Health approval, research should be conducted to assess the service-delivery implications of adding injectables with proved safety and efficacy to the range of methods available.

As a result of the assessment and of these recommendations, research was initiated in the municipality of Santa Barbara d'Oeste, in the state of São Paulo, to test a participatory approach to the expansion of reproductive choice that emphasizes organization development, as described below. The characteristics of this project, referred to here as the Santa Barbara Project, differ from standard introductory studies. (For a discussion of these, see Simmons et al. 1997.) The project was undertaken within a reproductive health framework that directs attention not only to contraceptive services but also to related elements of reproductive health. It has replaced the conventional emphasis on the acceptability and continuation rates of a particular contraceptive method with an investigation of means for improving the delivery system to enhance access, availability, and quality of care in the provision of all contraceptive methods—that is, those currently provided within a service-delivery setting and those added through the project.

Background and Framework

The Santa Barbara Project draws on three intellectual traditions, "organization development" (French and Bell 1994), "action research" (Whyte 1991; Chisholm and Elden 1993; Israel et al. 1993), and "participatory research" (Cornwall and Jewkes 1995; Tandon 1981; Parker et al. 1998). Organization development entails collaborative diagnosis of organizational problems, identification of possible interventions and of ways of facilitating implementation, and evaluation of effectiveness. Sharing several of the characteristics of organization development, action research and participatory research are egalitarian in focus. The project represents a collaboration[2] between the municipality of Santa Barbara d'Oeste, the Center for Maternal and Child Health Research (CEMICAMP—a nongovernmental organization linked to the University of Campinas),[3] and members of the local community.

In the wake of nationwide decentralization in Brazil, public health services have been placed under municipal jurisdiction for financing and funding allocations. Federal and state authorities establish policies and operational guidelines but do not have control over services. The project site, the municipality of Santa Barbara d'Oeste, located in the central-western region of the state of São Paulo, 30 kilometers (18.6 miles) from Campinas, was selected because of severe deficiencies in its family planning services, its location near CEMICAMP and its previous collaboration with CEMICAMP in the area of training, and because of the health secretary's and the mayor's strong commitment to improved services.

At the initiation of the project in September 1994, the municipality had an estimated population of 170,000. The region has experienced rapid population growth in the past two decades as the result of a high birth rate and heavy internal migration. The municipality is almost entirely urban. The majority of the population is poor and employed in the sugar-cane industry. Eighty-eight

percent of the population lives within walking distance of a health facility. Municipal health services are provided through 11 facilities: Nine primary-care facilities (health posts) are responsible for pediatric care, immunization, basic curative care, therapeutic nursing care, gynecology, and dentistry; two secondary-care facilities (health centers) have the same responsibilities as the health posts but benefit from a more favorable staffing pattern. Health centers can rely on the regular presence of a gynecologist for at least one four-hour session every weekday and may also have a resident specialist in cardiology or radiology. Auxiliary nurses and attendants in these municipal service sites have limited training: Typically, they have completed a six-month paraprofessional course, whereas attendants have been exposed only to brief training. In 1993, 113,166 people, of whom 79 percent were female, received some care at these facilities.

Project activities were implemented by an executive committee including members of the health secretariat of Santa Barbara d'Oeste, service providers, collaborators from CEMICAMP, and representatives from a local women's organization established to participate in the project. The executive committee began its work in September 1994. Researchers from CEMICAMP acted as outside catalysts in the project, using their expertise to stimulate service-renewal processes. CEMICAMP also assumed special responsibility for the conduct of research, receiving technical support from the Population Council and the University of Michigan.

Because a key objective was to test realistic solutions for service improvements within current institutional constraints, the project was undertaken primarily within the budget limitations of the municipal health services. Exceptions included support for facilitating project initiation: for training; for development of information, education, and communication (IEC) materials; for computer equipment; and for initial supplies of contraceptives.

Baseline Diagnostic Research

Baseline diagnostic research in Santa Barbara d'Oeste, conducted to provide detailed information for the development of interventions, was undertaken between November 1994 and March 1995 to assess: (1) the perspectives of community members, of users of clinic facilities, and of providers and administrators; (2) quality of services and patient flow; (3) physical and human resources; and (4) the management system. The various methods employed for this diagnostic research are discussed below.

Methods

Ten community-based focus-group discussions ascertained the perspectives of both users and nonusers of services. Six focus-group discussions were conducted with women, four with men. A total of 68 women participated in the groups. Their ages ranged from 17 to 49; 83 percent were married or living in union; the majority had one or two children; about three-fourths had no more than four years of education; none had been in school for more than 11 years; 76 percent had ever used or were using a contraceptive method, mainly tubal ligation or the pill. In these communities, many women work as maids in other households or secure income through home-based production. The 28 male participants were similar to the female participants in terms of marital status, number of children, and contraceptive use. However, they were slightly older (ranging from 22 to 57) and, on average, were better educated.

Participating women were selected through their contacts with community-based organizations such as day-care centers, neighborhood associations, or church groups. Women living both near and far from a municipal health facility were included. Male participants were selected from among employees of two municipal departments: water and sewage, and transport and maintenance. Although some of the male participants were administrators in the water and sewage department, most worked on repair or cleaning crews; primarily, they represented the population that seeks access to public services. Male participants came from different parts of Santa Barbara d'Oeste and were interviewed at their place of work.[4]

Clinic-based Interviews

Two sets of interviews were conducted at the clinic level: 95 exit interviews with individual women[5] who received care from a gynecologist and interviews with 75 users of other clinic services who were questioned either before or after receiving services. These interviews provided information on users' reactions to reproductive health care at municipal facilities. Twenty-eight percent of the gynecology patients were antenatal cases, 31 percent were seen in connection with a Pap smear, 6 percent sought family planning services, and 30 percent had received other gynecological care.

Interviews with Providers and Administrators

The perspectives of providers and administrators were assessed through group or individual interviews with staff from all 11 municipal health facilities, as well as with supervisors and administrators. Altogether, 31 providers or administrators were interviewed concerning such

topics as their roles and functions within PAISM; the difficulties encountered in their work; training; the need or demand for contraceptive services; method availability and demand for methods; and men's role in family planning. In addition, in-depth interviews were conducted with five officials from the federal, state, and regional levels. These interviews focused on decisionmaking authority within PAISM and on each level's role in providing contraceptive and other supplies to municipalities. Substantial information was gathered from the participants about the service system and its managerial constraints.

Patient-flow Analysis

Patient-flow analysis is a technique for tracking the exact amount of time patients spend in a health facility from the moment they arrive until they leave. This analysis was undertaken in all nine health posts and involved 107 visits with patients. These data provided information on waiting times and on the amount of time patients spent with each staff member at the clinic.

Observation

Information on quality of care was based on observation of the clinics' functioning and of the care provided by the five municipal gynecologists during 42 consultations with patients.[6] Each physician was observed during one clinic session that typically lasted 90 minutes. A detailed observation guide was used to assess interpersonal relations and the technical competence of the provider during the consultation.[7] Drug-storage facilities, informational displays, and cleanliness were also evaluated. In addition, the variety of diagnostic activities undertaken at clinic sites provided an extended opportunity for informal observation of the clinics' functioning.

Findings

Overall, the diagnostic study revealed basic problems with the availability and accessibility of women's health services. According to the Brazilian constitution, women have a right to receive care within the public sector, but the availability of physicians, especially of gynecologists, was found to be extremely limited. Availability of services was further curtailed because physicians working for the municipality are paid extremely low salaries[8] and therefore are eager to keep their clinic service to a minimum. Instead of attending 16 patients during a four-hour clinic session, they often saw fewer than 16 women and completed consultations in two hours or less. Pregnant women were given priority in obtaining appointments, leaving few slots for those in need of gynecological care or family planning services. Observers also noted inefficient use of medical personnel and underuse of attendants. As many as 51 percent of gynecologists' consultations were consumed with collecting Pap smears or with giving patients their Pap-smear results. When providing family planning services, physicians' limited time was devoted to routine dispensing of contraceptives, which could have been performed by auxiliary personnel.

Faced with physicians' time constraints and a great demand for services, clinic staff resorted to a complex process of appointment scheduling that discouraged women from seeking care. Appointments were scheduled on a limited number of days during the week for as long as one or two months in advance. Women had to arrive at the health post in the middle of the night and stand in line for several hours to obtain care or to make an appointment. Often, after waiting in line, they were told that the appointment schedule was filled, and sometimes they were blamed for not arriving earlier. As a consequence of these scheduling patterns, the rate of no-shows was high.

The difficulty of gaining access to reproductive health services emerged as the central theme of focus-group discussions. The complex process of appointment scheduling was perceived as a major hardship:

> *Woman 1:* It is hard; we have to stand in line for a very long time. It is very hard. I came here the first day of the month and I only got [an appointment] for the 16th day of the next month.
>
> *Woman 2:* Well, for me it was even harder; it took three months to get my consultation. Yes, that's about it: between two and three months, sometimes more. It takes so long, and sometimes you come and you don't get your consultation.

The problematic nature of access to care was also reflected in a sarcastic comment made in response to the question of where women seek family planning services:

> *Woman 1:* If she has the right conditions, she can go to a private doctor, but if she doesn't, then she goes to the health post.
>
> *Woman 2:* She can even have two children before she gets the consultation. *(Everybody laughs)*

Focus groups with men confirmed women's difficulties in obtaining appointments at health facilities. Sometimes men help their wives with the time-consuming task of standing in line. One man commented: "I go there at three in the morning, and at seven my wife comes and she stays in line and I go to work."

The problems associated with accessing reproductive health care were poignantly summarized in the

statement that getting an appointment "is like winning the lottery." Heavy time, energy, and transportation costs were involved in this gamble to obtain access to care. As a result, women felt they could not take care of their own health. One focus-group participant remarked: "We didn't take care in the right way; because to go to the health post is so far, we don't have the money to go; women cannot have time to go."

The Quality of Services

Quality of care is defined by "the way clients are treated by the system, or the actual process of care giving, and by a focus on the client's or user's perspectives of services" (Hull 1996: 11). The project diagnosed quality of care based on the six-element framework outlined by Bruce (1990): choice; information giving; technical competence; interpersonal relations; an appropriate constellation of services; and continuity of care. This diagnostic research showed that improvements were necessary, particularly in the technical dimensions of care and in the information provided to users. However, in contrast to the consensus that access to care constituted a massive problem, findings on the quality of services showed mixed results.

Only two of the 42 observations[9] of patient–provider interactions were family planning consultations. These two consultations, both with IUD users, reflected a good level of technical quality of care. However, in other consultations, gynecologists revealed poor knowledge of contraception or neglected attention to family planning even when such a service was clearly indicated. In one case, the gynecologist advised a woman to rest for a period of two years from her use of the pill and in another, suggested that withdrawal was a poor method of family planning, but because the patient was 42 years old and "could not become pregnant any longer," continuing with this practice would be appropriate.

In the provision of antenatal care, gynecologists attended only to the medical aspects of pregnancy and neglected emotional, psychological, and informational needs. In one case, a 15-year-old woman was given no information about her pregnancy although she had never been pregnant before. Gynecological exams were sometimes incomplete or of poor quality: Half of the physicians omitted a breast examination, and when one was performed, it was not always thorough. Providers washed their hands or used gloves only intermittently prior to examining a patient. Referrals, although indicated, were not always given, and frequently, pertinent information was not recorded.

Interpersonal relations were relatively cordial during the observed interactions. Physicians established a friendly relationship with patients. Their style, however, was authoritarian and provided little opportunity for women to ask questions. Patients' privacy was not maintained. Consultations tended to be rapid, lasting, on average, five to six minutes within a range of one to 15 minutes. Waiting time for a consultation ranged from two and a half to four hours. Records to allow continuity of care were not kept.

Focus-group participants mentioned issues relating to quality of care less frequently than they did problems related to access, and when they spoke of these, they expressed various opinions. Some women were satisfied, reporting good care and supportive relations with staff. For example: "I have nothing to complain [about]; once you get the appointment, the treatment is good." Another participant mentioned that she herself was well attended, but that the quality of services depends "a lot on the circumstances and on the doctor who will attend you."

Other women had complaints, primarily concerning the limited amount of information they received, about the lack of equipment, or about poor interpersonal relations with the attending staff. Some women commented both favorably and unfavorably within the same session and even within the same sequence of exchanges. For example:

> *Woman 1:* I have not found, up till now, anything bad. I have been well attended . . . educated.
>
> *Woman 2:* I always go there, to the [health post]. I go there, but I don't like the doctors there very much. They don't pay attention to us. We talk and talk, and they don't say anything about the exam. They only say it's good and give a prescription.
>
> *Woman 3:* They also make mistakes. There are some that don't say the right thing . . . .

Nurses received mixed reports as well. Some were perceived as gentle and accommodating, others as unhelpful and rude, failing to assist women with their problems. When women came to the health post because they felt ill, they were sometimes told they did not have a problem or that they could only receive care in case of major illness. Examples were given of women with serious health conditions who could not obtain services.

Even when women were asked specifically about the quality of the attention they had received, their conversation returned spontaneously to their difficulties in obtaining care. When access to care is a major barrier, the question of its quality becomes moot.

Because men do not generally seek care at municipal facilities, they discussed the quality of attention less

than women did. One commented that the doctors were good; the problem was the long wait to get appointments. A few of the other comments were extremely critical of the doctor and the attention received. Men also raised an issue that was not mentioned by women: the costs associated with medical examinations, which can be considerable even at public clinics.

The exit interviews revealed more favorable user reactions than might have been predicted from the comments made in the focus-group discussions. Almost all respondents said that they had received the attention they requested, considered the care to have been good, and felt well treated. Clearly, women who have just "won the lottery" and seen a gynecologist are more likely to express satisfaction than are community women who are reflecting upon a history of experience dominated by lack of access. These findings also reinforce the widely noted tendency for exit interviews, based on structured questions, to reveal positive reactions to services obtained (Simmons and Elias 1994). Overall, findings from the community and from clinic patients show that once the problem of access is resolved, women tend to be grateful for the care they receive.

Even the exit interviews, however, pointed to problem areas. Three-fourths of the respondents complained of long waiting times, and almost half considered the consultation too short. Women did not feel encouraged to ask questions; when they did, typically they received no answers.

The Status of Family Planning within Municipal Services

The diagnostic study in Santa Barbara d'Oeste confirmed what had been observed in the nationwide assessment: Although family planning services had lowest priority within an overall weak public health system, the community perceived a strong need for such services. Family planning existed at these facilities as a small, incidental part of gynecological care, for which providers had little preparation, a limited range of technological options, and almost no time. Provision of contraceptive services was extremely low. Facilities offered oral contraceptives, IUDs, and condoms, but the supply was irregular. Limited supplies of Depo Provera had been made available immediately prior to the inception of the project. Women using the pill received a one-month supply with no provision for follow-up. Only two of the gynecologists were trained in IUD insertion. Diaphragms were physically present at some posts, but they were neither discussed with nor offered to patients. Physicians had not received family planning training during their medical education, and paramedical clinic staff also were untrained and did not dispense contraceptives. No informational materials designed for providers or for clients were available. With the exception of nutritional education for pregnant women, no educational activities for family planning or other dimensions of reproductive health were undertaken.

Because of the low availability of services, many community women did not know that contraceptive services could be obtained at public facilities. Seventy percent of the women who had just visited a gynecologist did not know that the health post offered family planning services, even though half of them already used a method of fertility regulation. Of those who practiced contraception, fewer than 9 percent obtained care from municipal health services. Most went to pharmacies, private physicians, or unspecified other sources. In interviews, men pointed out that many people, especially the poor, were not practicing family planning because of the difficulty in obtaining appointments for services at municipal facilities:

> If they want to get family planning at the post, it takes a long time; they have to be in line; they have to go very early, so they don't go.

> My wife, she goes to the gynecologist. She usually gets up at four in the morning to get a place in line. But usually women don't go. They stay six months, for more than a year or two years without going to the doctor. How can you do family planning without going to the doctor? Sometimes they take the "remedy" [the contraceptive pill], but they don't know if this medicine is good, if it is effective, or if it isn't good for their health, because they don't go to the doctor.

Men also referred to the inadequate availability of contraceptive supplies at the health post:

> How do they expect us to do family planning to control births when they don't have methods? I have never seen methods or condoms given at the health posts.... There are women who don't have the money to buy these medicines. And it is the poorest ones that have more children, because they don't have the conditions to prevent [having them].

The Management System

The major problems with the provision of municipal reproductive health care were clearly systemic. In addition to those already discussed, several additional weaknesses in the overall management system were identified during the diagnostic research. Above all, technical oversight of municipal facilities and supportive supervision were lacking. Some administrative control was exercised, but it was not directed toward solving the press-

ing problems of service availability or quality of care.

A management information system was in place, but it did not discriminate among the various elements of reproductive health, thereby making the tracking of contraceptive-service provision impossible. As a result, these data were not adequate to aid in effective supervision, and full reimbursement from the Sistema Unico de Saúde (SUS), the national institution that reimburses health institutions for services they provide, could not be obtained.

Interventions

Are conditions such as those described in this study amenable to interventions undertaken within the resource and institutional constraints of the public sector? If so, what strategies are likely to succeed? Two basic premises informed the Santa Barbara Project from its inception: First, public institutions are subject to improvements through a rational process of diagnosis, intervention, and evaluation. Clearly, conditions cannot be transformed miraculously, but incremental change is feasible. Second, leadership commitment and a participatory process are essential ingredients of success.

A first step toward implementing change was to institute collaboration among municipal health authorities, CEMICAMP staff, and community representatives. Although such collaboration constituted a dramatic departure from standard administrative procedure, it was created with relative ease, in large measure because of Santa Barbara's health secretary's genuine desire to bring about change, and because of his long-standing relationship with CEMICAMP. The involvement of community representatives was stimulated with the help of the municipal coordinator of PAISM, who informed various community groups of the new project and supported the formation of a local women's organization, SOS Mulher. Members of this local group participated regularly in the project's executive committee meetings, representing the community perspective in the committee's decisionmaking process. After they had received basic training, they also provided health education at service sites.[10]

Even before the detailed diagnostic research was completed, some areas for intervention had been identified and discussed in the executive committee meetings: training, the management information system, contraceptive supplies, recruitment of additional personnel, and the system of appointment making and service delivery at health facilities. Some interventions—training, for example—were initiated prior to the completion of the diagnostic research. Interventions were further discussed by the executive committee in light of the findings from the diagnostic evaluation. Interventions were started sequentially, and new initiatives continue to be undertaken.

Systems Development and Quality of Care

Although the expansion of contraceptive options was a major project goal, both the nationwide assessment in Brazil and diagnostic research in Santa Barbara d'Oeste revealed that systems development was a prerequisite for working on these issues. When services are severely limited and family planning is largely unavailable, the first priority should be the development of a service system that has the capacity to broaden contraceptive choice and attend to related reproductive health needs. Specific interventions undertaken to accomplish these objectives are discussed below.

Training

All medical, auxiliary, and attending staff of the 11 health facilities received training that was interactive in nature and that aimed to update technical information, improve attitudes toward the patient's role in decisionmaking, and enhance communications skills. The training program used a five-step quality-of-care and participatory approach. It covered four broad areas: (1) the philosophy of reproductive health, with a focus on women's needs; (2) the characteristics of a high-quality family planning service-delivery system, including job descriptions, definition of functions, scheduling, and patient flow; (3) information about contraceptive methods, including injectables, which were introduced into municipal services as part of the project; and (4) counseling and communications skills. Training included a theoretical section, with role playing, case-study discussions, group activities, and learning games, followed by practical training for all personnel. The theoretical training was evaluated through a pre- and post-training questionnaire that showed significant improvement in technical knowledge and attitudes related to free choice and counseling.

The physicians' formal training lasted for five days and was supplemented by one week of individualized practical training at the CEMICAMP family planning clinic. The latter included IUD insertion and follow-up, contraceptive screening, and management of complications and side effects. The acquisition and implementation of skills were reinforced by subsequent monitoring and supervision by trainers. Auxiliary nurses and attendants received three days of classroom training, supplemented by a one-day practicum on Pap-smear collec-

tion and breast examination, followed by monitoring. Some community members who wished to volunteer to provide health education in the municipal health service participated in a training session covering family planning, breastfeeding, sexuality, and gender relations. A one-day workshop for all staff of health posts and centers on the topics of sexuality, sexually transmitted diseases, and HIV/AIDS completed the overall training intervention.

The experience of presenting the training sessions taught several lessons. The inadequate and often outdated knowledge about contraceptives that physicians revealed during the sessions reaffirmed the need for this training. The training alone did not suffice to change the practice of service delivery, however. For example, physicians who had been instructing women for years to begin the pill on the fifth day of their menstrual cycle were hesitant to give them newer guidelines. They were also reluctant to provide information about the newly ascertained and approved duration of IUD effectiveness, fearing that patients might believe they were being given incorrect information. Changes in technical norms must be supplemented with written materials, preferably those bearing the stamp of approval of a credible institution such as the World Health Organization. Modifying authoritarian attitudes of providers was difficult, especially those of physicians, as was moving toward a style of interaction in which patients' perceptions and rights predominate. By contrast, suggestions about the need to improve interpersonal relations were more readily accepted by both medical and attending staff.

The long-term impact of training has remained limited because of the major turnover in personnel. Whereas three of the trained gynecologists working at the newly created referral center (discussed below) were still in place by mid-1997, only one of the original four trained gynecologists remained at the other municipal health sites. Similarly, only four of the 11 trained receptionists remained in service, and six of the 24 trained auxiliaries/attendants left. Some additional training has been undertaken for replacement staff. However, this high turnover threatens the sustainability of change in public-sector health services. Currently, the referral center is beginning to address this problem by providing on-the-job training to newly recruited gynecologists at the other health-care facilities.

Changes in Scheduling and Service Delivery

Opening up the appointment scheduling system and improving the efficiency in the use of the gynecologists' time were steps that followed the completion of training courses. According to the new procedures, women could schedule appointments any day of the week. Pap-smear collection no longer required an appointment and could be performed during clinic hours by attending nurses and auxiliary staff. Women using oral contraceptives could be resupplied for as long as one year without seeing a gynecologist. Job functions of the auxiliary staff were expanded and clarified, allowing them to collect Pap smears and inform patients of normal results; to perform breast examinations on a routine basis; and to provide family planning education and follow-up care for pill and condom users, employing the IEC materials made available by the project. As a result, the doctors had more time for consultations in gynecology, antenatal care, and family planning.

Changes in appointment scheduling and service delivery were welcomed by the staff. That dysfunctional scheduling patterns persisted for so long is surprising in view of the general positive response to these changes. Staff members were frustrated with the previous appointment scheduling process because they witnessed the distress of women struggling to gain access to care. Staff did not have the confidence or the authority to undertake changes in what they perceived to be an unsatisfactory system. The patient-centered philosophy of care emphasized during training, as well as ongoing support from the project, encouraged a shift.

As time elapsed, however, physicians exerted pressure to return to previous patterns. Although dysfunctional from the patient's point of view, the old system served the physician's interest in limiting the time devoted to public service. Clearly, an additional level of innovation was needed.

Personnel, Supplies, and the Management Information System

Some service modifications were easier to accomplish than the planners had anticipated, although difficulties arose in areas where none had been expected. The dearth of gynecologists in health facilities had appeared as a major gap from the earliest contact with the Santa Barbara d'Oeste municipal health system, and the fear was expressed that the resources for additional recruitment could not be generated. The extremely low level of remuneration for municipal service suggested that qualified physicians and nurses would not be interested in these assignments. In fact, both the resources for recruitment and the medical personnel were found, making possible the addition of five gynecologists to the staff. With the project's emerging success increasingly visible, more positions were made available. Again, the critical factor facilitating this change was the commitment of the health secretary, because with increasing decentraliza-

tion, the authority for recruitment has shifted to municipal officials. Budget cuts recently instituted by the new municipal government, however, threaten previous gains.

The supplies bottleneck was solved with relative ease. Although the nationwide assessment and diagnostic research showed that irregularity and inadequacy of contraceptive supplies were major problems, requests for supplies from the Ministry of Health and for local purchases, using municipal budget-line items, were approved without great difficulty. A focus on these issues, the strong support of the health secretary, and input from CEMICAMP produced the necessary changes. Moreover, having endorsed and participated in the nationwide assessment in Brazil, the Ministry of Health was eager to support projects resulting from the assessment.

Efforts to improve the management information system in order to assure detailed tracking of family planning services and to obtain a higher level of reimbursement from SUS met with only partial success. The original plan had been to adapt the family planning management information system from the University of Campinas for use in Santa Barbara d'Oeste. The university hospital developed an elaborate and well-functioning system that allows reimbursement from the national program for a variety of contraceptive services.

Relevant staff were trained and a system was put in place. The new system now provides useful information about family planning services; however, several factors prevent its use for reimbursement from the SUS. First, the entire municipal health information system would have to be changed, not just the family planning information system. Although the university model could have been used for a total system change, the resources for doing so were unavailable. Second, the municipality of Santa Barbara d'Oeste was already approaching its ceiling for SUS reimbursement, and therefore, a more accurate system lost its potential for adding substantially to the level of resources. Third, reimbursement patterns are subject to prior negotiation between the municipality and the SUS. For example, when the municipality of Santa Barbara d'Oeste began to provide previously unavailable vasectomy services, reimbursement could occur only if the new services had been registered and approved by the SUS. Although such negotiations with the SUS are theoretically feasible, they require substantial investment in time and effort, which did not seem warranted financially.

Instituting a Family Planning Referral Center

Although the interventions described above made a difference, they could not, by themselves, produce substantial change in service availability. The quantity of contraceptive services increased during the first months of the project, but subsequently reached a plateau. A more basic structural innovation was required. It took the form of a specialized center for women's health care with an emphasis on family planning and other reproductive health care. Because of municipal resource constraints, such care could not be provided at all facilities. Adding a reproductive health referral center to one of the health centers was feasible, however, as was identifying sufficient gynecological medical staff to ensure regular availability of services throughout the week.

One of the two health centers, located centrally within Santa Barbara d'Oeste, was so designated. It was remodeled, additional staff (one gynecologist, two psychologists, and one nurse) were recruited, and staff members were trained. Since July 1995, women have received contraceptive and other reproductive health services at this center without enduring the long waiting times for appointments that were typical in the past. A broadened range of contraceptive options is consistently available: Depo Provera, the IUD, the pill, diaphragms, and condoms. In addition, vasectomy services have been organized, including individual and couple counseling and screening sessions, clinic services, and follow-up. By April 1998, more than 300 vasectomies had been performed by a gynecologist who had received training by CEMICAMP in vasectomy provision. The referral center also provides reproductive health services for adolescents. By mid-1998, on average, 60 adolescents were seen for antenatal care each month and 130 adolescents were consulting for "other" reasons, including family planning. Adolescent health agents meet regularly with program and CEMICAMP staff and perform educational and peer counseling services in schools and in the community.[11] In addition to providing family planning services for adult women, the referral center offers care in cervical pathology and in breast and cervical cancer prevention.

Both structural and motivational factors explain the success of the referral center. Restructuring, designed to identify a referral center with emphasis on family planning, elevated these services to the level of a medical specialty and created both the physical and organizational space to implement innovations in this designated setting. The creation of the center, together with the health secretary's support, made it possible to find committed gynecologists motivated to work in the field of family planning within the context of reproductive health. Physicians providing care in the referral center spend the required amount of time at a clinic session rather than following the usual practice of staying only briefly and attending 16 patients hurriedly.

The implementation of the referral center legitimates the concept of family planning services within the con-

text of municipal health care. Further work is required, however, to strengthen the referral mechanisms from health posts to the center.

As with some of the other successful interventions, this center was funded within the resource constraints of the public sector. The additional resources required were limited and could be mobilized once the value of this intervention became apparent and high-level commitment existed to proceed. An exception is the adolescent health agent program, which was organized with more intensive input from CEMICAMP than were the other services.

Findings from the Evaluation

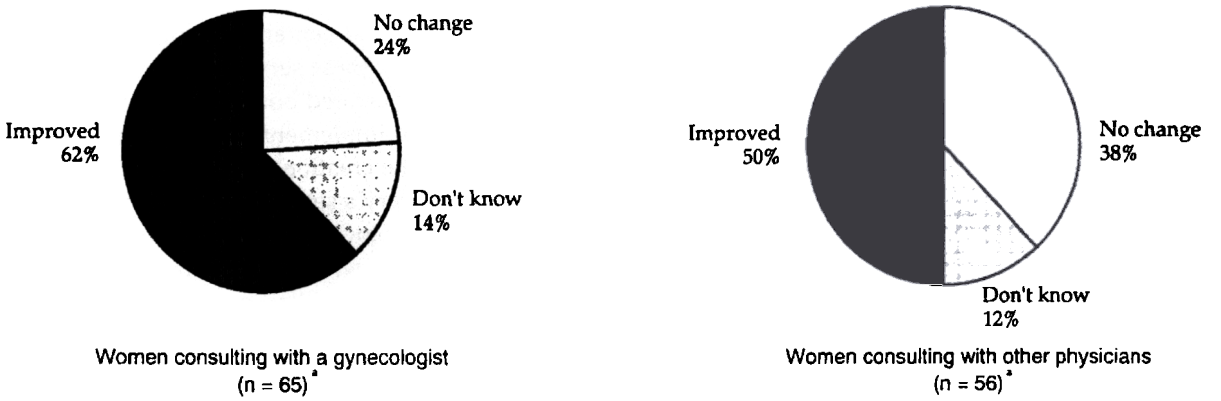
The results discussed above are based on observations obtained in the course of the implementation process, from executive committee meetings and referral center service statistics. Toward the end of the second project year, between July and September 1996, a formal evaluation was conducted using the same instruments and approaches as the baseline diagnostic study.[12] Findings from this evaluation and results from an analysis of management information system data for 1995–97 are presented below.

The evaluation confirmed that, overall, the innovations undertaken in the municipality of Santa Barbara d'Oeste were well received by the community. More than half of the women who had used municipal facilities for more than one year felt that services had improved. As major interventions were focused on women's health, satisfaction was greatest among those who had consulted a gynecologist (see Figure 1). The most frequently noted improvements were related to appointment scheduling, waiting times, and the availability of gynecologists. Such positive response was also evident from the community-based focus-group interviews.[13] In each of the four women's focus groups, referral center services were mentioned, although not all participants were aware of them. Members of one of the two male groups were aware of their existence as well. On the whole, referral center services were considered to be of good quality. Other municipal facilities were also more favorably evaluated than they had been in baseline focus groups. Overall, physicians received more favorable comments than they had previously. However, some of the old complaints remained, including long waiting times for appointments or consultations and unfriendly attendants.

Direct observation of service delivery showed the deleterious consequences of the turnover in gynecological staff. The technical competence of the doctors recruited to replace those who had been trained and had left the municipal services was weak. Of the two gynecologists who remained, one demonstrated good technical competence; the other did not, although both established good interpersonal relations. Attendants trained to perform breast examinations and Pap smears executed these tasks well. Receptionists were found to have improved their relations with patients. The quality of group education was good; however, because of staff shortages, educational activities were often interrupted.

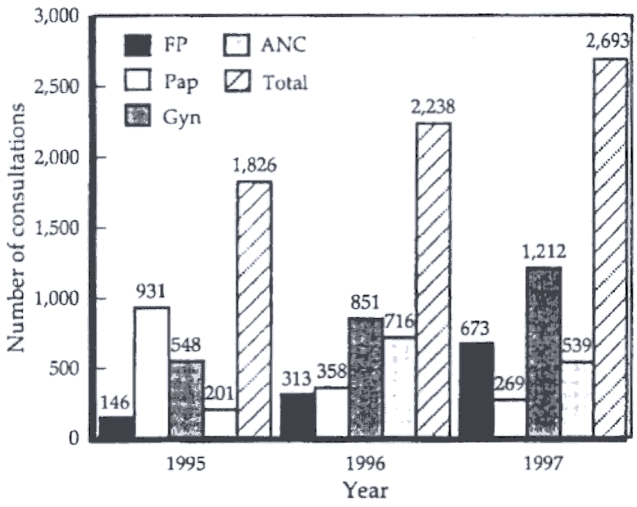
Figure 2 shows a considerable increase in the number of consultations provided by gynecologists. Average monthly reproductive health consultations at the 11 municipal health service sites increased by almost 50 percent between 1995 and 1997. The 1995 figure probably reflects some project impact, because by the time the new management information system (which made such tracking possible) was put into place, other interventions

Figure 1 Users' perception of quality of care 18 months after initiation of the interventions, Brazil, 1996



*Women who had been using the municipal health facilities for one year or more.
Source: Exit interviews with women consulting a gynecologist and clinic-based interviews with women consulting other physicians.

Figure 2 Average monthly consultations provided by gynecologists at 11 municipal health facilities, Brazil, 1995–97



Source: Management information system data from consultations provided by gynecologists for a six-month period (from April to September each year), in family planning (FP), Pap-smear collection (Pap), general gynecological services (Gyn), and antenatal care (ANC).

were already under way. These data also demonstrate a greater than fourfold increase in attention to family planning between 1995 and 1997.

Figure 3 confirms that increased efficiency in the use of the gynecologists' time allowed them to pay greater attention to family planning matters. The data distinguish between visits that were related exclusively to Pap-smear collection or return of Pap-smear results and visits to obtain other gynecological care that may or may not have included a Pap smear. As noted above, at the beginning of the project, gynecologists spent most of their time collecting Pap smears rather than providing care that required a specialist. As a result of project interventions, gynecologists devoted more attention to family planning, general gynecological services, and antenatal care.

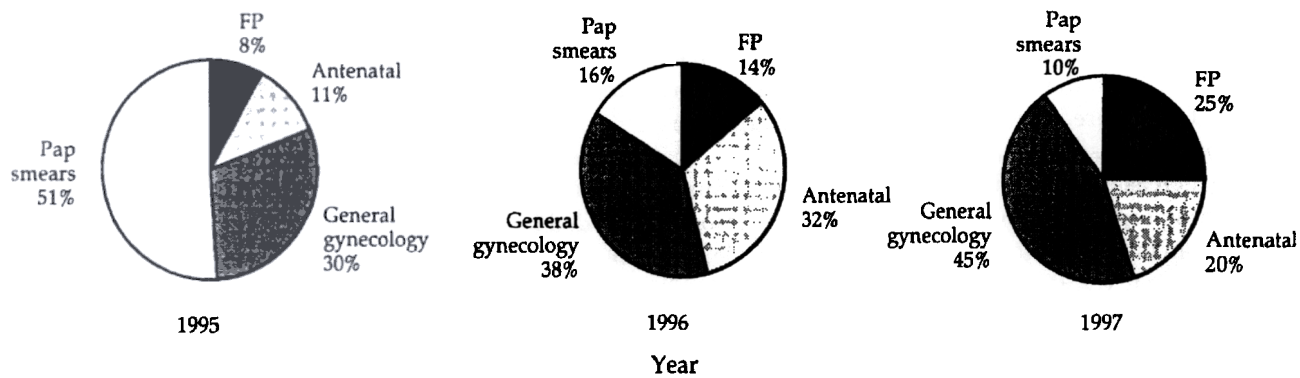
The changes in consultations devoted to antenatal care over the three-year period are surprising. Antenatal care increased in comparison with its level at the beginning of the project period, but the number of such consultations was lower in 1997 than in 1996. The relatively low proportion of attention given to those requiring antenatal care is surprising, because the dominant impression among providers, auxiliary staff, and service administrators is that gynecologists give priority to pregnant women. No clear explanations are apparent for this decrease in antenatal consultations during 1997.

Figure 4 demonstrates the important contribution of the referral center to the overall increase in service availability. In comparison with 1995, gynecologists provided on average 358 additional monthly consultations at the referral center in 1997. Increases were seen in each area of reproductive health care, with family planning in the lead, followed by "other" care, which includes primarily antenatal care and attention to cervical pathologies. At the beginning of the project, a monthly average of only 36 consultations was provided at the referral center for family planning; in 1997 this figure had risen to 271.

These results show that family planning services, which at the beginning of the project period were almost nonexistent in municipal health care, had become more widely available in 1997. Simultaneously, with the introduction of family planning, other components of reproductive health care were expanded. Thus, overall, reproductive choice was broadened, and many women who had not been able to obtain such services from municipal institutions are now able to do so.

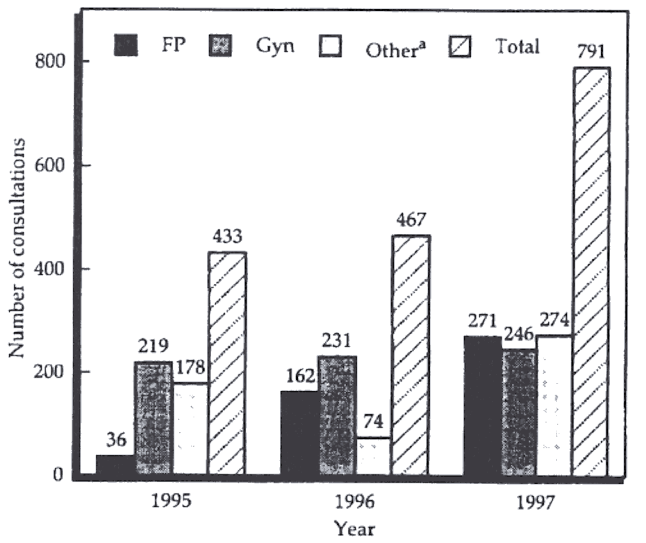
To what extent has method choice been expanded?

Figure 3 Type of consultations with gynecologists at 11 municipal health facilities at the beginning of interventions and at one and two years later, Brazil, 1995–97



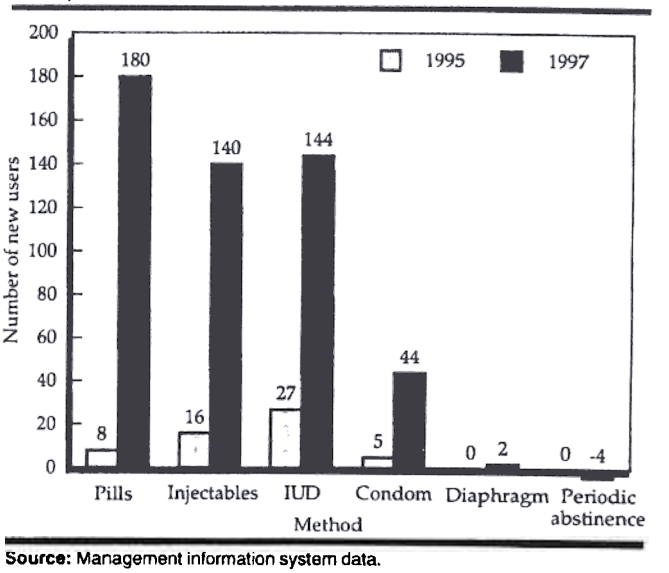
Source: Management information system data: consultations provided by gynecologists for a six-month period (from April to September each year).

Figure 4 Average monthly consultations provided by gynecologists at the referral center, by type of service, Brazil, 1995–97



[a]Includes antenatal care, postpartum visits, colposcopy, and cervical cancer care.
Source: Management information system data: consultations provided by gynecologists in municipal services for a six-month period (from April to September each year).

Figure 5 Number of new users of contraceptive methods who first consulted with a gynecologist in a municipal health facility for a six-month period (April–September), by method, Brazil, 1995 and 1997



Source: Management information system data.

Management information system and referral center service statistics reveal that women and men have more options than they did before the project was initiated. The clearest evidence is the vasectomy program, which introduced this method for men. By April 1998, two years after the program began, 310 vasectomies had been performed at the referral center, and a hundred men were on the waiting list. These figures are not included in the management information system data, because the system does not compile information on services for men. Vasectomy procedures in the private sector are costly and not readily obtainable. With the introduction of these services at the referral center, men's ability to participate effectively in fertility regulation has increased substantially. In addition, condom distribution at the center has increased considerably. Condoms are now provided to men and to women, whereas in the past, only women could obtain them. Condoms provided to men are not reflected in the management information system data, and therefore, condom distribution through the municipal health services appears limited.

The increase in availability and accessibility of family planning services in the municipal system is associated with an increase in the number of women who leave the health facility with a contraceptive method (see Figure 5). The greatest increase has occurred in the number of new users of oral contraceptives, reflecting women's strong preference for this method in Brazil. When family planning services become more widely available, women opt for those methods that are most in demand. When method availability was constrained, prior to the initiation of the project, IUD acceptors constituted the largest number of new users. When services are difficult to obtain, women will use them for methods that they cannot find elsewhere at an affordable price. Pills and even injectables can be procured through pharmacies; IUD insertion, however, requires the services of a trained provider. The numbers for pills, injectables, and the IUD for 1997 in Figure 5 show that these three methods are well represented in terms of new users, providing indirect evidence that women have the option to choose among these three methods. Injectables, which were introduced as part of the project's interventions, are clearly a significant component of service delivery.

Whether counseling about periodic abstinence and withdrawal and barrier methods improved as a result of the interventions is not clear. Information about these methods was provided during training and tends to be discussed in a balanced way during educational sessions, but provider bias against these methods appears to persist. Only two new users of diaphragms were recorded for a six-month period, and four women discontinued periodic abstinence after consulting with a gynecologist, perhaps reflecting both low demand for this practice as well as such a bias.

Table 1 provides a summary of problems identified, project interventions, and results. The latter are based

Table 1 Summary of problem areas, project interventions, and intervention results in municipal reproductive health services, Santa Barbara d'Oeste, Brazil, 1995–98

Problem area	Project intervention	Intervention result
Availability		
Inadequate or no services in family planning (FP)/reproductive health (RH) for women or adolescents; and no FP for men	Created referral center (RC) with special emphasis on FP; services for men; counseling; health education; and adolescent services	Greatly increased availability and access to FP and related RH services at RC
	Upgraded responsibilities of auxiliary nurses	Some increase at other municipal sites; sustainability is a problem
	Provided staff with training in FP and RH	Pap-smear collection performed primarily by auxiliaries
		Auxiliary nurses perform breast examinations, although not consistently
No counseling or educational activities	Recruited two psychologists at RC	Group education and counseling for women, couples, and adolescents available at RC; weak at other sites
	Trained all staff	Education and peer counseling by adolescent health agents in schools and in the community
Insufficient number of gynecologists	Recruited additional gynecologists	Some increase in availability of services; turnover of physicians and budget cuts reduce availability again
Gynecologists fail to spend required time at sites	Increased motivation through creation of RC	Four gynecologists at RC work full shifts
		Gynecologists at other sites continue old pattern
No referral from health posts to RC	Introduction of referral slip	Referral system still not working
Access		
Long waiting times to obtain appointment Long delays at time of appointment	Revised scheduling procedures	Open access to FP consultation and short waiting times at RC; some improvements at other facilities
Restrictive appointment scheduling Pressure from gynecologists to keep number of appointments low	Opened scheduling system	Increased number of consultations; some continued pressure from physicians outside of the RC to restrict appointments
Inappropriate use of gynecologists' time	Shifting of Pap-smear collection and delivery of normal results from gynecologists to attending staff	Increased availability of appointments
Quality of services		
Deficiency in technical quality of care Deficiency in interpersonal quality of services Lack of training Lack of RH orientation	Theoretical and practical training of all medical personnel, attending staff, and administrators in contraception, counseling, and related RH services	Improved quality of care at RC (better counseling, more contraceptive options, more humane treatment)
	Training of community members in health education	Attendants perform Pap-smear collection adequately; improved interpersonal relations
		Problems continue at other sites due to turnover of gynecologists and lack of supervision
Limited method choice	Increased provision of methods approved by Ministry of Health (MOH)	Depo Provera and other contraceptive methods offered in RC and at other sites with gynecologists
	Introduction of Depo Provera and vasectomy	No resistance to such broadening of services
Supplies		
No or inadequate contraceptive supplies	Local purchase through municipality and MOH allocations	Contraceptive supplies now regularly available at RC
		Greater availability at other sites; some inconsistencies
No or inadequate information, education, and communication (IEC) materials	Provided by project	Available and regularly used at RC
	New development of IEC materials	Also available at other sites; lapses occur
		IEC materials not always provided to users
Management		
Weak supervision	Recruited new, more capable, and better-motivated supervisor	Supervision focused on problem solving and quality of care now in place; some problems remain
Weak staff motivation	Creation of RC	Motivation increased, mainly among RC physicians and all auxiliary and attending staff
	Training	
Staff turnover		Remains a problem
Weak management information system	Instituted new system	New system allows detailed tracking of RH services for women; fails to track all health services
Community participation		
No participation of community representative in municipal health-service programs	Creation of SOS Mulher, local women's organization for project participation	Regular input from two community members at executive committee meetings; educational activities organized by community members at health facilities; input not as intensive as hoped

on several sources of information and time periods: qualitative and quantitative evaluation results for July–September 1996; management information system data for 1995–97; referral center service statistics; and observations from monitoring visits and participation in the executive committee through April 1998.

Conclusion

The Santa Barbara Project modeled a new approach to contraceptive introduction emphasizing quality of care, working within a framework developed by the World Health Organization. For anyone unfamiliar with this framework and its rationale, the use of the term "contraceptive introduction" within this context may appear startling. So much was accomplished in the Santa Barbara Project—expanding and improving service delivery not just in family planning but in other areas of reproductive health—that a recapitulation explaining why this project is fundamentally about contraceptive introduction and expansion of choice is useful.

Conventionally, contraceptive introduction has been defined as the point at which a new contraceptive product is made available on the market or added to family planning services. The introduction often includes training and the provision of supplies and information. Introduction may involve recently developed products as well as methods that have been available for some time elsewhere but not in a particular setting. Although a variety of motives may drive the introduction of new methods, from a reproductive health perspective, the purpose is to increase people's options. Past approaches to introduction have concentrated on making new technology available and ignored other aspects of service delivery. The Santa Barbara Project sought to demonstrate how these other aspects must be addressed while simultaneously adding new methods. Although important, availability of contraceptive technology alone is insufficient. We are challenged to expand our notion of what is required to broaden contraceptive choice.

In the municipality of Santa Barbara d'Oeste, systematic introduction of contraceptive methods—even in the conventional sense—had never taken place. Although a strong policy commitment exists in Brazil to deliver integrated reproductive health care, including family planning, this commitment had not been translated into practice. Contraceptive services existed as a minuscule component of gynecological care, which was extremely limited, and functioned in a service-delivery system characterized by resource scarcities and lacking attention to good management practice. In such a setting, the capacity to address weaknesses creatively must be increased within existing resource constraints. This program was accomplished through the adoption of a participatory approach that systematically called existing weaknesses to program managers' and providers' attention and initiated a process of productive problem solving. This process assured that the necessary prerequisites for the expansion of reproductive choice were put into place: increased availability and access; a restructured service system; improved motivation, morale, and supervision; adequate supplies; and enhanced technical and interpersonal competence of providers.

Within the context of systems renewal, family planning services could be increased and method choice broadened. The departure from conventional method-introduction approaches lay in the project's emphasis on all methods, avoiding a narrow focus on a particular technology. Thus the training program covered the range of available modern and traditional contraceptive technologies, including training in injectables and vasectomy, which were added to the service system. The concept and practice of high-quality services had to be introduced, or re-emphasized, because the meaning of patient-centered quality of care and its importance in service delivery was not well understood.

Establishment of a specialized referral center for family planning services provided an environment that attracted motivated gynecologists who treated contraceptive services as a priority. The referral center substantially improved availability and access for adult women and made possible the organization of a program for adolescents who had received little or no attention. The addition of vasectomy services within the referral center and the provision of Depo Provera throughout the entire municipal health system would conventionally be termed method introduction. Such introduction would not have succeeded without the broader changes in management practice and service organization.

Attention to broadened contraceptive choice occurred with simultaneous attention to other reproductive health services. Access to antenatal and general gynecological care was increased, and antenatal care for adolescents and referral for cervical pathologies and breast and cervical cancer prevention were instituted. The importance placed on patient-centered care and counseling in turn affected all women's health services, not only those concerned with family planning. The need for implementing family planning within a philosophy and context of reproductive health has been widely discussed in connection with the International Conference on Population and Development in Cairo in 1994 (Elias 1994; Garcia-Moreno and Claro 1994; ICPD 1994). The

Santa Barbara Project has shown how this goal can be translated into practice.

The participatory organization development approach, with a focus on government ownership, was essential to achieving these results. So was the emphasis on mobilizing public resources for these interventions. These project characteristics provided a basis for assuring the sustainability of results. Although at the end of a four-year period of collaboration, a sense of government ownership of project innovations is clearly evident, not all service-delivery and managerial weaknesses have been remedied and not all concerns about long-term sustainability have been eliminated. Continued attention is required to address such issues as improvements in supervision to ensure that the system does not revert to its previous inertia; effective use of the management information system for supervision; expansion of educational activities and counseling; training of newly recruited medical and auxiliary staff; and institutionalizing the participation of women's groups.

The Santa Barbara Project illustrates a central lesson related to the introduction of contraceptive technology: Efforts to broaden reproductive choice must be built on a thorough understanding of the service-delivery system and should incorporate mechanisms to enhance its capacity to provide high-quality services for all methods. Unless appropriate service-delivery conditions exist to ensure access and at least minimally adequate quality of care, the addition of contraceptive technology fails to have the desired effect. Key findings from the Santa Barbara Project demonstrate that considerable enhancements in service-delivery capacity are possible. Once such improvements have been made, the strengthening of family planning services and the broadening of the method mix and of reproductive choice more generally can be attained.

Notes

1 This high-dose, once-a-month injectable, containing 150 milligrams of dihidroxyprogesterone acetate and 10 micrograms of estradiol enanthate, is produced in Brazil.

2 For a discussion of the participatory methodology employed by this project, see Díaz and Simmons (1999).

3 CEMICAMP chose to undertake this project because of its commitment to the implementation of a reproductive health approach to family planning; its previous association with the WHO-funded nationwide assessment in Brazil; its extensive experience in women's health research, including introductory studies related to the IUD, injectables, and Norplant®; and its efforts toward ensuring high-quality contraceptive services at the family planning clinic of the University of Campinas. This clinic, which works closely with CEMICAMP staff, is one of the referral centers designated by the Ministry of Health for providing training and related technical assistance to health centers.

4 Focus groups were not stratified by age. They lasted for one and a half to two hours. Moderators used a detailed interview guideline, and each session was taped and transcribed. Focus-group discussions with women were initiated with general questions about what reproductive health meant to the informant, the availability of reproductive health services in the community, and participants' health-care-seeking behavior. These questions were followed by more specific inquiries about the availability and accessibility of municipal health services and respondents' attitudes toward their experience with these services. The final questions related to their knowledge of and attitudes toward service availability in family planning. Men's focus groups began with general questions about their health-care-seeking behavior and that of their wives or women generally; their knowledge of, attitude about, and experience with municipal health services; their knowledge of and attitude toward family planning; and their knowledge of family planning service availability. Finally, they were asked about men's role in family planning and the availability of services for men. A separate adolescent initiative with a separate needs-assessment methodology was undertaken within the project. Detailed analysis of the adolescent component of the project is not included in this paper.

5 Respondents' ages were: <19, 14 percent; 20–24, 20 percent; 25–29, 17 percent; 30–34, 18 percent; and ≥35, 32 percent.

6 Observations were conducted by two professional family planning trainers, one of them a midwife and the first author of this article and the other a nurse and the last author of this article. A formal observation guideline was used.

7 The assessment of interpersonal relations covered such areas as: greeting behavior; nonverbal communications, including posture, eye contact; and verbal communication, including listening, adequacy of information giving, supportiveness, use of clear language, use of visual material, and privacy. The technical competence portion of the observation included evaluation of record keeping, the physical examination, the breast examination, equipment used during exams, information giving, use of IEC materials, referral, contraceptive choice, and technical accuracy of contraceptive information and service provided.

8 Physicians' salaries vary by municipality; in Santa Barbara d'Oeste salaries are particularly low.

9 Numbers of observations, by kind of interaction, were: general gynecology (9), Pap-smear related (14), family planning (2), postpartum (1), antenatal care (16).

10 For a detailed analysis of the participation of community representatives in this project, see Díaz and Simmons (1999).

11 The vasectomy and adolescent programs will be discussed in greater detail in separate papers.

12 This evaluation of project impact included six focus groups (two with men, four with women); 21 observations of patients' consultations with a gynecologist; 65 exit interviews with patients who had seen a gynecologist; 56 interviews with patients who had seen other medical providers; 15 interviews with providers (nurses, attendants, supervisor of posts, and PAISM coordinator); and assessment of waiting times.

13 Focus-group guidelines for the evaluation included specific questions about whether people perceived changes in the municipal health services.

References

Bruce, Judith. 1987. "Users' perspectives on contraceptive technology and delivery systems." *Technology in Society* 9: 359–383.

———. 1990. "Fundamental elements of the quality of care: A simple framework." *Studies in Family Planning* 21(2): 61-91.

Cornwall, Andrea and Rachel Jewkes. 1995. "What is participatory research?" *Social Science and Medicine* 41(12): 1,667–1,676.

Chisholm, Rupert F. and Max Elden. 1993. "Emerging varieties of action research: Introduction to the special issue." *Human Relations* 46(2): 121–142.

Díaz, Margarita and Ruth Simmons. 1999. "When is research participatory? Reflections on a reproductive health project in Brazil." *Journal of Women's Health* 8(2): 175–184.

Elias, Christopher. 1994. "A puzzle of will: Responding to reproductive tract infections in the context of family planning programs." In *Reproductive Health Approach to Family Planning*. Presentations from a panel held on Professional Development Day at the USAID Cooperating Agencies Meeting, 25 February 1994. Washington, DC. Compiled by the Population Council, New York, 5–23 December.

Formiga, José Noble et al. 1994. "An Assessment of the Need for Contraceptive Introduction in Brazil." Geneva: World Health Organization. Publication number WHO/HRP/ITT/94.2. Monograph.

French, Wendell and Cecil Bell. 1994. *Organization Development*. Fifth edition. Englewood Cliffs, NJ: Prentice Hall.

Garcia-Moreno, Claudia and Amparo Claro. 1994. "Challenges from the women's health movement: Women's rights versus population control." In *Population Policies Reconsidered: Health, Empowerment, and Rights*. Eds. Gita Sen, Adrienne Germain, and Lincoln C. Chen. Boston: Harvard University Press.

Hull, Valerie J. 1996. "Improving Quality of Care in Family Planning: How Far Have We Come?" *The Population Council South and East Asia Regional Working Papers* No. 5. Jakarta: Population Council.

International Conference on Population and Development. 1996. "Programme of Action adopted at the International Conference on Population, Cairo, 5–13 September 1994." New York: United Nations Population Fund.

Israel, Barbara A., S.J. Schurman, and M.K. Hugentobler. 1993. "Conducting action research: Relationships between organization members and researchers." *Journal of Applied Behavioral Science* 28(1): 74–101.

Parker, Edith, Amy Schultz, Barbara A. Israel, and Rose Hollis. 1998. "East side village health worker partnership: Community-based lay health advisor intervention in an urban area." *Health Education and Behavior* 25(1): 24–46.

Simmons, Ruth, Peter Hall, Juan Díaz, Margarita Díaz, Peter Fajans, and Jay Satia. 1997. "The strategic approach to contraceptive introduction." *Studies in Family Planning* 28(2): 79–94.

Simmons, Ruth and Christopher Elias. 1994. "The study of client–provider interactions: A review of methodological issues." *Studies in Family Planning* 25(1): 1–17.

Snow, Rachel and Lincoln Chen. 1991. "Towards an Appropriate Contraceptive Method Mix: Policy Analyses of Three Asian Countries." *Working Paper Series* No. 5. Cambridge, MA: Harvard Center for Population and Development Studies.

Spicehandler, Joanne and Ruth Simmons. 1994. "Contraceptive Introduction Reconsidered: A Review and Conceptual Framework." Geneva: World Health Organization. Document Publication number WHO/HRP/ITT/94.1. Monograph.

Tandon, Rajesh. 1981. "Participatory evaluation and research: Main concepts and issues." In *Participatory Research and Evaluation*. Eds. Walter Fernandes and Rajesh Tandon. New Delhi: Indian Social Institute. Pp. 15–34.

Whyte, William F. 1991. *Participatory Action Research*. Newbury Park, CA: Sage Publications.

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When is Research Participatory? Reflections on a Reproductive Health Project in Brazil

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ABSTRACT

This article addresses women's participation in an organization development project designed to improve public sector family planning and reproductive health services in Brazil. Although community women collaborated in aspects of the intervention and research, the project nonetheless raises the basic question whether such involvement of community women does or does not correspond to what scientific writers consider to be the essence of participatory research. We review key project features in the context of recent literature and conclude that although the project is committed to the sharing of power and control, it does not fully correspond to the characteristics of participatory research. Moreover, we argue that given the project's central focus on reproductive health outcomes, complete adherence to the process-oriented, pure version of participatory research would have been inappropriate.

INTRODUCTION

THIS ARTICLE ADDRESSES WOMEN'S PARTICIPATION in an organization development project designed to improve public sector family planning and reproductive health services in Brazil. The development field has articulated the need for such participation over the past two decades. These calls have intensified subsequent to the International Conference on Population and Development in Cairo in 1994 and the International Women's Conference in Beijing in 1995. However, although the value of participatory approaches is widely affirmed and a large number of projects have been organized seeking to enhance such participation, methodological and practical issues remain unresolved. There are numerous examples in southern and northern countries illustrating how grassroots women's organizations or other nongovernmental organizations succeed in providing high-quality reproductive health services that are attentive to women's needs.[1,2] There is, however, no evidence that participation of grassroots women has been tried, let alone has succeeded, in public sector settings.

One major rationale for participatory research is to assure that health problems addressed and methods of intervention developed are congruent with local needs and priorities. When the identification of needs and the implementation of services occur without the participation of those most centrally affected, actual needs tend to be

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poorly served or neglected. In the project discussed here, local women participated in decision-making, in some aspects of the implementation process, and in articulating their experiences with and reactions to public sector health services. Although community women collaborated in the intervention and research, the project nonetheless raises a fundamental methodological issue: Is it or is it not participatory research? Does it correspond to what advocates of participatory research and scientific writers in the field consider to be its essence? If it is not participatory or not completely so, what difference does this make in reaching the project's health objectives?

We begin by providing background about the organization and main results of the project and then address theoretical concerns, findings, and lessons related to the participatory methodology. We conclude by articulating the need to institutionalize participatory approaches as a key priority issue for action and research.

ORGANIZATION AND OVERALL RESULTS OF THE SANTA BARBARA PROJECT

An assessment of the need for contraceptive introduction in Brazil, undertaken in 1993, had noted the limited availability of family planning and related reproductive health services in the public sector, which suffers from major weaknesses in management and human and physical resources.[3] Given these findings, the assessment concluded that there was an urgent need to organize service research focusing on the question of how contraceptive services of acceptable quality could be made more broadly available within existing public sector constraints. Subsequently, an action research project, referred to as the Santa Barbara project, was initiated in the municipality of Santa Barbara d'Oeste in the State of São Paulo in southern Brazil. The project was organized as a collaboration between this municipality and the Centre for Research on Maternal and Child Health (CEMICAMP), a nongovernmental organization linked to the University of Campinas. (For a detailed discussion of the overall Santa Barbara project, see reference 4.)

The municipality of Santa Barbara is a predominantly low-income, literate, urban community. At the beginning of the project in 1994, the municipality had an estimated population of 170,000. Municipal health services are concentrated in 11 health posts/centers, 2 of which are secondary service delivery points. In 1993, over 116,000 visits took place, 79% of which were female.

The participatory process was formally set in motion in September 1994 through the creation of an executive committee responsible for planning and decision-making related to all aspects of the project. It consisted of the municipal health secretary and his staff, service providers, CEMICAMP representatives, and members of a local women's organization, SOS Mulher. This women's organization was created for the explicit purpose of participating in the Santa Barbara project. It is discussed in greater detail later. The project used an organization development approach,[5] which entailed close collaboration among municipal authorities, service providers, researchers, and representatives of SOS Mulher in diagnosing organizational problems, identifying possible interventions, facilitating implementation, and evaluating effectiveness.

Between November 1994 and March 1995, CEMICAMP researchers implemented a baseline evaluation of municipal reproductive health services in order to assess community perspectives and needs, availability of and access to services, quality of care, the human and physical resources, and the management system. This baseline diagnosis used several methodologies including focus group discussions, clinic-based interviews with clients, in-depth interviews with providers and administrators in Santa Barbara and with regional, state, and federal health officials, patient flow analysis, and observational techniques. Findings revealed major constraints in availability of and access to reproductive health services for women, in particular in family planning, as well as severe deficiencies in quality of care.

Interventions designed to address these weaknesses within the resource constraints of the public sector focused on training, restructuring of provider roles and service delivery patterns, the creation of a referral center, the introduction of injectable contraceptive and vasectomy services, and the management process. The executive committee had discussed and initiated some of the needed interventions before completion of the diagnostic evaluation. Interventions were further discussed by the executive committee in light of the findings from the diagnostic evaluation. In-

terventions were started sequentially beginning with training and the restructuring of services and provider roles, followed by the creation of a reproductive health referral center. Toward the end of the second project year, between July and September 1996, a formal evaluation was conducted using the same instruments and approaches as the baseline diagnostic study.

After more than 3 years of implementing this approach, family planning services in the municipality of Santa Barbara have seen major improvements. Public sector services have shifted from a dysfunctional system focused predominantly on inefficient mechanisms to cope with excessive demand and inadequate supplies of services to a more woman-centered and problem-solving approach that assures expanded contraceptive options. Health services have been restructured to ensure that a broad range of contraceptive options is now available through the referral center. Recruitment of additional gynecological personnel and improved organization of service delivery at the health centers have increased the availability of reproductive health services including family planning. Training has updated personnel on both technical and interpersonal dimensions of quality of care.

A PARTICIPATORY METHODOLOGY?

Beginning with the early planning stages, interest in involvement of community women in the Santa Barbara project was strong. This commitment had two major origins. First, the strategic approach to contraceptive introduction, in which this project is anchored, is strongly committed to participatory processes involving women.[6,7] Second, the commitment to women's participation derives from a broader philosophical appreciation of the need for women-centered approaches to public sector service improvement.

The rationale of calling for women's participation at all levels in policy and program development is closely tied to explanations of why development programs generally and health service provision particularly often fail to serve women's needs. Kabeer,[8] in a radical critique of development and service programs in southern countries, sees the roots of failure in the absence of community women's voices in the definition of need, in the shaping of policies, and in the design and implementation of programs. Women are typically seen as "passive clients in need of enlightenment and uplifting" not as "competent but socially constrained actors who are capable of making choices, articulating priorities and taking responsibility."[8,p.235] Her point of view aptly describes the dynamics of policy development and program implementation in family planning programs in southern countries. Women are viewed as clients, as patients, as recipients of services that someone else decides are good for them. Most programs create little, if any, organizational space for the active involvement of local women or for women organized in advocacy groups. Women's sense of agency is considered to be extremely limited.

The baseline diagnostic evaluation established that availability of reproductive health services was severely constrained and that municipal staff used a complex system of appointment scheduling to ration the extremely limited services. Women had to reach the health post in the middle of the night and stand in line for several hours to see a physician or to make an appointment for care. As a consequence, women in the community equated being able to schedule a reproductive health appointment with municipal services as tantamount to winning the lottery. Moreover, when services were made available, they were limited in scope and poor in quality. Participation of local women, who are actual or potential clients of municipal health services, was seen as one mechanism for ensuring that these conditions would change in the course of a project committed to a process of diagnosis, intervention, and evaluation of service innovations.

Given the project's commitment to the involvement of community women in various dimensions of the project and given its broader collaboration with municipal authorities, it would seem logical that the project should be considered participatory research. However, current discussions in the literature suggest that such a conclusion would not necessarily be accepted by researchers in this field. We examine the Santa Barbara project in the context of the literature to clarify if it is or is not participatory research.

Definition of participatory research in the current literature

Cornwall and Jewkes[9] have provided the most comprehensive review of participatory research. The essence of such research, the authors argue,

is its commitment to the sharing of power with the people with and for whom researchers work.[9,p.1674] Whereas in conventional research, control over the research process rests entirely in the hands of the researchers, participatory research implies that at least some of this control rests with local people. Such nontraditional, participatory methodologies cover a range of approaches.

At one end of the continuum of participatory methodologies lies participatory action research (PAR), which could be considered a purist form of participatory research. PAR emphasizes that research cannot be considered participatory unless it is committed to radical social change and to a community-defined and community-directed process. PAR is inspired by the writings and teaching of Paulo Freire.[10] As Maguire sees it,[11] the pure form of participatory research constitutes an alternative paradigm driven by a rejection of existing social conditions and by the need to transform society, to analyze structural conflict, and to create more equitable social systems capable of serving basic human needs. It is committed to alternative ways of knowing and is critical of conventional social research in which

> . . . ordinary people are rarely considered knowledgeable, in the scientific sense, or capable of knowing about their own reality. They are excluded from the increasingly more specialized research industry, barred by requirements of the "scientific method," and by intimidating concepts and jargon, money, time, skills and experience. In addition to being excluded from meaningful participation in knowledge creation processes, oppressed and ordinary people are subjected to research processes which treat them as objects and things. Hence, traditional research processes are often alienating and dehumanizing.[11,p.36]

According to this conception, participatory research seeks to return the knowledge creation process to ordinary people and, therefore, is committed to assuring that the problem definition arises from within the community and that local people function as colearners in the research process.

Cornwall and Jewkes[9] summarized key differences between the two polar extremes in a table contrasting the role of local people in the shared knowledge creation process of participatory research with conventional approaches driven by researchers and institutional interests. They acknowledge the variety of combinations in which the elements coexist in both intention and practice. Cornwall and Jewkes also note the contentious nature of the debate and the position of some practitioners that the polar extreme is the only version deserving the label of participatory research.

Locating the Santa Barbara project within a comparative framework of participatory and conventional research

In practice, few research endeavors correspond to the pure form of participatory research. Although some of the literature implies that this pure version is the only one deserving that label, we concur with Cornwall and Jewkes[9] that participatory methodologies should be viewed more broadly. In fact, it is of interest to identify where a given project is located within a comparative framework of participatory and conventional research. Table 1 presents such an analysis for the Santa Barbara project.

The Santa Barbara project in many respects fits squarely within both the participatory and the conventional paradigms. The research serves both local people and institutional and professional interests, the knowledge of both local people and scientists counts, the topic choice is influenced by local priorities and institutional agendas, and so on. The Santa Barbara project is focused on the reproductive health needs of local women. At the same time, however, the research also tests the viability of the strategic approach to contraceptive introduction[7] and, in that sense, pursues a larger institutional agenda. As one of the fundamental concerns of the strategic approach is to redirect research related to contraceptive introduction toward greater attention to women's real needs, there is complete overlap between the institutional agenda and the needs of local people.

Both the knowledge of local people and that of the researcher are critical in this project. Community people's perspectives on municipal services were ascertained through a series of dialogues with members of the community. However, service conditions were also assessed by researchers through participant observations of provider-patient exchanges. The logic of relying on the knowledge of both local people and researchers is to emphasize the importance of ap-

TABLE 1. LOCATING THE SANTA BARBARA PROJECT (SBP) WITHIN PARTICIPATORY AND CONVENTIONAL RESEARCH AS DEFINED BY CORNWALL AND JEWKES[a]

	SBP[b]	*Participatory research*	SBP[b]	*Conventional research*
What is the research for?	• • • •	Action		Understanding with perhaps action later
Who is the research for?	• •	Local people	• •	Institutional, personal, and professional interests
Whose knowledge counts?	•	Local people	• • •	Scientists
Topic choice influenced by?	• •	Local priorities	• •	Funding priorities, institutional agendas, professional interests
Methodology chosen for?	•	Empowerment, mutual learning	• • •	Disciplinary conventions, objectivity, truth
Who takes part in the stages of the research process?				
Problem identification	•	Local people	• • •	Researcher
Data collection		Local people	• • • •	Researcher, enumerator
Interpretation	•	Local concepts and frameworks	• • •	Disciplinary concepts and frameworks
Analysis		Local people	• • •	Researcher
Presentation of findings	• •	Locally accessible and useful	• •	By researchers to other academics or funding body
Action on findings	• • • •	Integral to the process		Separate and may not happen
Who takes action?	• • •	Local people, with or without external support	•	External agencies
Who owns the results?	• •	Shared	• •	The researcher
What is emphasized?	•	Process	• • •	Outcomes

[a]This table adapts the table presented by Cornwall and Jewkes[9] by adding scores for the Santa Barbara Project.
[b]The bullets confer the degree to which the SBP fits the various dimensions of participatory versus conventional research. For instance, on the first dimension "What is the research for?", there are four bullets to indicate that the SBP can be considered exclusively participatory research. On the second dimension "Who is the research for?", two bullets under each type of research show that the SBP is research to serve both local people and institutional, personal, and professional interests. For the third dimension "Whose knowledge counts?", one bullet under participatory research and three under conventional research signify that the research is more directed by scientists than by local people and, hence, is more heavily weighted on the conventional research side.

proaching issues from a variety of perspectives. The two perspectives are complementary. Even though the users of services cannot necessarily assess the technical competence of care, their perspective is essential to understanding how they experience the service system.

In two areas the project falls entirely into one or the other mode of research, however. In terms of its orientation to action, the Santa Barbara project fits squarely within the participatory model. The central purpose of the project is to improve public sector services for women. In regard to the data collection, by contrast, the project fits only in the conventional mode. Data collection related to the baseline diagnosis and evaluation was entirely the responsibility of the scientific team from CEMICAMP.

The number of bullets in Table 1 shows, however, that although the Santa Barbara project has elements of both the participatory and the conventional modes of research, greater emphasis can be placed on one rather than the other. When taking the degree of emphasis into account, it is clear that the project is more centrally located within the conventional model of research than in the participatory one. Researchers play a stronger role in the process of problem identification, interpretation, and analysis of results than local people. Similarly and very importantly so, the Santa Barbara project emphasizes outcomes

more than process. The fundamental goal is to improve access, availability, and quality of care. Although valued, the participatory process is predominantly intended to ensure that appropriate interventions are undertaken.

The emphasis on process in participatory research must be seen in terms of its roots in educational research and action. In those fields, process is essentially an end in and of itself. However, in action research designed to improve access to and the quality of women's health services, outcomes are of the highest priority, even though the commitment to involving the community is strong. The support and participation of local people in the research enterprise depend in large measure on this emphasis on outcomes. As we discuss in greater detail later, the very survival of the Santa Barbara project was due in large measure to its success in accomplishing such service improvements.

Local people and local health authorities/providers

The Cornwall and Jewkes[9] framework establishes a dichotomy between local people and researchers/scientists. The central actors in the Santa Barbara project are not completely captured by this dichotomy. It leaves out the local health authorities and health providers with whom the project collaborates in the process of diagnostic research, the design of interventions, and their evaluation. Local health authorities originated the project by requesting support from CEMICAMP in achieving improvements in municipal health services for women. Researchers from CEMICAMP used their involvement with WHO's new strategy for contraceptive introduction as a mechanism for blending their interest in working with this new approach while at the same time responding to the needs of local health authorities in Santa Barbara.

Thus, the project is participatory in two senses. It collaborates with local authorities while at the same time involving members of the local community in the research process. Clearly, health authorities and health providers are not what most authors consider local people. That concept typically refers to ordinary members of local communities in the sense that they are not health professionals, officials, or researchers (later, we discuss the complexities involved in the concept of local community). Nonetheless, the collaboration with local health authorities and providers is participatory in the sense that bridges are built from the research community to the actual users of research. This participatory nature is further reinforced by the fact that such collaboration with municipal health authorities represents a local collaboration in which local authorities chose to solicit the help of researchers to accomplish service improvements.

From the researcher's perspective, such tripartite collaboration magnifies the burden of work while at the same time providing the foundation on which successful interventions can be built. The contrasting dimensions of the participatory and conventional research processes identified by Cornwall and Jewkes[9] could be raised with regard to the collaboration with local health authorities and providers as well. It is not our purpose to do so. We merely wish to draw attention to the tripartite nature of the collaboration as the background against which the participatory relationship with members of the local community can be understood and appreciated.

FINDINGS FROM THE PARTICIPATORY PROCESS

Patterns of participation over time

In summarizing major trends in participatory research, Cornwall and Jewkes observe that "the research process is neither continuous nor predictable."[9,p.1673] This point was amply confirmed by the Santa Barbara project. The dynamics of involving local women produced several surprises.

The first surprise was the spontaneity and speed of the community's response. Shortly after the newly appointed municipal coordinator for women's health requested participation through a series of community forums, the local women's group SOS Mulher was formed. The explicit purpose of the organization was to participate in the new project. Leadership was provided by women who had been active in other local organizations—a teacher's association, as well as the local Rotary and Lions Clubs. Most of the other members of SOS Mulher were also of relatively high social and economic status. The group began meeting twice a month and consisted of approximately 50 women at its height. A meeting place for SOS Mulher was made available in the house of a local woman, three representatives for the project's executive committee were selected, and

after a short basic training course in reproductive health from CEMICAMP trainers, members of SOS Mulher initiated educational activities in municipal health posts.

The swift response to the call for participation was undoubtedly a reflection of the strong culture of grassroots women's activism in Brazil. Although the municipality of Santa Barbara d'Oeste did not have a local women's group focused on health at the initiation of the project, hundreds of such organizations existed throughout Brazil.[12] Clearly, the call for participation had struck a responsive chord, reflecting a strong local need and desire for involvement with the effort to change municipal services for women's health. The swiftness of the community's response allowed researchers, municipal authorities, and the SOS Mulher representatives on the executive committee to focus on the main tasks of the project: diagnostic research and action designed to improve the glaring inadequacies of services for women's health.

The second surprise came with the realization that women's participation was relatively short-lived. Although the start of the educational activities was rather vigorous, involvement of most members of SOS Mulher gradually decreased after the first year. Participation in the project's executive committee became less frequent, and educational activities began to be more sporadic. Only one participant, whose role is discussed later, stayed extremely active. As the search began for possible reasons for this decline, it became necessary to take a closer look at the participatory process, particularly the nature of the group's composition.

The progressive decline in participation was linked to two factors: first, the social composition of SOS Mulher and what this implied for the motivation to participate; and second, the municipal electoral process. The membership of SOS Mulher did not represent the users of municipal health services but instead came from better-off social backgrounds. One member of the executive committee explained that membership in SOS Mulher for many participants was motivated by a desire to gain social prestige through association with a municipal project. Because sustained involvement in shaping the municipal health service system was not the motivating force, participation was relatively short-lived.

This experience reflects the complexities involved in seeking to assure the participation of local people. Not all local people have the same interests, motivations, or abilities to participate in project activities. The tendency to attribute a degree of sameness to local people or communities borders on fiction.[9] In almost all social settings, local communities are comprised of heterogeneous groups of individuals, varying in social background, economic status, culture, political affiliation, and interests. Decisions related to the selection of participants in the research process thus imply critical choices influencing both the nature and the outcomes of the participatory process.

The spontaneous creation of SOS Mulher was fortuitous because it implied that local people took strong initiatives in response to the call for participation. Such local initiative reflects authentic participation and fits well within the overall model of participatory research. However, this process also confirms the observation that "unless a definite commitment to working with the powerless is part of the process, those who are relatively inaccessible, unorganized and fragmented can be easily left out."[9] In retrospect, it might have been appropriate to make an effort to solicit the involvement of women who more closely represented the class of local people who use public sector health services, yet we also know that participation of such women has inherent limits. They are least likely to be in a position to donate their time and energy.

Another important surprise emerged as the municipality of Santa Barbara d'Oeste began to prepare for upcoming local elections. During the election campaign, local women—those who had created SOS Mulher as well as others—explained that they did not wish to participate because project activities could not be separated from politics. Although the CEMICAMP research team attempted to maintain a professional and neutral stance, the electoral process was so all-encompassing that in the eyes of the community there could be no neutral activities during that time, especially not as the health secretary of the municipality was running for mayor. Community women did not wish to be involved in a participatory project that appeared to be tied to a larger political agenda. The fear was that parties or the government would use local people's support for the project for their own political gains.

This pattern distinguishes the participatory process in the public sector from other community-based participatory processes involving

women. Women understand where their interests lie and when it does or does not serve their interests to participate.

What participation contributed

The participation of community women in the Santa Barbara project contributed a great deal in some areas and much less than expected in others. Community participants in the executive committee did not add as extensively to the decision-making process as had been expected. Several factors explain the passive stance most representatives of SOS Mulher took toward deliberations in the executive committee. First, because participation in the shaping of policy and programs is so unusual, it is unrealistic to expect that change can be brought about simply by inviting participation without at least some attention to a screening process. However, such screening implies greater proactive direction on the part of the researcher, illustrating once again the myriad complexities and even contradictions implied in the commitment to participatory research.

Second, retrospective analysis also revealed a high degree of initiative and direction on the part of the research group rather than an emphasis on the nurturing and facilitation of a participatory process. Bringing about changes in the availability, access, and quality of care of reproductive health services in the municipality often took precedence over encouragement of a more active participatory process. The time and effort required to cultivate and nurture meaningful participation can place more extensive demands on the researchers than can be accommodated.

In another area, however, participation of community women was unexpectedly high. Members of SOS Mulher elected to organize educational sessions on breastfeeding and related reproductive health topics in municipal health posts and a local hospital. Although these activities fit broadly within the scope of the project, they were clearly activities that SOS Mulher members sought to accomplish. Their approach to correcting the gaps in reproductive health was through health education rather than through more active participation in the decision-making processes of the executive committee. Their preference for focusing on education may also be evidence of a discrepancy between what local people and what scholars/researchers consider of prime importance.

An important level of participation by ordinary local women was attained through dialogue with community members that took place in the context of focus groups. As part of the baseline diagnostic phase, a series of focus groups was organized to assess how local people evaluated municipal health services. The process of identifying potential participants for these focus groups was facilitated by one of the members of the executive committee, who used her influence in the community to persuade local leaders of the significance of this undertaking. As a result, people joined the discussions with a clear understanding that they were contributing toward the improvement of municipal health services. Thus, although the typical focus group format was on the whole maintained, the process was seen as a channel through which local people, most though not all of whom were women, could exert their influence. Members of focus groups participated with the expectation that their views would be heard and that there would be improvements in the availability and quality of reproductive health services. Such changes did indeed occur, partly because with the strong statements from local people in hand, the need for change could be argued persuasively.

Dona Geni, community anchor and project champion

The final surprise and critical lesson from the participatory process was represented by Dona Geni, a natural leader from the community. She surpassed all expectations about the potential for women's involvement in transforming reproductive health services at the municipal level. A local leader long before the project started, she discovered in the research team a natural ally for her own mission and, therefore, put her full weight behind the effort. She used her work at a local radio station for regular broadcasts about the project, thereby increasing public awareness about its existence and its impact. Even though her radio station was run by one of the opposition parties during the previous political regime, she put all concerns for politics aside and regularly spoke about the project and invited municipal authorities to appear on the station even when they belonged to another party.

When the project initiated a program of activities and services for adolescents, it was Dona Geni who opened doors to educational institu-

tions and authorities in the community. Her standing in the community and the respect she had gained from municipal authorities facilitated innovations that otherwise would have taken much longer to achieve. Her most crucial contribution, however, occurred during the process of electoral change. She steered the project through the difficult period of the electoral campaign and was essential to its ability to survive a change in government in which the health secretary who originally sponsored the project was defeated by his political opponent for mayor.

CONCLUSIONS

In concluding this review of the Santa Barbara project as participatory research, we first wish to suggest that the answer to the central question we posed is: Yes, indeed, the project should be considered participatory research. At the same time, however, we want to clarify that the project does not and never set out to follow the traditions of the pure version. Participatory research covers a spectrum of endeavors dedicated to the involvement of local people in the research process. To use, once again, the words of Cornwall and Jewkes, "Ultimately participatory research is about respecting and understanding the people with and for whom researchers work."[9] There are many meaningful forms of achieving participatory research, not all of which have or should have the characteristics of its purest form. Hybrids are both appropriate and productive and may, in fact, be the norm rather than the exception.

Engagement in a participatory process forces researchers to confront complex choices and multiple contradictions. Clearly, the overall conclusion must be that research aimed at improving women's health should be committed to the sharing of power and control. As long as there is such authentic commitment, there is no one single best way of conducting participatory research, but the nature and degree of participation must be tailored appropriately to the specific research enterprise.

This leads us back to the question we raised at the outset: Would a greater degree of participation by local people have made the project more productive in reaching its health objectives? The answer is both yes and no. Although community participation was essential to the project's success and survival, a greater degree of participation by local people in the project's decision-making process, in mobilizing community action that demands public sector service improvements, and in otherwise furthering the specific objectives of the project would have produced even greater impact.

On the other hand, it must be recognized that research with the goals of the Santa Barbara project cannot be purely participatory in the sense that it has been defined by Cornwall and Jewkes.[9] The project is centrally committed to the attainment of specific outcomes regarding the improvement of health services and to collaboration with local and international health authorities in the implementation of a reproductive health agenda. Although these goals are congruent with local needs and perceptions, they are expert driven and did not arise out of the type of community-led process considered ideal by the pure form of participatory research. By defining these broad outcome-oriented goals and objectives of research, local and international health authorities and researchers set limits on the participatory process involving community people. Resource constraints, in turn, limited the extent to which energy could be invested in nurturing participation. Local participation was further curtailed because the project was committed to a participatory process involving both local people and health authorities, thus engaging a more complex level of interaction than is anticipated in the pure model of participatory research. The literature will benefit from a broadened articulation of participatory research to include the important role of local authorities as well as by further clarification of what is meant by local people. In addition, it should be considered that measures of successful participation be at least partially defined by local people themselves.

Other important insights derived from the project relate to the nature of the participatory process. One of the assumptions behind participatory research is that it empowers local people to initiate social change. However, in Santa Barbara, the most central contribution in the participatory process came from someone who was already empowered, who had a vision of the common good, and who was actively engaged in working toward social problem solving. Her support and defense of the project during the trying days of the electoral campaign and its aftermath stood in contrast to those who chose to withdraw

from active involvement at this time. It is important to note that both are intelligent moves, and both should be viewed as examples of participation.

In our view, the most central priority for research and action relates to the institutionalizing of participatory processes. We know a great deal about the essential characteristics of participatory research, but we know nothing about how such participatory processes can be institutionalized. What is needed to sustain participatory processes over time, especially when external support is withdrawn? How can such endeavors be replicated? We have no answers because these questions themselves are just now beginning to be articulated.

As part of the strategic approach to contraceptive introduction, CEMICAMP is studying mechanisms for the transfer of participatory approaches from Santa Barbara to other municipalities. A great deal has been learned about participatory research since the Santa Barbara project was initiated. However, the extent to which sharing of power and control in the research process can be more broadly applied and sustained over time remains an unanswered question with which we continue to struggle. Certainly, this is an area that should be considered an important priority for research.

ACKNOWLEDGMENTS

We thank the community of Santa Barbara d'Oeste for its engagement with this project, as well as our colleagues from the municipal authorities, CEMICAMP, the Population Council, the University of Michigan, and the World Health Organization. In particular, we wish to acknowledge the role of Carlos Cavalcante, Peter Hall, Peter Fajans, Jane Cottingham, Anibal Faúndes, Juan Díaz, Maria Yolanda Makuch, Francisco Cabral, and Eliana Hebling. Kathryn Carovano, Juliana van Olphen, and Laura Ghiron provided valuable assistance in writing this report.

REFERENCES

1. Bruce J. Women-oriented health care: New Hampshire feminist health center. Stud Fam Plan 1981;12: 331.
2. Simmons R, Kay BJ, Regan C. Women's health groups: Alternatives to the health care system. Int J Health Serv 1984;14:331.
3. Formiga JN, Simmons R, Díaz M, et al. An assessment of the need for contraceptive introduction in Brazil. Published monograph from Expanding Family Planning Options series. Geneva: World Health Organization, 1994.
4. Díaz M, Simmons R, Díaz J, et al. Expanding contraceptive choice: Findings from an action research project in Brazil. Stud Fam Plan 1999;30 forthcoming.
5. French WL, Bell CH. Organization development, 5th ed. Englewood Cliffs, NJ: Prentice Hall, 1994:287.
6. Simmons R, Hall P, Díaz J, Díaz M, Fajans P, Satia J. The strategic approach to contraceptive introduction. Stud Fam Plan 1997;28:79.
7. Simmons R, Fajans P. Contraceptive introduction reconsidered: A new methodology for policy and program development. Paper prepared for the MIWH Workshop on Methods and Measures: Emerging Strategies in Women's Health, Ann Arbor, Mich., July 14–18, 1997. [*Editor's note:* See p. 163 of this issue.]
8. Kabeer N. Reversed realities: Gender hierarchies in development thought. New York: Verso, 1994:346.
9. Cornwall A, Jewkes R. What is participatory research? Soc Sci Med 1995;41:1667.
10. Freire P. Pedagogy of the oppressed. Translated by Myra Bergman Ramos. New York: Herder and Herder, 1970:186.
11. Maguire P. Doing participatory research: A feminist approach. Amherst, MA: Center for International Education, University of Massachusetts, 1987:253.
12. Alvarez SE. Engendering democracy in Brazil: Women's movements in politics. Princeton, NJ: Princeton University Press, 1990:304.

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3.3. Etapa III

Em 1996, foi realizado um seminário para a apresentação dos resultados do programa implementado em Santa Bárbara d'Oeste. Foram convidados a participar alguns municípios vizinhos e de outros estados, que haviam solicitado apoio ao Cemicamp para implementar programas de planejamento familiar. Também participaram autoridades de saúde, municipais e estaduais. Após o seminário, foram selecionados três municípios que iniciaram a Etapa III. São eles: Anápolis, (GO), de 300 000 habitantes; Ituiutaba, (MG), 90 000 habitantes e Sumaré, (SP), 200 000 habitantes.

O principal critério de escolha foi o interesse e compromisso manifestado pelas autoridades de saúde e a necessidade de se incorporar um programa nesses municípios.

3.3.1. Objetivos

1. Documentar o processo de replicação das atividades da Etapa II e avaliar o impacto dessas ações em Ituiutaba, Sumaré e Anápolis.
2. Avaliar o impacto da assistência técnica de alta e baixa intensidade (Alta intensidade no município perto de Campinas e baixa nos mais distantes).
3. Avaliar o impacto do projeto sobre as autoridades de saúde e as agências internacionais em atuação no país.

3.3.2. Método

Esta etapa de replicação também incluiu, em cada um dos municípios participantes, diagnóstico de base, intervenção e avaliação.

No diagnóstico os instrumentos utilizados foram uma adaptação, mais simples, dos instrumentos utilizados na Etapa II. Fez-se isso pensando na possibilidade de que pudessem ser usados posteriormente em outros municípios por profissionais de saúde, não necessariamente pesquisadores.

O conjunto de instrumentos foi pré-testado na Etapa III e, posteriormente, elaborada uma versão definitiva, que atualmente está sendo utilizada na expansão do projeto, ficando então à disposição dos municípios (anexo 4).

As intervenções/ações realizadas foram semelhantes às da Etapa II. Entretanto, cada um dos municípios teve suas especificidades e prioridades de acordo com suas características e necessidades. As principais atividades desenvolvidas nos três municípios são apresentadas no quadro 1.

Quadro 1: Principais Ações Desenvolvidas nos Três Municípios

PRINCIPAIS AÇÕES	***ANÁPOLIS***	***SUMARÉ***	***ITUIUTABA***
Capacitação da Equipe	✓	✓	✓
Implementação do Comitê Executivo	✓	✓	✓
Implementação do PAISM	✓	✓	✓
Implementação do Planejamento Familiar	✓	✓	✓
Implementação de atividades educacionais/orientação (escolha livre e baseada em informações)	✓	✓	✓
Implementação do centro de referência	✓	✓	✓
Melhoria do sistema de referência		✓	✓
Implementação do Programa de Adolescentes		✓	
Implementação de atenção à mulher na Menopausa	✓		
Implementação de biblioteca no Centro de Referência	✓	✓	✓

A avaliação foi realizada pela mesma equipe de pesquisa e usando os mesmos instrumentos do diagnóstico. Seus resultados são apresentados na publicação *Final Technical Report*, a seguir.

Nesta etapa de expansão, o componente educação também foi fundamental, e cabe destacar que o processo de aprendizagem da própria equipe, na Etapa II, contribuiu para facilitar a utilização da experiência de um município por outros.

Entre as lições aprendidas pode-se citar a importância do reconhecimento de que qualquer pessoa da equipe de saúde e da comunidade pode usar os instrumentos para fazer o "diagnóstico", ou seja, pode atuar como "pesquisador". A possibilidade de participar desta etapa é o fator fundamental para a tomada de consciência de que é preciso mudar.

Entretanto, também é importante falar um pouco sobre as mudanças, e aproveito para isso as reflexões de Adriano Nogueira e colegas (2001), que afirmam que todo sujeito tem direito de viver mudando, já que vida é sinônimo de transformação. Porém, toda mudança implica um dever ético. Em primeiro lugar a pessoa tem que saber por que e em que direção está mudando e, em segundo, o sujeito tem que assumir não só que está mudando mas também as transformações escolhidas. O que não é possível aceitar são sujeitos que aceitem opções e mudanças sem assumir que mudou em relação ao que era.

O papel da equipe de pesquisa atuando como "educadores", compartilhando conhecimentos e informações e facilitando o processo de participação para olhar sua realidade, identificando possíveis mudanças, elaborando propostas, executando as ações e supervisionando-a continuamente é um dos fatores que merecem ser assinalados dentre os que contribuíram para o sucesso da expansão.

Outro município – Piracicaba, no estado de São Paulo – foi incorporado posteriormente, e atualmente estamos engajados num processo de expansão dessa experiência em larga escala.

Para isso, estamos empenhados em aprender não somente a partir de nossa experiência, mas de outras, já que pela revisão da literatura nos inteiramos de que há muitos projetos pilotos bem-sucedidos. No entanto, o desafio é fazer a expansão desses projetos.

Segundo o Dicionário Aurélio, “expansão” significa estender, difundir, espalhar, ampliar etc. e “estender” quer dizer esticar, espalhar, desdobrar, abrir e divulgar.

Sob o olhar da educação é pertinente lembrar a análise crítica Paulo Freire faz do termo “extensão”, que embora seja diferente de “expansão” tem na linguagem comum significado semelhante.

Na opinião de Freire, o termo “extensão” induz a pensar em transmissão, num sujeito ativo (o que estende) e num passivo (o que recebe a extensão), e diz também que no campo associativo o vocábulo se encontra em relação com transmissão, entrega, doação, mecanismo, messianismo etc. Todos esses termos, em sua opinião, negam o homem como um ser transformador do mundo (Freire, 1992).

Ele analisa e discute a prática dos agrônomos extensionistas que dão “assistência técnica” aos camponeses, estendendo conhecimentos e técnicas, tentando fazer que eles substituam seus “conhecimentos” empíricos de lidar com a terra por outros, os deles (Freire, 1992).

De acordo com seu pensamento e prática, a extensão é educativa, mas uma educação não com o verdadeiro sentido de educação – de comunicação e diálogo – mas como prática da liberdade: *“*Educar e educar-se na prática da liberdade não é estender algo desde a ‘sede do saber’ até a ‘sede da ignorância’ para ‘salvar’, com este saber, os que habitam nesta.*”* (Freire, 1992, p. 25).

Isto significa que para expandir um projeto é crucial que a extensão do conhecimento não se realize, como dizia Paulo Freire, de maneira estática, ou seja, considerando os sujeitos como meros objetos que recebem dócil e passivamente os conteúdos que outro lhes imponha. O conhecimento exige uma presença ativa dos sujeitos como tal, reclama a reflexão crítica de cada um sobre o próprio ato de conhecer e se reconhecer conhecendo, implica uma busca constante e uma ação transformadora da realidade. Isso significa que no processo de aprendizagem só aprende verdadeiramente quem se apropria do aprendido e é capaz de aplicar o que aprendeu a situações de sua própria vida e que é capaz de reinventar o que foi aprendido (Freire, 1992).

Essas reflexões nos permitem ver com mais clareza nosso papel de educadores dispostos a expandir a outros o conhecimento aprendido num determinado lugar.

3.3.3. Publicações

- Díaz, M. Final Technical Report: "Evaluating the project 96323 **"Brazil stage III: researching the utilization and dissemination of findings from a project on the improvement of contraceptive choice within the context of reproductive health".** Campinas: Cemicamp, 2000. 82 p.
- Simmons, R.; Brown, J.W.; Díaz, M. "Facilitating large-scale transitions to quality of care in family planning programs: An idea whose time has come". **Studies in Family Planning**. (Aceito para publicação).

FINAL TECHNICAL REPORT

Project title: Evaluating the Project 96323 "Brazil Stage III: Researching the utilization and dissemination of findings from a project on the improvement of contraceptive choice within the context of reproductive health"

Principal investigator: Margarita Díaz
Head of the Department of Education and Communication on Sexual and Reproductive Health

Institution responsible for the research project:

Centro de Pesquisas das Doenças Materno-infantis de Campinas (CEMICAMP)

Campinas, March 2000

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LIST OF ACRONYMS

BEMFAM	Sociedade Civil Bem-Estar Familiar no Brasil
CEMICAMP	Centro de Pesquisas e Controle das Doenças Materno-Infantis
CIM	Centro Integral da Mulher
CSM	Centro de Saude da Mulher (Center for Women's Health)
DHS	Demographic and Health Survey
FGDs	Focus group discussion
HA	Adolescent health agent participant in Santa Bárbara
HIV/AIDS	Human Immunodeficiency Virus/Acquired imuno-deficiency syndrome
IEC	Information, education and communication
IUD	Intrauterine device
KAP	Knowledge, attitudes and practices
LAM	Lactational amenorrhea
MAC	Contraceptive method
MIS	Management and information system
MOH	Ministry of Health
NGO	Non-governmental organization
PAISM	Programa de Assistência Integral à Saúde da Mulher (Program for Integrated Women's Health Care or the Women's Health Program)
RC	Reproductive health referral center in Santa Bárbara
RTI	Reproductive Tract Infection
STDs	Sexually transmitted diseases
SUS	Sistema Único de Saúde
UNICAMP	State University of Campinas
WHO	World Health Organization

INTRODUCTION

Brazil was the first country to initiate the implementation of the WHO new strategy for contraceptive introduction, and was the first country where the three stages of the approach were completed. The first activity (Stage I) was a qualitative assessment of the reproductive health/family planning situation in Brazil that was undertaken at the end of 1993 and published in 1994. Based on the recommendations of the assessment, CEMICAMP, in partnership with the Secretariat of Health of Santa Bárbara d'Oeste (Santa Bárbara), and with the collaboration of the University of Michigan and the Population Council of Brazil, implemented a participatory action research project aimed at improving the access to, and quality of reproductive health/family planning services (Stage II).

The most important characteristics of this project were:

a) The institution of a collaboration among the researchers implementing the project, service providers and the Santa Bárbara community with a focus on the reproductive health needs of the local population. This continuous collaboration created the sense of ownership that is critical for the motivation of project personnel.
b) Holistic, participatory, on-site training of all personnel, followed by refresher training and supportive supervision
c) Community participation that allowed feedback from the community about their needs and recommended solutions
d) A problem-solving approach to action research
e) The incorporation of services for adolescents and men, two groups frequently ignored by reproductive health services.

The results of this project showed that it was possible to increase the quality of services in a municipality, without the addition of resources beyond those spent for training, the research, some specific activities like meetings and workshops, and the maintenance of the collaboration of the participating institutions. The results of this project, presented in a workshop held in Santa Bárbara in 1996, encouraged other municipalities to request technical assistance from CEMICAMP to replicate the process.

The selection of the municipalities for participating in Stage III was based on several criteria that included: the interest and commitment of the authorities; willingness to participate in a collaborative process; some basic resources to implement changes; proximity and accessibility from Campinas; feasibility of communication between the research team and the municipal health authorities; and the need for improvements in reproductive health services. After selection, the process was implemented in a stepwise fashion following the same steps used in Santa Bárbara, but using simpler instruments in the diagnostic assessments to ensure they could be implemented by local staff after a brief training.

The three municipalities that participated in the process made significant efforts to replicate, and even improve upon what was done in Santa Bárbara. Due to the number of municipalities involved, CEMICAMP could not give the same level of technical assistance

as was given to Santa Bárbara, but maintained continuous communication with these new municipal partners during the process of the Stage III project. As expected, when working with public services which are strongly influenced by political change, the project faced several administrative and even political problems that made project implementation slower than expected.

For these reasons, at the end of the Stage III replication project period (August 1998), there was evidence that the project had been successful in several areas, but it was also clear that some aspects of the process had not worked as expected. The research team and the municipalities were extremely interested in performing a formal and detailed evaluation of the process that would be very useful in replicating it to other municipalities. A proposal was prepared and presented to WHO requesting resources to conduct an evaluation with the following main objectives:

1) To evaluate the results and impact of two activities initiated in Stage II

    - A men's vasectomy program; and
    - An adolescent program, including referral center services and a peer education project

2) To evaluate Stage III

    - To document replication in three municipalities
    - To assess the impact of the project on quality of, and access to family planning/reproductive health services
    - To assess the impact of the dissemination of results on other municipalities and at the central governmental levels

WHO recognized the need for such an evaluation and funded CEMICAMP to perform it. Several administrative/financial problems made the approval of the project slower than expected and, in addition, there were also some local problems that delayed the actual evaluation. Therefore, the evaluation presented here was undertaken several months after the official support for Stage III activities had ended. For this reason the evaluation results provide a valuable longer term perspective on the effects of the project, its regional influence, and its sustainability.

IMPLEMENTING VASECTOMY SERVICES FOR MEN WITHIN A REPRODUCTIVE HEALTH REFERRAL CENTER

1. INTRODUCTION

Most international population and family planning programs worldwide have failed to take men into account. A clear call for greater men's participation as partners in reproductive health has been made (Wegner, et al., 1998; Liow, 1996; Green et al, 1995; United Nations, 1994), but how to respond adequately to this call and how to meet men's reproductive health needs without compromising programs devoted to women and their needs remain unclear. While seldom adequately reported in the literature, the few population and family planning programs that have attempted to address men's needs have frequently been externally funded, vertically organized, and/or segregated from women and their services (Suarez et al, 1996; de Castro et al, 1995) .

In the mid 1980's Brazil adopted an ambitious program aimed at giving integrated health care for women. Before the new program, women's health was seen only as maternal health. Other activities such as family planning and cancer detection were vertical programs that had very limited resources and were not priorities. The program, known as the Programa de Assistência Integral à Saúde da Mulher (PAISM – "Program for Integrated Women's Health Care"), proposed a new vision of women's health care. With PAISM, family planning (FP), cancer detection, and STD prevention acquired the same level of importance as maternal health.

Despite the fact that it is an official program, PAISM was not effectively implemented. In 1993, a nationwide assessment of Brazil's reproductive health services showed that the quality of services was poor; and the contraceptive method mix was skewed towards the two methods most easily available, namely the pill and tubal ligation and access even to these methods was severely constrained in the public sector (Formiga et al, 1994).

After the Cairo and Beijing conferences, the Ministry of Health has continued to encourage the introduction of a RH approach to services but men have not been effectively incorporated into public sector services. In Santa Bárbara d'Oeste, a municipality in São Paulo state in the southeastern region of Brazil, a baseline diagnosis performed in 1994 confirmed that access to surgical contraception was very limited and was largely restricted to tubal ligation because vasectomy was completely unavailable (Díaz et al, 1999).

In Brazil, vasectomy has been available at least since 1994 in the private sector and in some NGO and university facilities, but knowledge about these services is not widely disseminated. In the public sector vasectomy is available in some universitary Hospital like Unicamp. PROPATER, an NGO financed by international agencies has been one of the institution that is maintaining a vasectomy program, but it is restricted to the capital city of the State of São Paulo (de Castro et al, 1995).

This report discusses the vasectomy component of an innovative, participatory public sector program whose goal is to enhance reproductive health and expand contraceptive choice for men and women in the community of Santa Bárbara d'Oeste (Santa Bárbara). The Santa Bárbara project, with its focus on enabling free and informed choice for men and women(as described in detail below), has given men the opportunity to actively participate in the maintenance of reproductive health for themselves and their partners.

2. DATA SOURCES

Three aspects of the program were documented and evaluated: 1) The steps required for establishing a vasectomy program within municipal services and the lessons that have been learned from operating such a program for over two years; 2) the process of service delivery and 3) patient satisfaction with services and outcomes. In the evaluation of both the process of service delivery and outcomes, both quantitative and qualitative methodologies were employed. The quantitative data arise from referral center service statistics and from a questionnaire completed by all men who requested a vasectomy. The questionnaire had discrete and open-ended questions and collected demographic data, psycho-social information, current contraceptive use, etc.

The qualitative evaluation took the form of 1) in depth interviews with program managers and providers, including the head of the reproductive health referral center, the municipal health secretary and the two vasectomy service providers; and 2)focus groups with men who fell into one of the following four categories:

- those who had a vasectomy performed through the referral center;
- those who requested a vasectomy and were rejected because they did not fulfill the selection criteria;
- those who were accepted to have a vasectomy but decided not to undergo the procedure (group interview)
- non-users of clinic services (reached through local industries).

Focus group guidelines focused on knowledge about the program, knowledge and attitudes about vasectomy, opinion about the selection criteria for men, knowledge about other contraceptive methods. All focus groups with men were tape-recorded, transcribed and coded (code selections were verified by a second person) according to an outline of variables identified by the research team.

3. THE INTERVENTION

The vasectomy program in Santa Bárbara was implemented as part of the participatory action research project that was the main activity of the second stage of the WHO strategic approach to contraceptive introduction in Brazil. For details on this project, its continuation, and the characteristics of the population of Santa Bárbara, see the Stage II final report, Díaz et al, 1999 and Díaz and Simmons, 1999.

3.1 Design and planning

The Stage II project used a highly participatory process of program design where, within the resource constraints of the public sector, an executive committee composed of various stakeholders decided on the needed reproductive health improvements. The objective was to implement reproductive health services where almost none existed previously. At the beginning, the program was focused on women's health because the baseline diagnosis showed an urgent need for some services like family planning and cancer detection.

Once some rudimentary services were being routinely provided, the executive committee developed the following four-step strategy to create space for men's participation in contraception:

1. To create the opportunity for men to come to the referral center with their partners;
2. To include men in educational activities in order to increase knowledge about contraception for both men and women;
3. To open the referral center to men as clients in their own right and not as the husband or partner of a registered woman. For example, condoms began to be supplied to adult men, adult women and adolescents who requested them - even those not registered at the center;
4. To implement an integrated vasectomy program, using the same facilities and existing personnel to expand contraceptive options for couples. Both men and women who come to the facility for family planning are provided with information about vasectomy as a contraceptive option.

The executive committee decided that the vasectomy program should be organized within existing RH services. The first program activity was to obtain the commitment and support of different stakeholders not all of whom were convinced of the benefits of including vasectomy in the RH services. The authorities and some political leaders of the municipality were reticent to move ahead with this project because of the fear of political backlash from the Church and other conservative sectors of the population. At that time, vasectomy was not included in MOH guidelines and its legal status was unclear.

Data collected as part of a baseline diagnosis in Santa Bárbara showed that the population was very concerned about the lack of surgical contraception in the municipality. The very active advocacy role of the community through the executive committee allowed the municipality to arrive at an agreement between the mayor and the secretary of health to move forward with the vasectomy program. As part of their agreement, the authorities insisted that vasectomy be offered as an expansion of existing RH services and not as a special service. In addition, authorities insisted on avoiding explicit advertising about the vasectomy component. Vasectomy was offered to men and women who came to the referral center for family planning and no special effort was made to attract a new and larger clientele.

It is very important to highlight that the plan to provide a surgical contraceptive option had the strong support of the community, not only through the executive committee but also from other community organizations. Both the executive committee and these organizations understood that a vasectomy program would be easier to implement than a tubal ligation program and would be more cost-effective.

3.2 Training

According to the general philosophy of the project, training was participatory, holistic, and oriented to user needs. It was not centered only on technical competence but also included counseling and general improvement of communication skills. All referral center personnel, including those who would not participate directly in the vasectomy program, were informed of the characteristics of the project.

A gynecologist was trained at the State University of Campinas (UNICAMP) in a theoretical and practical training course. He observed eight vasectomy procedures and then performed 24 procedures while being observed by the University trainers. The training was based on obtaining a certain skill level, not on performing a preset number of procedures. The physician was certified to do vasectomies alone after proficiency was demonstrated. In addition, the physician was trained in counseling about the psychosocial aspects of the method since he would share responsibility for confirming that men were adequately prepared to undergo the procedure. He was prepared to give appropriate counseling at any time during and after the surgery. In addition, the physician and the psychologist visited a Profamilia men's clinic in Colombia in order to learn more about counseling and about their experiences providing the procedure.

The psychologist of the group, who already had experience in counseling men in sexual and reproductive health, provided short refresher training for all personnel who would be involved in the program, to review the procedures of the University for managing requests for vasectomy.

3.3 The service delivery system (protocol)

After the training, using as a basis the acceptability criteria of UNICAMP, the entire team (the physician, the psychologist, the nurse, and the coordinator of the Stage II project) determined, in a participatory way, the protocol and minimum requirements to be used for the provision of vasectomy services. A system for registering all activities was defined since this was a new activity at the referral center and no forms were available to meet this purpose.

A record system was maintained with the purpose of meeting two basic objectives: the first one was to allow a careful evaluation of project implementation, and the second to enable and allow reimbursement from the federal-level authorities for services.

3.4 The process for screening the candidates

Men who had expressed interest in undergoing vasectomy at the referral center had to meet the minimum eligibility criteria established by the program before they could proceed with the process of obtaining a vasectomy.

The screening prerequisites were:

- To be at least 30 years old
- To be in a stable relationship for at least five years
- To have at least two living children with the youngest at least one year old
- To have at least one child with the current partner

3.5 The process of approval

a) Men began the process for approval by participating in an educational session where all contraceptive methods available in the service were explained to them. The sessions made clear to the candidates that there were several contraceptive options available through the referral center.

b) Those pursuing their request for vasectomy after this general educational session were scheduled, with their partners, for a second educational session discussing male and female surgical methods in detail. The main focus was on the permanence of these methods and the main factors that lead to regret after the surgery.

c) After this second session, the man and his partner were interviewed separately by the psychologist, the nurse or the gynecologist to discuss their reasons for wanting the vasectomy as well as their expectations. After these interviews, couples maintaining their decision to have the surgery signed an informed consent form. They also received a booklet to take home about surgical methods that included all comprehensive information about vasectomy, including pre-operative preparation and post-surgery care.

d) Once this process was completed, the request was analyzed by a committee (a psychologist, a nurse and a physician from the referral center), who reviewed each step of the process and decided whether the man should be allowed to undergo vasectomy through the program.

3.6 The surgical procedure

When the project was initiated, all approved candidates received appointments for the surgery based on service availability and based on the order in which they were approved. As a result of the approval of the Brazilian law allowing surgical sterilization, which took effect during the implementation of the project**,** all approved candidates had to wait for the

procedure at least 60 days after the first contact with the service. They also had to restate their desire to undergo vasectomy at the end of this period. This delay proved not to be a problem because, due to limited resources, the normal delay of the service was approximately two months. Men stated that the delay was not a problem. More than that, several men stated that the delay was important to have time to think about the decision: "The waiting time gave a good opportunity to discuss other possibilities." Having to restate the decision before surgery was indicated as a factor that decreases the chances of regret: "We had time to make the decision and we had to restate our decision at the end. I think that the possibility of regret is almost nonexistent"

The surgery was performed in the reproductive health referral center's gynecological clinic room with local anesthesia. The no-scalpel surgical technique was used because it was demonstrated to be less invasive and less risky with equal success rates as previous methods (Skriver et al, 1997; Arellano et al, 1997)). This method uses small amounts of anesthesia, is conducted in a very short period of time and is performed on an outpatient basis, allowing men to leave the facility about 15 minutes after the completion of the surgery.

Follow-up included a one-week post-operative visit to check the site of incision for signs of infection and to reiterate the need to use condoms or some other contraceptive protection until after achieving a zero-sperm count, demonstrating that no spermatozoa were present in the ejaculate. The instruction given to men was to return for a sperm count after at least 20 ejaculations or three months after the surgery. Men who had a zero-sperm count were released from medical checkup, but during the research period they were requested to return for follow-up after one year.

4. RESULTS

4.1 Demand for surgery

At the inception of the program, following a local radio interview with the secretary of health announcing the program's availability in the reproductive health referral center, more than 100 men requested information about the procedure within the first week. For this reason procedures were performed after a relatively long delay for some men because the service capacity of the referral center was limited to only two vasectomies per week. Throughout the entire project period demand for vasectomies was maintained and the referral center slowly increased its service capacity to eight vasectomies per week, thereby making it possible to accommodate all the approved requests within a reasonable period of time.

It is important to highlight that after the first announcement of the initiation of the program no other promotional activities were implemented. The demand for vasectomy was maintained only through word-of-mouth. Women brought their husbands/partners to receive information on the method and men referred their friends and colleagues from their

workplaces. Men and women who participated in focus group sessions said that the original announcements and the interview with the health secretary were very important in their decisionmaking. In addition, the announcement of the availability of the method provided a very good stimulus for the couple to discuss reproductive health issues. The quality of the services men and women received was the most important factor bringing about the steady demand through word-of-mouth. Several men reported telling their friends and colleagues that the quality of the service was very good and better than the best private services.

In the first three years of the project, 888 men requested to have a vasectomy. 535 of these men completed the entire screening process and underwent the operation. 353 were rejected, discontinued the process because they changed their minds, or were lost to follow-up

4.2 Men's characteristics

During the first three years of the project, 564 couples passed the initial screening criteria and completed questionnaires during the psychological interview. The average age of these men was 35.7 (SD = 5), were living with their partners for, on average, 11 years (SD = 4.32), and had, on average, 2.6 children (SD = 0.94). Their average monthly family income was around R$ 673, the equivalent of approximately US$ 370. The majority (52.1%) had attended school for 5 to 8 years, 28% for 1 to 4 years, 17.5% attended high school, 1.6% attended university, and only 0.7% had no formal education at all.

4.3 Men's motivations and reasons for wanting a vasectomy

During the interview with the psychologist, men were asked about their motivations and reasons for wanting the vasectomy, as well as their and their wives' expectations of changes in their lives after surgery. When asked about the reasons for their decision to stop having children, the most frequent answer given was related to a poor financial situation (54.7%). The second most common answer related to satisfaction with the current number of children**.** The third reason was related to a concern for their partners' health (9.7%).

Their concern with their partners' well-being also came up when asked about the reason for choosing vasectomy, since 31.8% of the reasons given was that vasectomy was a better method than tubal ligation, and 23.4% were related to the sharing of responsibility for family planning, or to protect the health of their partners.

The experiences with vasectomy of friends or acquaintances played an important role in men's decision making processes, with 21.5% of the men saying this was the primary reason they chose vasectomy.

Table 1. Contraceptive method used by men seeking vasectomy at the time of the interview with the psychologist.

Method	Frequency	Percentage
Pill	187	33.2
Male condom	154	27.3
Withdrawal	65	11.5
Injectable	46	8.2
IUD	22	3.9
LAM	8	1.4
None	8	1.4
Other	16	2.9
Partner is pregnant	57	10.1
Does not know	1	0.2
TOTAL	564	100

When asked about their reason for discontinuing the current contraceptive method, the main reason given was again related to concern for their partner's health (34.8%). The other reasons given were that they thought the current method was not reliable (28.5%), and that they did not like it or that it decreased their sexual pleasure (28.4%). Table 1 shows that these men are predisposed to using male methods (38.8%) and that they do so at a much higher rate than the 1996 national average (BEMFAM/DHS 1996). In the 1996 DHS, 14.7% of all men, and 5.2% of men married or living in union, were using condoms.

Neither the men nor their wives' had negative expectations for changes in their lives as consequence of the vasectomy. They either thought nothing would change or they expected some positive changes to happen in their lives (see Table 2).

The fact that men and women did not reveal myths or any anticipation of negative consequences of the surgery during the psychological interviews can be considered a strong indication of the quality of the educational sessions and the counseling in successfully diminishing myths, doubts and fears about the procedure: "The information was complete and they gave the possibility of asking all the questions and gave the opportunity of changing our minds."

Table 2. Expectations of life changes after vasectomy by men and their partners.

	MEN		PARTNERS	
Expectation	Frequency	%	Frequency	%
Nothing will change	289	33.7	284	34.1
Life will be more relaxed	286	33.4	281	33.8
Life will improve	185	21.6	210	25.2
There will be no need to use a method	54	6.3	52	6.3
Other expectations	43	5.0	5	0.6
TOTAL	857	100	832	100

4.4 Process of approval and follow-up

As stated in Table 1, 535 men actually completed the entire screening process and underwent the procedure. Table 3 presents why the others did not complete the process.

Table 3. Reasons why men did not complete the process

Reason	N	%
Lost to follow-up	232	65.7
Did not meet requirements	81	22.9
Changed mind	30	8.5
Lacked appropriate documentation	7	2.0
Other reasons	3	0.8
TOTAL	**353**	**99.9**

Many of the men who were lost to follow up had been enrolled in the program by their wives and never came back. Others went to the center to ask for vasectomy after learning about the project over the radio but before the program was active. Many of them did not know about the selection criteria.

Even when the procedures for the initial screening were in place and functioning, a few men insisted on continuing the process even after being informed that they did not meet the criteria and would most likely not be approved. A proportion of these men were either close to the necessary age or their youngest child was close to the age required. Some returned to have the surgery after they met the necessary criteria. These do not appear in Table 3.

Interviews and focus groups with men showed that men agreed with the objectives of the screening process. Several men reported that the counseling they received throughout the process was very important and useful.

Of the 30 men that changed their mind after completing the entire screening process, most stated that the reason for discontinuing was that as the couple had decided to undergo female sterilization. This group makes evident the need for a counseling process, and also validates the need for confirmation of the decision immediately before the surgery.

4.5 Follow-up

More than 90% of the men who underwent the vasectomy came to the first post-operative visit between 7-12 days after the surgery. The complications rate was very low (less than 3% including small hematomas and skin reactions) and is consistent with international rates (Filshie, 1996). Only 60% of the vasectomized men returned to the referral center for a sperm count and had zero sperm present in their semen. Almost 40% did not perform a sperm count or never came back with the result. The qualitative evaluation determined that some men had conducted their sperm counts elsewhere. Eleven cases (2%) did not reach the zero level after 2-3 tests and were re-operated.

Four partners of operated men became pregnant:

Case # 1. Surgery 01/31/97. Sperm count zero 04/17/97.
Wife became pregnant April 1998. Two new sperm counts showed normal amount of spermatozoa in semen. He was re-operated and after the second surgery two sperm counts showed zero spermatozoa.

Case # 2. Surgery 02/14/97. Sperm count zero 04/23/97.
Wife became pregnant in October 1997. Sperm count 12/03/97 = 40,000. New sperm count 03/12/98 showed zero spermatozoa. He was not re-operated. His wife underwent tubal ligation.

Case # 3. Surgery 08/01/97. He did not come back for sperm count. Continued using coitus interruptus. Wife became pregnant 02/15/98. Sperm count = 28,000,000 11/13/98. Second surgery 01/07/99. Sperm count 03/13/99 showed zero spermatozoa.

Case # 4. Surgery 01/31/98. Sperm count 05/03/98 = 14,500,000. Wife became pregnant May 1998. Sperm count 09/10/98 = 4,200,000. He used condoms during all the period. His wife underwent tubal ligation.

4.6 Sustainability of the program

The fact that the service, both the screening and the surgery, is performed by the same staff handling reproductive health services for women increases the possibilities that the program be continued since no additional staff were added to conduct this service. The time allocated to this function is not more than 25% of physician public sector service time. In addition, the trained gynecologist trained other colleagues in the municipality that may replace him and even expand the service to other health facilities. In fact, during the evaluation period, after the Stage III project was completed, vasectomy services were implemented in another health center in the municipality that is being upgraded to become a second referral center. This activity has been undertaken without any external technical support from CEMICAMP.

Interviews with health authorities showed that the strong support of the community through the executive committee enabled the project to continue when the new health secretary and mayor came aboard and demonstrated that they were reluctant to continue the project because it was politically sensitive. At the present time the political authorities consider the program as a first priority because they realized that it gives great visibility to the secretary of health and to other authorities.

Another important issue that contributed with the sustainability is that in 1998 vasectomy was included in the MOH guidelines and after that vasectomies are paid by SUS.

5. DISCUSSION AND CONCLUSIONS

The results of this project show that even within a relatively constrained public sector system, the implementation of a vasectomy service was feasible without adding additional resources beyond training needed to implement the service and reorient personnel functions to allow inclusion of men in educational activities.

The participatory process, which encouraged strong community involvement throughout the planning, implementation, and sustaining of this project, was critical for maintaining the program when it was threatened during a period of political change. CEMICAMP played a key role in the entire process by giving support to the authorities to continue with the project, even though there were political risks associated with it.

All health personnel, including those not directly involved in the project, supported service changes although it meant an increase in their workload. The reason for such high acceptability was the recognition that the program made an important contribution to providing men in the municipality with new contraceptive options.

Men and women using the services agreed that including men in reproductive health care delivery did not make attending the services uncomfortable and nor did it adversely affect the normal functioning of services. On the contrary, men's participation allowed the discussion of the array of options by the couple, thereby allowing them to arrive at their best solutions.

After three years of the project, the vasectomy service has been institutionalized in municipal health services, and municipal and medical authorities have ensured that this service will continue to be available even if all technical support from CEMICAMP is withdrawn. The participatory nature of the project greatly facilitated such ownership.

The fact that the initial very high demand for services was sustained throughout the whole project period is an indicator of the project's success, satisfaction, and acceptability within the community. Further, without any additional public announcement of service availability, the continued high demand could only have been maintained by word-of mouth promotion by satisfied users, as mentioned by men during the interviews. Such results demonstrate that men are willing and able to participate in family planning when institutional space and quality services are provided to meet their needs.

The consistent attention to delivering high quality services and attention to implementing careful follow-up are not only good for the project's image, but also serve practical purposes. Sperm counts allowed the project to detect eleven cases who still had spermatozoa remaining in the semen and who were subsequently re-operated. These eleven men recognized that the follow-up care and diligent concern with quality, even when a technical failure had occurred with the surgery, avoided negative consequences.

This project illustrated well how informed free choice can and should be implemented. Men's participation contributed to a general improvement of information and counseling

both for women and men because the space for discussing the options was recognized by users and providers as an important factor of service delivery. According to the users, joint counseling facilitates free and informed choice and probably contributes to improved relations of the couple.

The careful selection process played an important role in the success of the project. Even though data still do not permit evaluation of the long-term results of the project, the initial results showed that men are very satisfied. Even though the new law allowed using more liberal screening criteria, the project decided to maintain its original selection criteria in hopes of minimizing sterilization regret. Now that the evaluative research has been completed, the vasectomy program should revisit the selection criteria.

References

Arellano LS, Gonzalez-Barrera JL, Hernandez OA, Moreno-Alcazar O, Espinosa-Perez J. 1997. "No-scalpel vasectomy: review of the first 1,000 cases in a family medicine unit." Archives of Medical Research, 28(4):517-22

BEMFAM/Macro International. 1996. 1996 Brazil National Demographic and Health Survey Preliminary Report. Rio de Janeiro, Brazil. 47 p.

de Castro MPP and BM de Castro. 1995. "Meeting men's reproductive health needs: Pro-Pater in Brazil" in *INNOVATIONS: Innovative Approaches to Population Program Management* published by the International Council on Managment of Population Programmes (ICOMP), Kuala Lumpur, Malaysia: vol. 3:11-22

Díaz M and R. Simmons. 1999. "When is Research Participatory? Reflections on a Reproductive Health Project in Brazil" Journal of Women's Health vol 8, no 2, pp. 175-184.

Díaz M, Simmons R, Díaz J, Gonzalez C, Makuch MY, and Bossemeyer D. 1999 "Expanding Contraceptive Choice: Findings from an Action Research Project in Brazil" Studies in Family Planning 1999 vol 30, no 1, pp. 1-16.

Filshie M. 1996. "No-scalpel technique for vasectomy". European Journal of Contraception and Reproductive Health Care, 1(3):231-5.

Formiga, José Noble, et al. 1994. "An Assessment of the Need for Contraceptive Introduction in Brazil". Geneva: World Health Organization. WHO/HRP/ITT/94.2.

Green CP, Cohen SI, Belhadj-El-Ghouayel H. 1995. "Male involvement in reproductive health including family planning and sexual health." UNFPA Technical Report #28. 104 p.

Liow ML.1996. "Putting men on the agenda." in *INNOVATIONS: Innovative Approaches to Population Program Management* published by the International Council on Managment of Population Programmes (ICOMP), Kuala Lumpur, Malaysia: vol. 4: 1-13.

Skriver M, Skovsgaard F, Miskowiak J. "Conventional or Li vasectomy: a questionnaire study." British Journal of Urology, 79(4):596-8

Suarez LGAL. 1996. "Involving men in population activities: Services for men through male clinics" in *INNOVATIONS: Innovative Approaches to Population Program Management* published by the International Council on Managment of Population Programmes (ICOMP), Kuala Lumpur, Malaysia: vol. 4: 45-55.

United Nations. 1995. Cairo Conference on Population and Development Programme of Action.

Wegner MN, Landry E, Wilkinson D, Tzanis J. 1998. "Men as partners in reproductive health: From issues to action". *International Family Planning Perspectives*, 24(1):38-42.

INCREASING ACCESS TO AND QUALITY OF SERVICES FOR ADOLESCENTS

1. INTRODUCTION

1.1. Problem statement

In Brazil, sexual and reproductive health indicators for adolescents have worsened including rising numbers of early pregnancies, unsafe abortions, and STDs, and a high vulnerability and exposure to HIV/AIDS, drugs, violence, sexual abuse and prostitution. Recent DHS data suggests that youth are generally well-informed about the need for condoms, but utilization rates remain low, calling for new strategies for prevention of STDs/HIV/AIDS and pregnancy. The need for health services directed to adolescents and young adults is clear as they frequently lack access to such services (DHS, 1996).

In order to respond to some of the needs outlined, an innovative program for adolescents was created in the southern region of Brazil, in the city of Santa Bárbara D'Oeste (Santa Bárbara), within the context of the Stage II Santa Bárbara project (Díaz et al, 1999, Díaz and Simmons, 1999). A baseline survey of health services in Santa Bárbara confirmed national and regional data showing a high pregnancy rate among adolescents. Service statistics showed that approximately 20% of women who attended prenatal care consultations were below the age of 20; most adolescents had less than four prenatal care visits and were not aware of the services available in the municipal health system. This diagnosis also found that many adolescents were not aware of the importance of prenatal care, most never had attended a gynecologist before becoming pregnant, and frequently the prenatal care consultation was their first contact with the health services.

The lack of access to specific services for adolescents was also evident, particularly in the area of sexual and reproductive health. Youth did not feel comfortable attending health services for adults because providers would generally censor their attitudes or behaviors in issues related to sex and contraception. Furthermore, the baseline diagnosis also pointed out that although sexual activity is being initiated early during adolescence, both the family and the educational systems are neither prepared to, nor are they providing adequate information and/or orientation. Hence, the majority of young people are not consistently using any protection against unwanted pregnancy or STDs, including HIV/AIDS.

1.2. Previous findings

Several programs in Brazil are serving the needs of adolescents, but most have not been evaluated systematically. Some programs report significant improvements in knowledge about sex and contraception but without commensurate behavioral changes. These programs tend to be more concerned with the process of serving adolescents rather than with impacts like influencing behavior change. The gap between knowledge, attitudes, and practices (KAP) has been maintained and adolescents continue with high-risk behaviors.

Programs have not successfully integrated the health and educational systems. Most of the sex education programs which include contraception are school-based and have not been

coordinated with reproductive health programs and services. For this reason, the demand created by the educational programs has not systematically been channeled to services and nor were those services adequately prepared to attend to the new adolescent clientele.

2. PROJECT DESIGN AND ACTIVITIES

The decision to implement an adolescent program in Santa Bárbara was made in a participatory way based on the need, the previous experience of stakeholders, the opinion of adolescents and health providers, and the resources available. The program, under the general coordination of the Santa Bárbara Stage II project's executive committee and project coordinator, had three main components: implementation of referral center services specifically for adolescents, training adolescents as health agents, and implementation of a support group for pregnant adolescents. These interventions were implemented in a stepwise fashion.

The three components of the program are complementary and allow the maintenance of a comprehensive approach, looking at adolescents holistically taking into consideration their emotional and social circumstances instead of focusing narrowly on sexuality, reproduction and contraception.

2.1. Implementation of reproductive health services for adolescents

The main objective of this project was to create a space to provide specific and integrated attention to adolescents for contraception, pregnancy and other aspects of reproductive health (e.g. RTIs, sexuality, counseling and information and general health). In addition, the program was intended to provide a place where adolescents could meet one another to discuss and exchange experiences on different issues, related to reproductive health or not, in a friendly environment.

Space was created for adolescents within the reproductive health referral center (RC) created as part of the Stage II Santa Bárbara project, because no resources were available to secure a separate, additional place. By being in the same location, adolescents had the benefit of easy access to the health center because it is centrally located but somewhat distant from the residential neighborhoods where they live. This latter was perceived as an important benefit because adolescents do not feel at ease if their parents or relatives see them attending a health center.

In order to make access easy, adolescents were attended for two periods per week, and for these times the RC was dedicated exclusively to adolescents. Originally only one period was reserved for adolescents but the great demand for services made it necessary to increase availability to two periods. All the health posts in the municipal network were informed of the availability of adolescent-specific services at the RC and were instructed to refer all adolescents requesting services.

The staff selected to provide care to adolescents in the RC included a female physician, two psychologists (a woman and a man), and the nurses who were already providing improved services to adults during other times.

2.2. Adolescent health agents

An adolescent health agent program was undertaken as part of this project. The adolescents who participated were selected from the city schools after a meeting held in April 1996 that was attended by more than 200 adolescents (10 from each of the 20 public and two private schools). The meeting was a participatory workshop to discuss the main problems faced by adolescents in relation to sexual and reproductive health. At the end of the meeting participants were invited to become health agents. The large number of volunteers led the research team to implement a selection process. The selection was participatory and democratic where the adolescents themselves defined the selection criteria. 40 adolescents were chosen.

The adolescents selected were trained on how to provide sexual and reproductive health information to their peers in the schools, in the community, and in the referral center. The members of the group were prepared to provide information, counseling and referral to the RC. Training used participatory techniques and was not only limited to technical aspects of reproductive health and communications skills. Other aspects, such as their role as health agents, sexual and reproductive rights, gender and sexuality, and relations with their parents were also included. They were also prepared to distribute condoms to adolescents who did not wish to go to the RC. Training was performed in 14 three-hour sessions, held once a week, coordinated by the CEMICAMP project coordinator and a psychologist working at Santa Bárbara and at CEMICAMP. The health agents had weekly meetings with the coordinators to allow for follow-up and supervision of the activities and to reinforce training.

2.3. Support group for pregnant adolescents

The main objective of the support group for pregnant adolescents was to provide assistance during pregnancy and to prepare them for delivery and motherhood. The support group was also intended to attend to the social and emotional aspects of pregnancy. A female psychologist was in charge of coordinating and facilitating the program and each session discussing different aspects of pregnancy and delivery, and other issues like contraception and RTI prevention, etc.

The program was implemented in January 1997. The first activity was to train the psychologist, the nurse and other health workers involved in the program. The training course was given by CEMICAMP. All the pregnant adolescents consulting for prenatal care at municipal health facilities were informed about the program for pregnant adolescents at the RC. Those who chose to continue consulting at their health post continued receiving routine pre-natal care. Those who wanted to participate in the program were referred to the RC. Adolescents had the option of being seen just for prenatal care without participating in the support group.

After the first consultation at the RC, adolescents were scheduled for routine pre-natal care on a monthly basis. The appointments were made trying to maintain the stability of the composition of the groups. Prenatal consultations and support group activities were performed the same day. When participating adolescents arrived they were weighed and their blood pressure was taken. After this they went to the support group session. Before the group was completed, those who came first had the opportunity to use the educational materials and to talk about their questions and/or concerns with each other and with the psychologist who coordinated the support group activities.

The support group is an open group, meaning that adolescents did not always participate with the same people. All sessions begin with discussion of how everybody is feeling, how their relations with family and their partners are going, everyday life experiences as pregnant adolescents, and any questions and concerns. Discussions and role-plays take place about the themes/issues proposed. When necessary the group coordinator introduces topic areas. The second part of the session is dedicated to physical exercise and relaxation and breathing exercises. Previous group members who had since delivered their babies return to the group to share their experiences. This is viewed as an important opportunity to discuss and learn from peers' real experiences with delivery and early experiences with babies. It is a good opportunity to reinforce information and stress basic concepts like breastfeeding and family planning.

3. METHODOLOGY OF THE EVALUATION

3.1. Quantitative data

3.1.1. Data collection and processing

As part of improvements to the RC's management information system (MIS), a form was created to register provision of women's health services (PAISM form) thereby enabling accurate billing to the federal government. A registration system was started in 1996 and was maintained throughout the project period evaluated although it did experience some data collection interruptions due to hardware and software problems. These problems created gaps in the data collection making it impossible to evaluate the entire project period. However, reliable data were available for the same four-moth period (March-June) over a four year period (1996 to 1999) allowing a reliable comparison of relevant data.

Another source of information used was a RC logbook tracking adolescent visits, which collected limited demographic data and data on who referred the adolescent to the RC. The logbook covered the period 13 May, 1996 to 27 October, 1999. The coordinator of the pregnant adolescents group kept a logbook from January 1997 to April 1998 which collected basic demographic information of the participants, their attendance at the support group sessions, their post-partum follow-up, and whether they chose to use a contraceptive methods post-partum.

Adolescent health agents were requested to maintain a daily log of their activities from which data on the types and frequency of their activities performed as health agents would be obtained.

3.1.2 Data Analysis

The research team identified the following variables of interest derived from service statistics and logbooks: total caseload of adolescents since program initiation; caseload of adolescents by type of service utilized; total caseload of adults using RC services; source of adolescent referral to the RC; and uptake of contraception by adolescent RC clients.

3.2. Qualitative data

Eleven focus group discussions (FGDs) and two in-depth interviews were performed between November 9 and December 2, 1999. The focus group discussions were conducted with adolescent health agents, pregnant adolescent users of the service, non-pregnant adolescents users of the services, and adolescent non-clinic user (male and female). The number of FGDs and participants, were as follows: 1 with health agents (6 female and 5 male adolescents); 2 with adolescent pregnant service users (1 with 6 adolescents and 1 with 8 adolescents), 3 with adolescent non-pregnant service users (1 with 4 adolescents, 1 with 5 adolescents and 1 with 5 adolescents), 2 with male adolescents non-users (two with 8 adolescents each), 2 with female adolescents non-users (1 with 14 adolescents and the other one with 9 adolescents).

Selection criteria for participation in focus groups required that adolescents were: 15-19 years old; living in Santa Bárbara; trained as a health agent (for health agents focus groups); pregnant and using RC services (for adolescents pregnant service users groups); a RC service user (for adolescents non-pregnant user groups); and a non-user but had the opportunity to have contact with an adolescent health agent (for adolescent non-users groups). Adolescent non clinic-users from schools and Guarda-Mirim (a philanthropic society in Santa Bárbara which employs adolescents) who participated in adolescent health agents' activities at any time were invited to participate in FGDs. Adolescent service users (pregnant and non-pregnant) were invited to participate when they were at the RC for consultation.

Two in-depth interviews were performed: one with the previous municipal health secretary of Santa Bárbara who was in office when the adolescent program was first undertaken; and the other with the local coordinator of the adolescent health program.

Participation in FGDs and in-depth interviews was voluntary. All participants received a complete explanation of the objectives of the research project and of their right to refuse to answer any questions or to cease their participation at any time. Confidentiality of the information was also emphasized. All participants signed an informed consent form. With the consent of the participants, all discussions were tape recorded.

3.2.1. Data collection and processing

The research team prepared guidelines to conduct the different FGDs and in-depth interviews according to the population to be interviewed and the variables to be investigated. One member of the research team moderated the discussions and another acted as note taker. Specially designed forms were used to record basic demographic data of participants, to evaluate how the group was conducted and the note taking, and to record a summary of the main points discussed. All sessions were transcribed, double checked for accuracy and then analyzed/coded by two separate individuals.

3.2.2. Data Analysis

The research team established categories of analysis for each subgroup participating in focus group discussions based on the variables of interest as follows:

For health agents:

- reasons for participating
- meaning of being a health agent
- number of adolescents participating
- what was needed to participate, essential characteristics to become a health agent
- perception about training/preparation and follow-up
- types/frequency of activities performed, preferred activities
- perception of community and peer response to program
- opinion on the adolescent health program
- impact on their personal life
- reason for continuation in the program
- successes/failures of the program
- perceived program impact
- lessons learned

For pregnant adolescent service users, non-pregnant adolescent service users and adolescent non-users focus groups:

- access (knowledge; facilitating factors/difficulties of access, consultation, and being an adolescent; source of information about service; suggestions to facilitate access)
- services (knowledge of existing services; reasons of consultation; signs; waiting time; which service characteristics were liked and disliked; perception of location; perception of specific service; qualifications; public/private comparison; services needed; suggestions; satisfaction)
- quality of care at RC (informed choice; IEC; counseling; user-provider relationship; technical competence; follow-up; service delivery options)

- contraceptive methods perception (knowledge/myths; attitudes; use; decision-making process; male participation/gender; access; sources of information)
- health agents (knowledge; roles; perception of usefulness; perception of technical competence; importance of counseling to health promotion and prevention)
- STD/AIDS (perception of risk; KAP)
- sexuality and gender (perception of risk related to sexual practice; perception of role; male participation)
- perception of community/parents (knowledge; perception of usefulness; reactions/opinions about service)
- other problems (health; violence)

The categories of analysis for in-depth interviews were: perceptions about their role in the program, the program's objectives, difficulties and facilitating factors, costs, resources required for program implementation, participation of adolescents and program successes and failures.

4. RESULTS

4.1. Referral Center

1715 adolescent clients were registered in the RC's adolescent logbook between 13 May, 1996 and 27 October, 1999. 2.8% of these clients were male. The attendants at the referral center neglected to register a relatively important proportion of the consultations: For the male adolescents who came to the clinic for information and/or to obtain condoms, no personal information was recorded. Therefore, data on such consultations by male adolescents is missing. For female adolescent users, the caseload in the adolescent logbook counted 15% less visits than those counted through the PAISM registration form for national reimbursement of services.

Figure 1 presents the source of referral for adolescents visiting the RC. Considering the total logbook caseload: 37.4% of the adolescents who came to the RC were referred by municipal health posts; 18.8% by parents or relatives; 4.3% by health agents, and 5.9% by friends. Some of the adolescents who said that a friend referred them may indeed be speaking of adolescent health agents since the nature of the project is for the health agents to work with their peers. Almost one third of the adolescents said they came "spontaneously" without a referral. After long lapses of time, adolescents who had previously had contact with health agents may state that they came spontaneously but they may still have heard about the availability of services via health agents' activities.

As shown in Figure 2, the total number of consultations by both adolescents and adults at the RC increased steadily over time. The percentage of all consultations corresponding to adolescents increased from 15.4% in 1996 to 26.8% in 1999. Figure 3 shows the number of first-time visits by both adolescents and adults. In the analysis of first-time visits alone, the

proportion of adolescents consulting at the RC also increased from 16.6% in 1996 to 27.4% in 1999. It had its peak in 1997 and diminished in 1998 and 1999.

The municipal health posts also saw an increase in the number of first visits by adults, over the four-month period March-June, from 1,307 in 1996 to 1,672 in 1999. The number of first visits by adolescents remained approximately the same (from 470 in 1996 to 510 in 1999), however in 1997 less visits were registered (248 visits).

The total number of consultations for all RC services by adolescents increased a great deal over the project period except for Pap smear (see Figure 4). However, when analyzing first visits at the RC by adolescents, family planning services increased from 1996 to 1997 and then decreased in 1998 and 1999 (Figure 5). On the other hand, at the first visits for family planning services by adolescents at the health posts showed the reverse pattern, decreasing in 1997 and increasing in 1998 and 1999 (Figure 6).

Adolescents began to use a greater range of contraceptive methods after consultations at the RC. From 1996 to 1999, there was a large decrease in the number of adolescents leaving their first family planning consultation without a contraceptive method (from 11.3% to 3.1%). Adolescents also began to choose injectables more frequently with an increase from 7.0% in 1996 to 25.0% in 1999. Conversely, the number of pills prescribed decreased from 54.9% in 1996 to 30.9% in 1997, and went back to 50.0% in 1999. The number of adolescents using condoms also increased in 1997 and 1998 in relation to 1996, but decreased almost 3 fold in 1999 when compared to the beginning (Figure 7).

Adolescents perceptions about RC services: The users of the RC agreed that the availability of specific services for adolescents was very important because the RC is the only place where adolescents feel at ease to talk about and obtain assistance for their health problems. Although access to the RC was perceived as easy, non-users of the service stated that the center is not well known in the city.

Clinic users liked educational activities because they provided an opportunity to discuss their problems with qualified professionals and peers and because the educators were very well prepared and friendly. Some criticized the repetition of the same topics such as contraception, STDs and cancer prevention. Others pointed out other negative aspects of the quality of care. They complained about the waiting time, the reception, and the treatment they received from physicians. The chief complaints were about one physician stating that she was impolite, authoritarian, and did not leave room for questions. In addition they felt that she was not technically competent. This physician was later dismissed. Adolescents felt that physician who replaced her is very good and they are satisfied with her.

Health agents have a very positive opinion about the services for adolescents offered at the RC. Their perception is that adolescents appreciate the existence of the services and are generally satisfied with the services received.

Authorities perceptions about RC services for adolescents: The authorities agreed that providing services to adolescents is important. The local supervisor recognized that the

services are mainly oriented to female adolescents and that more opportunities should be created to incorporate male adolescents into RC services. They felt that the problem areas pointed out by adolescents are mainly the result of frequent changes in personnel, requiring constant training of new professionals. The other problem mentioned by the health secretary was the lack of a separate space for adolescents, which he believed would considerably improve quality of care and increase the number of consultations available.

Authorities also pointed out that the social impact of the program was limited due to a lack of political will and strategies of program advertisement among adolescents. They recognized that the coordination between authorities was not always good and this translated into lack of effective support to the program at times.

4.2. Adolescent health agents (HAs)

4.2.1. Training

For several reasons, the number of adolescents who completed the training process was less than expected. The majority of the adolescents who did not complete the training process ended their participation due to personal problems, mainly financial, or due to a lack of family support. Nevertheless, 18 of the original 40 completed the training and initiated activities as HAs.

4.2.2. Activities of the HAs

The main activities of health agents included performing educational activities at the RC, in the schools, in the community and in other cities. Quantitative analysis of HAs' activities was based on the daily registration they were requested to maintain. Unfortunately, only four HAs maintained accurate registrations so a great deal of data about HA activities is missing.

Lectures and meetings at the schools: The HAs provided several lectures in many schools, mainly on sexuality, family planning, and STDs/HIV/AIDS. Although these activities were highly appreciated by the students and teachers of the schools, it was not possible to meet all the requests, basically because the adolescents did not have either enough time or resources for expanding these activities.

Referrals to the RC: All the HAs were very active in disseminating information on the availability of RC services and encouraged their peers to go there to receive contraception and/or orientation. HAs were a key factor in the dissemination of the program and the RC more generally to adolescents of the municipality.

Counseling on contraception and delivery of condoms: Although the HAs main activity continued to be referral to the RC, the HAs implemented a system for teaching about the use of condoms and distributing condoms to their peers. It was very clear that adolescents who were reluctant to go to the RC began using condoms delivered by the HAs and thereafter were more at ease to visit the RC.

Implementation of a radio program: The increasing number of requests to the HAs for counseling led them to create a radio program giving their peers the opportunity to ask questions on the air. Technical assistance was given by the project coordinators. It was a very big success. City-wide surveys showed that a large audience listened to the program and the number of questions received by phone was very high. The program, which ran for one hour per week, was maintained for two months and had to be discontinued due insufficient financial support.

Use of computer technology: The success of the radio program demonstrated that Santa Bárbara adolescents were very eager to receive information about sexuality and family planning. One of the HAs started an email account on a school computer for "questions and answers" about adolescent reproductive health, virtually without technical assistance from the coordinators. In a very short period they had received more than 100 questions. This led them to launch an internet site to provide a similar service to a wider audience. This site broadened who could ask questions and became a very important activity. In the first three months, the site had been visited more than 5000 times. The coordinators of the study provided ongoing technical assistance for answering the questions. The questions revolved mainly around sexuality, contraceptive methods, and STDs/AIDS.

Participation in other activities in the community: The group of HAs became well known in the city and they began to be invited to participate in other community activities sponsored or supported by the municipality such as vaccination campaigns or other types of campaigns. It is generally known and agreed upon in the city that the HA group is one of the most active community groups.

4.2.3. Perception of the community

Some people of the community were initially afraid when the project began because they thought that if adolescents talked about sexuality it might lead them to initiate their sexual lives earlier.

The adolescents from the community who were interviewed had different levels of knowledge about the health agents and the activities they performed. The participatory approach used by the HAs was strongly appreciated and valued by adolescents in the community with whom they had had contact. They compared the HA approach with the classes taught at school and said that teachers are boring because they give "lectures". They recognized that HAs are very well prepared enabling better interactions and that they speak the same language. Adolescents liked very much interacting with the HAs, and mentioned that because they are adolescents this facilitates communication. Some of the adolescents expressed interest in becoming a health agent, but referred to personal problems that impeded their participation in the group, such as the need for a remunerated activity. For this reason, it is difficult to find adolescents who have the time to participate in the group.

Most of the adolescent interviewed thought that the group of health agents should be more active in the dissemination of information about their work. They presented some suggestions about HA's activities: to work more in schools, create a radio program, reduce

the number of participants in each group, and discuss some themes in greater detail. In their opinion, HA activities helped them to adopt safe behaviors and to talk about sexuality with their parents and partners.

For HAs, participation in the program means adopting a life style, to be distinguished among their peers and to be a point of reference for other adolescents. They pointed out some necessary characteristics of the group: awareness about adolescent health, intention to help other adolescents, and responsibility. In their opinion, they are a group open to other adolescents.

The facilitating factors mentioned by the HAs as important for the maintenance of their activities were the financial support received, the support of the coordinators and adults in general and the flexible time schedule for implementing the activities. Difficulties in their work included mainly the need to have another job and the lack of stronger support from the schools.

For the authorities, HAs represent the linkage between adolescents in the community and the municipal health services. They emphasized the need for financial and technical support for the HAs.

4.3. Services for pregnant adolescents

4.3.1. DEMAND FOR SERVICES

The RC began offering improved and additional services for pregnant adolescents in January 1997. The first support group started with 2 adolescents and this number grew very quickly in the early months. Between January 1997 and February 1999, out of a total of 451 adolescent pregnancies, 268 (59.4%) participated in the program at the RC and most of them received antenatal care and participated in the support groups. The majority of the adolescents attended by the program were between 14 and 17 years old, had between 5 and 8 years of schooling, and slightly more than 40% were living with their partner. Of the 268 adolescents who consulted at the RC, 43.3% returned for postpartum consultation, and of those 80% initiated contraceptive use. Figure 8 summarizes the activities of this program. It is clear that the follow-up rate was influenced by the location of the center. Adolescents were able to come to the center during pregnancy but, with a child this becomes more complicated which may be the reason why less than half returned. It is also highly plausible that these adolescents went to other closer health facilities for their post-partum consultations. However, this data was not collected as part of the evaluation.

4.3.2. Pregnant adolescents' evaluation of the program

Adolescent focus group participants who had participated in the pregnant adolescents program did not mention difficulties in accessing the services. Although they sometimes had to wait up to 2 weeks to obtain an appointment, they were not bothered by the waiting time. In addition, if they did not feel well or had any problems during pregnancy they could consult without scheduling. Even though the time between their arrival at the service and the actual medical consultation is long, this was not considered a problem because during

that time they attend the support group. Friends, relatives or other municipal health facilities referred them to the RC for the program. They said that the RC lacked signs indicating the services for adolescents and this made it difficult for some adolescents to find to the services.

In general, they liked the attention they received by the receptionists. They felt the receptionists were well educated. They mentioned that the nurses also treated them very well, in a polite manner. Overall, they considered the attention to be good. They received information on sexuality, contraceptive methods, and learned how to use the condom. They expressed their strong dislike for one of the gynecologists, who gave very short consultations and did not give them an opportunity to ask questions. They are very satisfied with the new gynecologist.

They considered the support group very useful and stated that was the main reason why they continued coming to the RC. They said that the meetings with the psychologist were very important for them.

> "She asks questions, she answers questions, teaches exercises, a lot of things; she teaches us to take care of the baby, to take bath, to breast-feed."

The pregnant teens emphasized the importance of the support group in clarifying their questions. They repeatedly stated that it was important to receive information about pain during labor and delivery, and to have the opportunity to discuss these issues. They appreciated learning new things and learning that sometimes the information they had was not correct. They received information about what were the appropriate times to go to the hospital and they were encouraged to ask questions about different issues like breastfeeding. They also liked having the opportunity to discuss their problems with their parents and partners. Some said that they liked the way the group starts, asking everybody how they feel and giving all the participants a chance to talk about themselves and talk with the other adolescents in the group. They suggested that the support group meet for more time because sometimes they did not have time to ask all their questions, talk about all the issues that they needed to, and to do all the exercises. They suggested that the group could start earlier so they could have more time before the gynecologist comes or divide the group into two.

The teens graded the services for pregnant adolescents at the RC as excellent, and recommend the group to their pregnant peers. They praised the attention to the other aspects of RH that are included in the support group and/or in the medical consultations such as STDS/HIV/AIDS and breastfeeding. They also knew contraceptive methods are available for free at the RC. When comparing what they heard about STDS/HIV/AIDS at other health centers and through the media, they thought that the information received at the RC is better than in other places.

The HAs feel that the support group for pregnant adolescents is very good. They think that it is useful because it reduces tensions during pregnancy and prepares the adolescents for how to handle the delivery. Providers perceived that support group participants had a greater probability of a normal delivery.

4.3.3. SUSTAINABILITY OF THE PROGRAM

The pregnant adolescents' program was well accepted by the authorities, the community and the providers. The health authorities expressed their interest in its continuity. When the psychologist that coordinated the group resigned, they transferred another psychologist interested in this activity from another area of the municipality. This professional was trained and received supervision from CEMICAMP.

Currently another health center, in a different region of the municipality, is replicating this experience and they are starting to work with pregnant adolescents based on the RC model. A psychologist was hired to coordinate these activities.

5. DISCUSSION AND CONCLUSIONS

The experience of implementing the adolescent program in Santa Bárbara was very rich, and provided several lessons for the researchers, the municipal authorities, health providers, and the community. Generally speaking, the program was highly successful and showed that it is possible to implement high quality services for adolescents within the resource constraints of a municipal system, with very few additional financial inputs. The main factors that can explain the success and the lessons learned during the process are analyzed below. It is very difficult to define which are the most important facilitating factors and lessons learned. The points that are discussed below are loosely ordered by importance according to the research team and begin with the more important elements. However, the hierarchy chosen is not that important because **all** the factors analyzed were key to the implementation of the program.

5.1 THE PROVISION OF ADOLESCENT SERVICES IN THE MUNICIPAL HEALTH SYSTEM

- **Political will and support from the authorities**

Although all politicians and other community leaders consistently publicly recognize that adolescents need special care and attention, that they are the future of the society, and that they need to be oriented but not repressed, etc, the actions taken are not consistent with this recognition. Due to religious traditions, political pressure from the Catholic Church, and cultural conservatism, the RC programs geared to adolescents had to be somewhat restrictive at the beginning because adults were afraid that the program could encourage adolescents to initiate their sexual lives earlier.

Santa Bárbara's mayor, secretary of health, and authorities from the secretariat of education had the courage to support the adolescent program, even taking some political risk in doing so. Before the end of two years of the project, there was a political change of the authorities and the new authorities wanted to stop or strongly modify the project. At this time in the project's evolution, the strong support of the community was crucial in applying pressure to maintain the project. The result was that new authorities continued to support the project and now there is no longer resistance.

Currently, the secretariat of health has publicly recognized that the adolescent program has gained a specific identity within the reproductive health program and has been institutionalized. As a consequence, the secretariat has allocated specific resources to maintain and expand it.

- **Participatory approach and community participation**

The program for adolescents was, from the very beginning, oriented to the needs of the community and planned and directed in a participatory way. Since the first meeting, health and educational authorities and providers were involved. The views of adolescents were always taken into account and they participated in all the activities. All the decisions made by the executive committee were widely discussed with the adolescents, and adolescents had representation on the committee. Adolescents were, from the very beginning, the true owners and beneficiaries of the program. The interviews and FGDs during the evaluation showed that one of the main reasons why the program was so well accepted by the adolescents in the community is because the activities are performed by adolescents.

- **Specific training and continuous technical assistance**

Working with adolescents requires specific training. Although the problems faced by adolescents do not differ technically from problems of other age groups, the approach should be different. Adolescents feel that they are discriminated against when they attend health services because health providers, and frequently also educators, treat them as people who lack a sense of responsibility. Phrases like "adolescents do not care about health", "adolescents only think about sex", "adolescents are not reliable", are frequently heard amongst health providers and educators. Training for providers and educators who work with adolescents should facilitate a change in attitude of the trainees to allow them to have a good rapport with adolescents and to gain their trust. It is common to hear adolescents saying that they do not go to services because they cannot rely on providers who only criticize them. Training should also enhance the technical capacity of the personnel, mainly in the areas of sexuality and contraception. Providers should be prepared to deal with adolescent sexuality and prepared to dispel myths and misconceptions on reproductive health and contraception.

But training is only one component. Continuous supportive supervision is crucial in all areas, but is perhaps still more important for working with adolescents. Due to pressures from the community, providers tend to revert to old practices without continuous support from the coordinators of the activities. For example, condom provision to adolescents is a very criticized activity of the program. It is believed that providing condoms to adolescents promotes irresponsible sex, and that providing sex education stimulates teens to begin sexual activity earlier and to have sex more frequently. These opinions in the community are very strong and can interfere with project activities if project personnel are not continuously reinforced and supported.

- **Attitude and technical competence of the providers**

As stated above, training should ensure that technical skills and attitudes of providers are appropriate. This was attained in this project in a very high proportion of cases and was highly praised by the adolescents and the community. The quality of care given by the auxiliary nurses and attendants was very important to creating a comfortable environment for adolescents in the clinic.

On the other hand, despite training, one physician working in the center for a time had problems interacting with the adolescents. She was distant with them and did not provide opportunities for them to talk about their problems. Despite good technical preparation, adolescents always tried not to consult with her because of her attitude. Interviews with adolescents showed that they considered that her poor attitude influenced the quality of services. Adolescents insisted that a person who cannot communicate properly is not technically competent despite the clinical skills she might have. The problems with this provider were reflected in the quantitative results of the project, because during the period in which she was responsible for medical attention, the number of consultations for contraception and sexuality decreased significantly.

The rest of the professionals were graded as excellent by the adolescents who also recognized that the collaboration of the health agents was also very important in creating a friendly environment.

- **Integration with educational authorities and providers**

Despite the fact teachers were not trained in adolescent sexuality and reproductive health as originally intended, they collaborated actively with the program and were critical to its success. The educational authorities and the teachers were generally open to collaborating with the program. The schools participated in the first adolescent meeting, with some research activities such as the questionnaire completed by adolescents at schools, and for the baseline diagnosis and evaluation. In addition they invited the adolescent health agents to participate in educational activities in the schools giving them time during the routine lectures. This facilitated the dissemination of the program and gave legitimacy to the process.

Due mainly to lack of resources, the program failed to increase the collaboration between the health and education sectors. Despite efforts, the personnel of the project were unable to implement additional activities with teachers, as was planned, because there was no time available to perform more training courses or seminars in the schools.

- **Replication of the adolescent program**

The adolescent health agent experience was replicated in Sumaré (Stage III) and is now being replicated in another municipality, Piracicaba. In these efforts the educational sector is being strongly involved from the beginning of project activities.

5.2 THE PREGNANT ADOLESCENTS COMPONENT

The service for pregnant adolescents was very important because it increased the antenatal attendance of adolescents. Adolescents stated that they came to these services because they felt at ease with the personnel of the program and that they were treated with respect and cordiality, and were not made to feel guilty because they were pregnant. The preparation for the delivery that the project provided was also very important in helping adolescents to come to the maternity hospital with a realistic attitude that benefited the evolution of labor and decreased unnecessary cesarean sections.

With regard to post-partum follow-up, it is clear that the group activities during pregnancy should stress the need for follow-up, not only for contraception, but also to ensure the health of the mother and child.

5.3 THE ADOLESCENT HEALTH AGENTS COMPONENT

The adolescent health agent component of the program proved to be crucial to the success of all adolescent services provided at the RC. The HAs were key to making the program known to the community, in referring adolescents to the RC, in collaborating in the educational activities of the RC, and in giving education and assistance to the community in schools and other places.

- **Selection and training of the health agent group-members**

Training of adolescents to become HAs is labor intensive and requires great dedication for a relatively long period of time. For this reason the selection of the participants should be made with care. In this program, despite careful selection, only 18 of the original 40 adolescents who initiated the training became health agents in the end. The main reason for discontinuation was that many of them needed to work and help their families, making active participation difficult.

- **Continuous training and supervision of the HAs**

After training, HAs needed continuous monitoring and refresher training sessions. As they became known in the community and began to become more reliable among their peers, they began receiving more and more complex questions requiring technical knowledge. Continuous training improved their ability to adequately answer difficult questions or to give support in difficult situations.

- **Integration with other components of the program**

The group of HAs, as they became more well-known, began to participate in other activities of the municipality, some of them not directly related to the reproductive health program.

For example, they participated in several educational campaigns including for STDs, cervical and breast cancer and prostate cancer. They also collaborated in vaccination campaigns. This was very important for the program's image because the community began to understand that the group's concerns were not limited to sex and contraception and that their activities were more comprehensive. The HAs also had the intention to increase and expand their activities but, mainly due to time and resource constraints, they could not expand the activities much more.

- **Assistance through the Internet**

Use of the internet was a very important element of the adolescent program and was an initiative which originated with, and was implemented by a group of HAs with a small amount of technical assistance from CEMICAMP. Some HAs were feeling that they did not have enough time to really communicate with all the people who wanted their assistance. They opened the email account and internet site to have another space for communication.

The site was intended to disseminate information about the group and to give adolescents the opportunity to ask questions and discuss their problems with absolute privacy and confidentiality. The site was a great success from the very beginning, receiving hundreds of visits every week and receiving a sizable number of questions through the e-mail. The coordinators of the project provide technical assistance to HAs to assist them in answering the questions but the adolescents always provide the answers. The two HAs originally devoted to the Internet service are now experiencing time limitations to respond the large numbers of consultation requests they receive.

According to adolescents, the Internet is an attractive venue for them because they feel at ease in the informal environment it creates and it allows them to discuss a wide range of issues while maintaining anonymity. A special program in Brazil allocated computers to public schools, which greatly facilitates Internet access for adolescents. The great number of requests for assistance through the Internet, and the constant growth of the audience, shows that greater investments are needed this area and also demonstrates the need to have more people prepared to work in this field.

- **Information dissemination**

The HAs have been crucial to the dissemination of information about the program. They have participated in community activities called "Fairs of Citizenship", where they present educational displays and give lectures and advice to the public, both in Santa Bárbara and other cities. In addition they work in the city's schools where they distribute IEC materials. The Internet site and the two-month long radio show have both been very good tools for information dissemination about the project.

The group of HAs have been important in information dissemination not only about the adolescent program but also for the entire Stage II referral center project. There is no doubt

that the limitation of resources has been the only inhibiting factor. The group members have been very enthusiastic and the community really appreciates their activities but the resources available have been a major constraint to the expansion of their activities. One of the adolescents of the group was elected to be a representative for the National Adolescents Program of the Ministry of Health. This will allow an adolescent to have influence on official policies designed to address the sexual and reproductive issues faced by adolescents.

5.4 SUSTAINABILITY

To sustain the adolescent program in general and specifically the HAs group is a major challenge. Although the program has now been institutionalized, the resources for ongoing training and supervision are almost nonexistent. The municipality has made concerted efforts to maintain the professional team in the RC and has even opened a second RC in another city neighborhood, but the continuity of the HA group is at risk for several reasons:

- The period of adolescence is transient. Trained HAs grow older and have to abandon the group because they are they are beyond adolescence and also because they have to take up paid work.
- Not all trained adolescents are able to participate in all group activities. For example, some lack the necessary skills to manage educational sessions with 30 people discussing sexuality. These adolescents should perform other activities they are capable of doing. The activities are diversified, and it is possible to insert them in some of them.
- Adolescents' access to resources are severely constrained. Usually adolescents do not have economic independence and do not have resources for transportation to conduct and develop activities.

The solution is not simple because the municipalities have a chronic lack of resources. On the other hand, municipalities should realize that this activity could be cost effective. The project coordinators have advocated with the authorities to provide more resources to the project and some improvements have been made. The health authorities in Santa Bárbara should find legal mechanisms to ensure regular and permanent resources for this program and then perhaps this experience could be replicated elsewhere.

It seems that in this stage of the project, external technical assistance is still needed to maintain the project. The coordinators will continue providing assistance through another project and this will ensure the continuation of the project in Santa Bárbara and the other municipalities, but still the question that remains is how to make this program sustainable.

Figure 1. Referral for all adolescents registered in the logbook

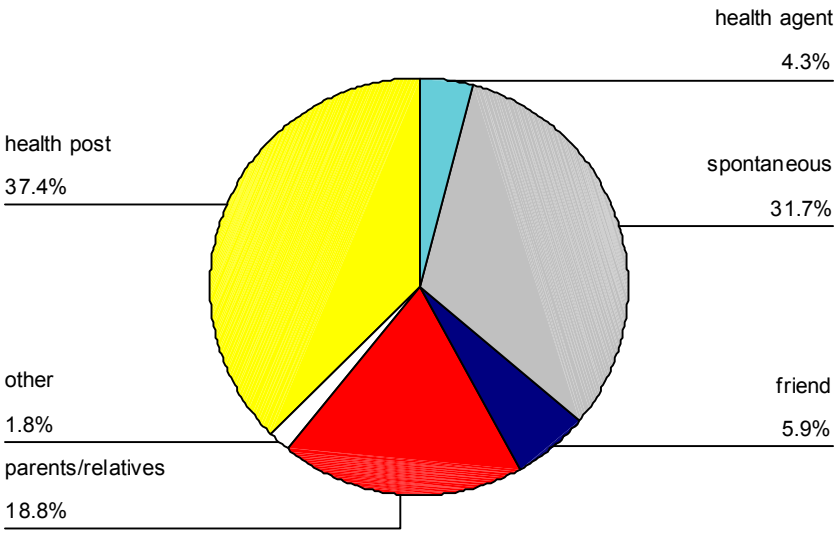


Figure 2. Total number of consultations at the RC by adolescents and adults

(from March to June)

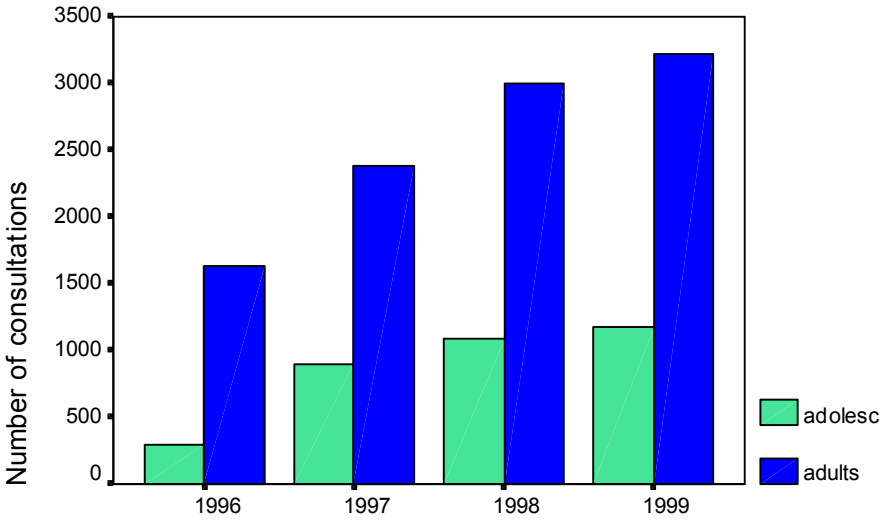


Figure 3. Number of 1st time consultations by adolescents and adults at the RC

(from March to June)

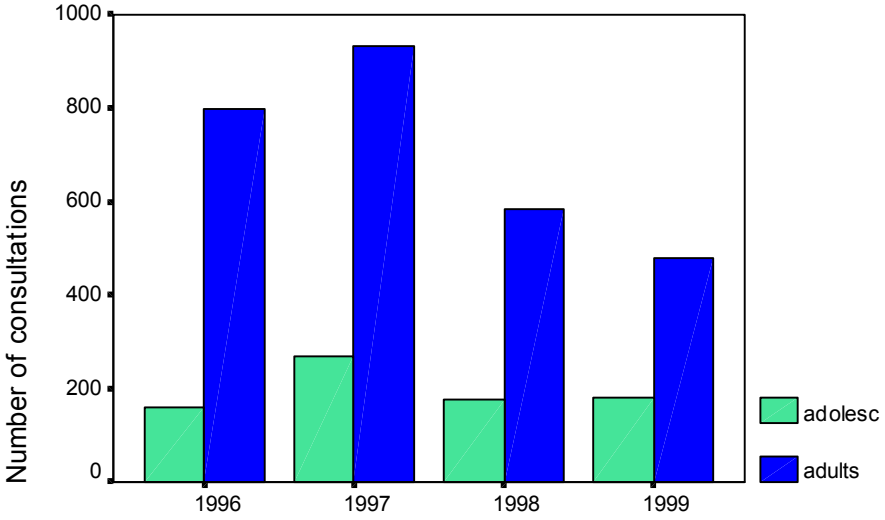


Figure 4. Total number of adolescent consultations at the RC by type of consultation

(from March to June)

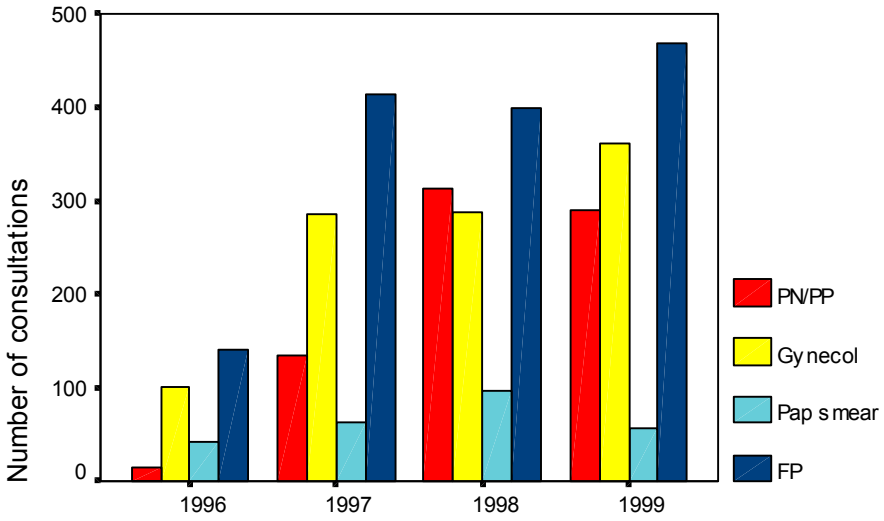


Figure 5. Number of adolescents consulting for the first time at RC by type of consultation

(from March to June)

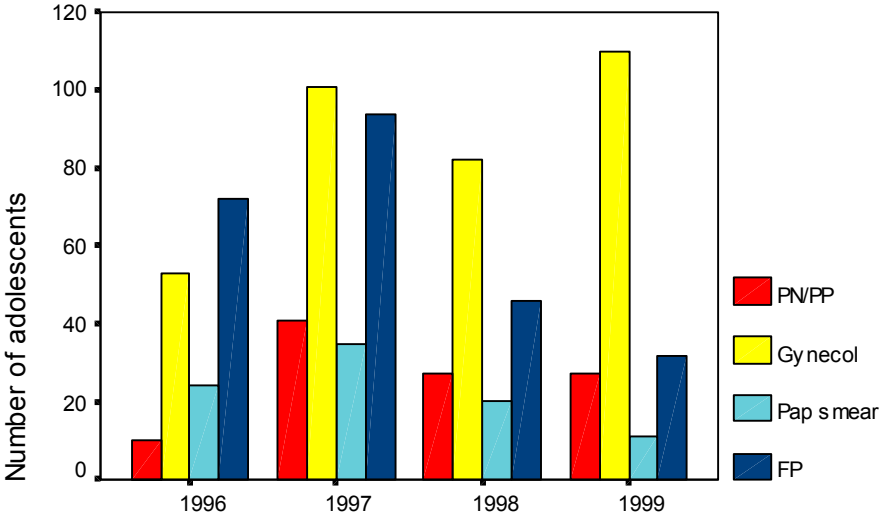


Figure 6. Number of adolescents consulting for the first time at health posts by type of consultation

(from March to June)

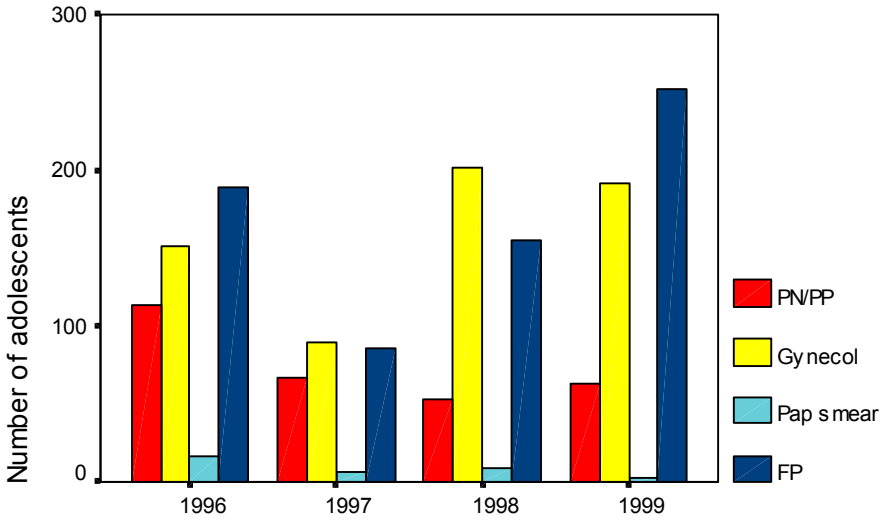


Figure 7. Number of adolescents leaving first FP consultation at the RC by type of method

(from March to June)

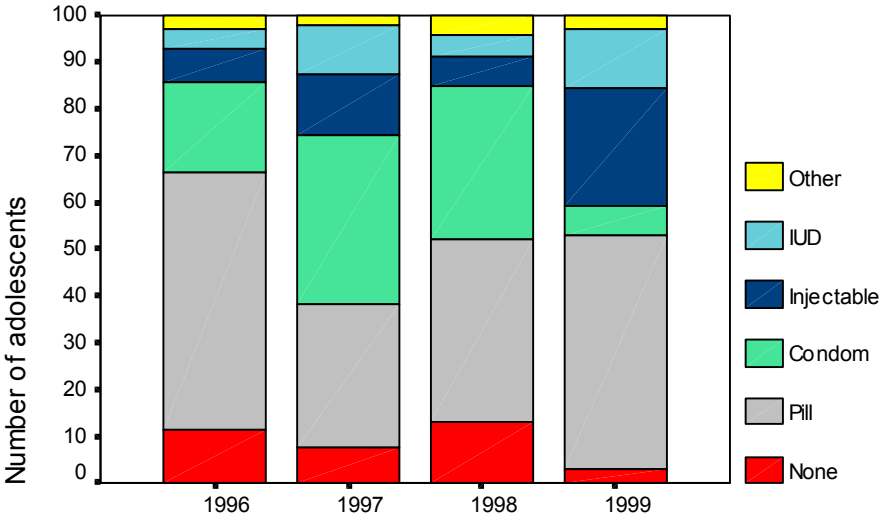
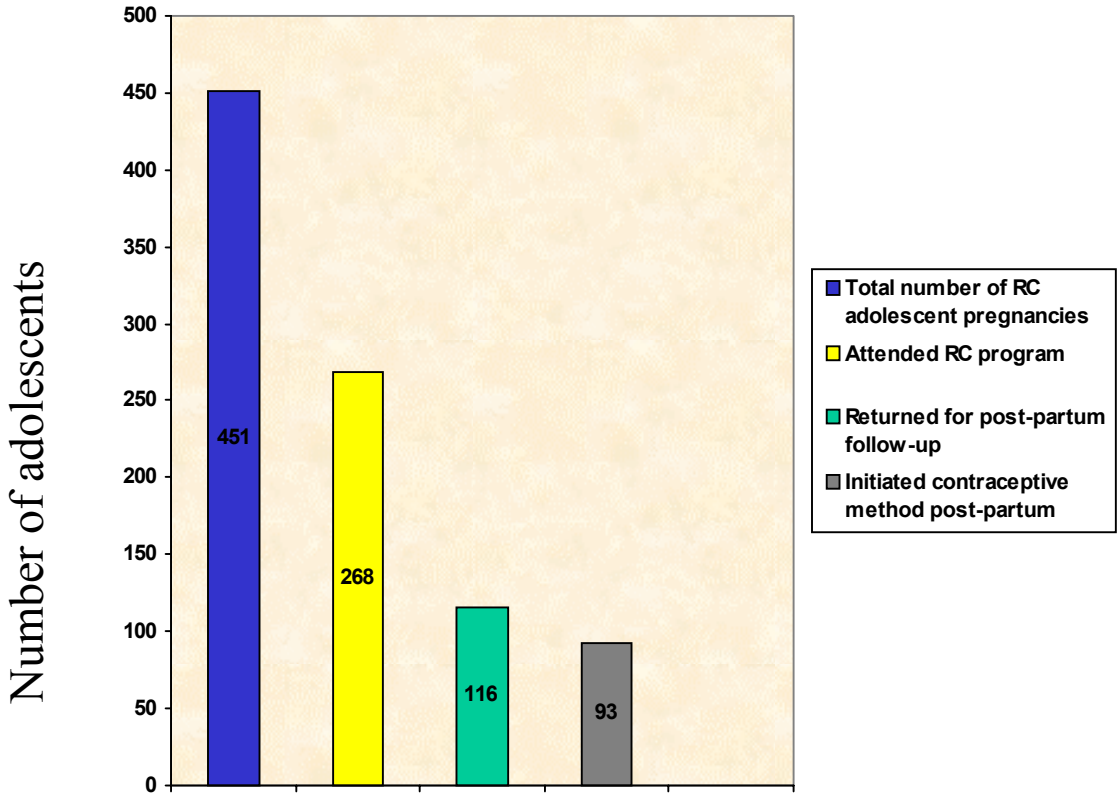


Figure 8. Referral Center (RC) services provided to pregnant adolescents (January 1997 to February 1999)



Source: Adolescent logbook

SUMARÉ CASE STUDY

1. BACKGROUND

Sumaré is a municipality in the state of São Paulo, close to Campinas and to Santa Bárbara d'Oeste, with a population of approximately 170,000 inhabitants. The municipal health system has eleven health posts. There is a state maternity hospital (the Maternity) that is not part of the municipal health system but that has a contract to provide services to the municipality through the Sistema Unico de Saúde – the national system for reimbursement of health services rendered. Prior to the beginning of the Stage III replication project, a few activities had been organized relating to family planning but they did not meet the needs of the community. One gynecologist at the Maternity had a keen interest in providing family planning services. He had already begun to provide some family planning services at the Maternity, with support from CEMICAMP's president. During this time, he attended a seminar for physicians in Santa Bárbara where he learned about the strategy and during the seminar he requested technical assistance from the CEMICAMP team to implement the strategy. After this initial contact, he organized a meeting with the staff of the Health Department, where CEMICAMP's team presented the strategy. After that meeting the municipality of Sumaré and CEMICAMP signed an agreement to implement the strategy. The discussion and signature of the agreement was a public event with the participation of providers and different segments of the community. Because of Sumaré's location nearby to CEMICAMP and to Santa Bárbara d'Oeste where the Stage II project was implemented, it was decided to provide high intensity technical assistance to the project.

In Sumaré the process of municipalization, also known as decentralization of power and control over resources, has not been completed. Therefore, there is not a secretariat of health as there are in other municipalities. Instead there is a department of health, that does not have the same autonomy that secretariats have, and whose activities are supervised by the mayor who makes all the final decisions.

2. BASELINE DIAGNOSIS

A baseline assessment of the current status of reproductive health services and needs within the municipality was performed between August and November 1997. Simplified versions of the assessment instruments prepared for the Santa Bárbara project were utilized and the assessment was performed by CEMICAMP researchers with the participation of two senior staff members of the municipal department of health. The main findings showed that priority for consultations at the health posts was given to antenatal and gynecology clients. There were deficiencies in family planning and cancer screening services and there were no services for menopausal women, adolescents or for men. The referral system was also deficient. A two to three month waiting time for a consultation and a three to four-hour wait on the day of consultation was common. This was a very important limitation to access.

In baseline focus groups, some women stated that services were good. Their basis for considering the services good was because they liked the doctor, were treated well, or

received needed attention. However, they complained about the long waiting times for a scheduled consultation and on the day of consultation. Some said that the services were average or bad because the health posts were unorganized, were not always clean, had long waiting times, the doctors weren't always available and cancellation of scheduled consultations was frequent. Some women knew that family planning and some other reproductive health services were available to women at the Maternity. The women said there was a need for such services and for information about family planning and contraceptive methods. Most of the women who were interviewed used oral contraception (38%) or tubal ligation (38%) and most had paid for the method they were using.

Municipal health providers agreed with the diagnostic results that found reproductive health services were limited to antenatal care and gynecological consultations and that family planning was essentially unavailable. Only four of the eleven health posts had some family planning services and there was greater demand for these services than was being met. Most had not received specific training and had no job descriptions. The organization of health posts was not based on systematic planning. Training was lacking at all levels. The concepts of reproductive health and quality of care were not part of the conceptual framework used by providers. The Maternity was the only institution providing family planning on a somewhat regular basis in the municipality. The staff, a psychologist and a gynecologist were very motivated to improve the quality of attention through the provision of better quality and a broader range of services.

3. INTERVENTIONS

The Process

At the start of the project, an executive committee was organized with a large number of representatives from different segments of the community including female clinic users, providers, authorities and employees from local industries. The director of the health department was designated as president. All participants of the executive committee had a substitute in the event that they were unable to attend a meeting. Senior members of the CEMICAMP team participated in nearly all of the monthly executive committee meetings that took place during the first year of the project. The CEMICAMP team also monitored project implementation. During the first year two monitoring visits to the health posts were performed.

Based on the data resulting from the diagnosis, the executive committee defined some activities aimed at improving service delivery and rationalization of staff functions. Activities undertaken at the beginning of the project included the implementation of educational activities and the training of nurses to collect Pap smears.

For the first year the executive committee was functioning very well and all decisions about which project activities to undertake were made at these committee meetings. Before the first year of the project ended, the director of the health department, who began with the project, resigned from his position for political reasons and a new director took over this position. The mayor and the PAISM coordinator remained in place throughout the course of

the project. When the new director took office he was not well informed about the project and did not immediately assume the same level of involvement as the previous one. During this political change, almost all the personnel (three out of five) conducting the project resigned and a fourth person (the coordinator of the health posts) resigned two months later. This situation left the project without directors and all decisionmaking on the reproductive health program was transferred to the PAISM coordinator who played a key role in maintaining the project's continuity. In addition, some personnel who had been trained were transferred to other programs and their replacements were not trained and thus were not motivated to participate in the project. The municipality also had financial difficulties at this time. It was during this time of change that executive committee meetings ceased for a time, resumed briefly and then stopped altogether.

Sumaré's incomplete municipalization meant that the authority and autonomy to make resource allocations and to purchase health supplies did not belong to the health department. Over the course of this project this incomplete municipalization caused some conflicts and resulted in shortages of supplies. Further, because the Maternity operates under state regulations, and is not a municipal facility, differential salaries and allegiances caused some tension.

Specific Interventions

1. Training: At the beginning of the project, it was decided that the services of all health posts would be upgraded. In August 1997, the CEMICAMP team provided training for 21 providers including nurses, auxiliary nurses, attendants, physicians, psychologists and social workers. Thereafter, the CEMICAMP team conducted another short training exclusively for receptionists which was then replicated by the psychologist of the Maternity for receptionists, attendants and auxiliary nurses in the municipal health system. The CEMICAMP team provided on-site supervision, attended educational activities, observed receptionists' and physicians' attention in some of the health posts and in the Maternity and then provided constructive feedback. For example, they found one physician at a health post who was against the use of the IUD. After a discussion with CEMICAMP team-members, the physician maintained his refusal to insert IUDs but decided to refer women interested in the method to the referral center. Monitoring visits were oriented towards rationalizing staff activities and providing supportive instruction to personnel at the posts.

   Not all municipal health system physicians attended the CEMICAMP training. It was therefore decided to strengthen at least one health post in each region of the city. Early on, educational activities were implemented in each health post, but after the lapse of time, some of them continue only giving individual counseling. In some health posts, personnel was limited and attention was mainly focused on urgent needs, and educational activities were not implemented.

2. Referral Center: The Maternity has a contract to provide the municipality with hospital-based and out-patient attention. Deliveries in the municipality take place at

the Maternity. As part of the program it was decided that the Maternity would become a formal referral center for family planning, especially for surgical methods. As part of the interventions, the Maternity began accepting referrals from the health posts for people interested in surgical contraception. The CEMICAMP team provided the Maternity with screening instruments developed for the Santa Bárbara Stage II project (based on the model developed by the University of Campinas) to facilitate their provision of surgical methods. Because the Maternity could purchase supplies directly there was greater opportunity to keep contraceptive supplies current.

3. Transfer of functions to nurses and auxiliary nurses: Nurses, auxiliary nurses and attendants were trained in the provision of routine collection of Pap smears, breast examination, and administering contraceptives (condoms without restrictions, and pills and injectables only with medical prescription). These changes were implemented in eight of the eleven posts. Although these tasks were shifted to the auxiliaries, nurses and attendants, physicians resisted this innovation because they felt it threatened their control.

4. Supplies: As part of the agreement with CEMICAMP, the municipality had agreed to maintain the supply of contraceptive methods in all health facilities. At the beginning of the project, the municipality upheld their agreement to keep the supply regular, but when the municipality encountered financial problems, the distribution of supplies was discontinued in all the posts. Only the Maternity continued to have supplies because they had a separate budget.

5. Group Education: Educational sessions about family planning and STDs were organized and implemented after the CEMICAMP training in all health posts and at the Maternity. Coincident with the discontinuation of the executive committee meetings and the resignation of key project personnel, many of the health posts had to discontinue educational activities and switch staff to perform other duties. At the time of the evaluation, only three health posts continue to consistently provide educational sessions. At the Maternity, educational sessions for general family planning and for those interested in surgical methods continue to be offered regularly.

6. Improving the Scheduling System: Before the project, women said that had to wait three months to receive a consultation at a health post. Most health posts then attended 16 women per day and made women come to the health posts several times before they received an appointment. As part of the project interventions most health posts attend more women and schedule consultations for either the same day or in the days following. Emergencies are almost always seen on the same day. Only one health post was found to schedule consultations for up to 30 days later.

7. Attention to Special Populations:

   Adolescents: Looking at the results of the diagnostic research and published indicators for the city, the executive committee decided that an adolescent program

was needed in the municipality. The project began with a school-based meeting of 200 adolescents (March 1998) which included adolescent health agents from Santa Bárbara, CEMICAMP team members, teachers, the department of health's team, the PAISM coordinator and other project personnel. During this meeting, two adolescents were selected to attend the National Annual Meeting of Adolescents. Upon their return, these two adolescents organized a group of health agents in Sumaré to replicate the Santa Bárbara experience. The group participants were trained by the psychologist of the Maternity, the coordinator of the adolescent program and two adolescents health agents from Santa Bárbara collaborated with the training at its inception. The group works primarily within the schools they attend and through a radio program they produce. They do not maintain links with municipal health services.

Men: Prior to the project, vasectomy was not available in municipal health services. Vasectomy services were introduced in the Maternity as part of the project and they are performed by the same gynecologist who performs them in Santa Bárbara d'Oeste. Educational sessions throughout the municipality incorporate discussion of vasectomy as a contraceptive option for limiting childbearing and when users express interest they are referred to the Maternity for follow-up. A similar protocol for screening of vasectomy candidates as the one used in Santa Bárbara is used at the Maternity. Men come to educational sessions which discuss all contraceptive options and then have a psychological interview. At the time of the evaluation 155 vasectomies had been performed in Sumaré.

4. RESULTS

Community Participation

At the beginning of the project, the executive committee functioned with very well with good community representation and all decisions for interventions were made by this committee. After the resignation of the first director of the health department the executive committee meetings stopped. They resumed temporarily after a meeting between a CEMICAMP team member and the new health department director and then ceased completely because it was not clear who should be responsible for scheduling and elaborating the agenda for the meetings. Many participants felt that the project lost momentum when the executive committee stopped meeting. Several of the activities recommended by the executive committee, like improving the appointment scheduling system, were discontinued. Some committee members felt that the program lacked solid leadership. Community members felt that to have productive community participation, the project leadership would need to "open the door" to that participation by giving guidance and support. One of the community leaders said: "We the users are the last priority. We do not have power to say what we need. Nobody gives us the opportunity to say what we think. However if somebody opens the door and allows us to speak and collaborate, we will come and give support". Many committee members correctly perceived that the new director of the health department was not interested in providing this type of support. Other committee members felt a more active, responsible and dynamic committee was needed

and one that had very clear functions. Others thought that community participation waned because after the economic crisis few people could afford to do volunteer work.

Support from health and political authorities

The PAISM coordinator, as a physician working within the municipal system at a health post and outside of it as the director of the Maternity, played a key role throughout the entire project. In the beginning of the project, he helped link the Maternity with the municipal health posts. He was selected as the PAISM coordinator because before the project he had independently initiated a family planning program in the Maternity and because of his strong ties to CEMICAMP and to the mayor. He was respected for his work in family planning by the other gynecologists working in the municipal health system. During the project, however, he had some difficulties with other project participants, especially other physicians. He found it difficult to convince them to change the appointment scheduling system: He wanted physicians to provide attention based on a four hour block of time, not based on seeing 16 women in whatever amount of time it took. Physicians use the widespread norm of 16 patients per session to keep their hours in the public sector to a minimum since they would see them hurriedly. These and other changes pioneered by the PAISM coordinator were rejected by the other health system physicians such as: changing the appointment scheduling system; allowing auxiliaries, nurses and attendants to collect pap smears and breast exams; and, in some health posts use of the IUD.

The team of the first health director had been extremely motivated to conduct the project and took charge of disseminating the project in the community. One team member began conducting family planning and STD educational activities throughout the municipality. The PAISM coordinator was resistant to her activities, because she was not a medical professional and he thought this person was not adequately trained, and so discouraged her from continuing performing educational activities. She eventually left the project and this caused a major rift between himself and the director.

Access

The project strengthened the ability of the Maternity to provide family planning and enabled the health posts to provide much needed services. Prior to project implementation, family planning appointments in the municipal system required waiting times of up to three months, and only four health posts were offering even limited family planning services. The results of the evaluation showed that eight health posts are providing family planning services and that all health posts provide at minimum information and counseling on contraceptive methods. As a result of the implementation of the new appointment scheduling system at both the Maternity and one health post, women are able to receive services on the day they requested an appointment. The evaluation also showed that, with the weakening of the program, when newly trained staff were shifted to other duties it became difficult to accommodate demand for family planning services.

As a result of the project, men now have access to educational sessions and are able to share responsibility for fertility regulation by using the vasectomy services provided at the Maternity. Adolescents are now able to receive care in family planning in one of the health posts and at the Maternity.

Quality of Care

Method choice

Method choice went up early on in the project, but diminished some when the project lost momentum. At the Maternity and in the health post where the PAISM coordinator works, contraceptive methods are always or nearly always available because the Maternity purchases their own contraceptives. However, in the health posts, supplies are not always available. Vasectomy was made available as an additional option within the context of free choice, at the Maternity, but many men are on a waiting list because the facility cannot meet the demand in a timely manner.

Information-giving

Educational activities continue in some of the health posts, but in others the staff who had been trained to perform them have been shifted to other duties. The Maternity continues to offer educational sessions daily. Information/education/communication materials related to contraceptive methods were made available for use within most health posts and the Maternity but materials are not available for clients to take home. Women who are service users know the methods' names and how to use them as a result of attending the educational sessions. Women reported being very appreciative of the educational sessions and the information received. The observational component of the evaluation found that the information given at the educational session was of good quality, however physicians gave very little information during consultations.

Interpersonal relations

Men and women users reported that they liked the way they were attended by the receptionist, nurses and auxiliaries. However, problems remain in patient-physician interactions. Physicians received mixed reviews from women ranging from disliking the attendance due to the physician being abrupt and/or not listening to the women, the lack of examinations in some cases, and lack of explanation of the prescribed treatment.

Technical competence

There were few opportunities to observe client-provider interactions during the evaluation but the one physician who was observed, who also was observed during the diagnostic assessment, continued providing very short consultations and his technical competence had not changed. He did not wash his hands between patients and neglected to use a second layer of gloves while conducting exams.

Follow-up

The implementation of the walk-in scheduling system in the Maternity and some of the health posts facilitates patient follow-up because patients can come any day of the week and be seen for urgent care or routine visits. Follow-up was requested, at times, more frequently than necessary due to supply shortages. Same-day attention for emergencies was implemented in all health posts. However, little else is known about follow-up in the health system.

Constellation of services

Information about STDS is incorporated into all educational activities. In most of the health posts, including the Maternity, other aspects of reproductive health were incorporated into family planning services such as Pap smears and breast examinations.

Supplies

Initially, contraceptive supplies were regularly available in the Maternity and the municipal health system. However, after the change in health department directors, supply difficulties arose for many health posts because of purchases are made centrally within the municipality. The Maternity's ability to buy their own methods did not completely eliminate interruptions in their method supply. In the health posts, which lacked this authority, contraceptive supply was a major problem. Frequently, some physicians at the health posts obtained samples of contraceptives from the laboratories to distribute but the supply was unreliable and irregular.

MIS

The management information system continues to be a problem in the municipality. While the municipality recognized the need to track service and supply usage, there was noone in a position to handle implementing a new system. This remains an area requiring attention.

Attention to special populations

Men

Male service users interviewed during the evaluation perceived the wait for vasectomy services to be extremely long although they expressed liking all other aspects of the service. The Maternity has the capacity to attend only four surgeries per week, which explains the long waiting times. Male users were referred by the health posts and by friends, family and their jobs. They said that the educational sessions were comfortable, that it helped to dispel their myths about vasectomy and helped them to make the decision. They learned about other contraceptive methods including the female condom, and received a booklet about vasectomy. Male users on the waiting list said that they would not otherwise have had

access to the surgery if not for the project because in the private sector the cost is too high. They also said that having this method available to them will improve their lives and the lives of the community.

Adolescents

While adolescents received prenatal attention in the past, they now also have access to information and contraception through public sector educational activities and family planning services. The PAISM coordinator remains committed to starting a service specifically for adolescents, but has not been successful in organizing this yet. The adolescent health agents continue to disseminate their programs through the schools and their radio program and they have maintained their participation in the national adolescent health movement. They are currently trying to obtain funding to expand their activities.

Perception of authorities, providers, users and other local people

Health providers, authorities and community members all agreed that the project was a very good idea and that at the beginning community participation was high and adequately represented the concerns of the people of Sumaré. While most participants perceived improvements resulting from the project, many providers and authorities also recognized that several of the problems identified during the diagnostic research had returned when the project experienced a weakening. Examples of such problems included a return to old patterns of appointment scheduling and discontinuity of contraceptive methods. It was generally recognized that things were better than in the past, like access to surgical methods, but that things could be still better since this possibility had been demonstrated.

One community leader who participated in the executive committee felt that the early implementation of the program was good but that it lost continuity. She observed that at the project's initiation women in the community felt skeptical about nurses' abilities to perform Pap smears but that later they felt comfortable and happy with this shift. While at the start all providers seemed receptive to project changes, physicians began to resist certain aspects of the program: Some had biases against certain methods and some resisted other health personnel doing activities that typically fell into their domain such as Pap smears. Additional tension arose with physicians when the project attempted to shift the health post management from physicians, who typically were at the clinic for short periods, to nurses who were in attendance for much greater time-spans. The PAISM coordinator did not feel vested with the authority to implement these controversial changes without sufficient support. He also lacked the time and expertise to supervise the project and he recognized that his demeanor in providing supervision was not always positive.

Another community leader felt that the project's continuation was essential and that good project leadership is highly crucial to that success. She felt that the project requires a strong leadership that is able to take criticism. Providers and authorities all agreed with the sentiment that strong leadership and a clear division of labor are key components of success. Most people involved in the project felt that the midstream change of the health department director was the singlemost important factor leading to the weakening of the

project. The director himself was not well-informed about the project's existence, nor did he see family planning as a priority area when other problems in the health system seemed more pressing. With the loss of its main supporters, the project had difficulty maintaining activities. The project also suffered because of the municipality's financial troubles. The authorities recognized the specific importance of having the autonomy to make decisions for the benefit of the project. While no specific data on cost was gathered, the impression of the authorities was that the project is not very costly. And, in fact, a great deal of resources were mobilized within the municipality to support the start-up and the early continuation of the project.

The men who were on the waiting list for vasectomy said that having tubal ligation and vasectomy available at the Maternity for free was very good because it provided access to these services for the poor. Women service users who participated in focus groups and who completed exit interviews stated that they greatly appreciated the information provided during the educational sessions: Many were hearing information about their bodies for the first time.

The Role of CEMICAMP

Providers and authorities unanimously agreed that the CEMICAMP training was essential to enabling the shift towards quality of care, and were especially appreciative of the updating of information and materials about contraceptive methods and other aspects of quality of care such as interpersonal communication skills. The previous health director said that the role of CEMICAMP had been crucial because, even though the women's health program was a priority, they did not know how to initiate the process of improving the program. He pointed out that the methodology used by CEMICAMP was very useful because it establishes a detailed diagnosis of the situation with the strong involvement, from the very beginning, of local staff. Decisions were not imposed by the research team but made collaboratively through the executive committee, where different perspectives were taken into account instead of discussions limited to technical issues. He also highlighted the importance of encouraging the participation of community representatives and women's groups representatives in the executive committee.

One community leader felt that the CEMICAMP team's work was very good and that the project weakened due to lack of continuity among project personnel during the financial and political changes, and not for any lack on CEMICAMP's part. Health authorities viewed CEMICAMP team members' role as crucial in the diagnosis and implementation of family planning activities. The PAISM coordinator felt that whenever he needed CEMICAMP's support or training for professionals of the health network of Sumaré, that he always received what he asked for.

The technical assistance provided by the CEMICAMP team was very intense at the beginning of the project when the executive committee was functioning and then subsequently decreased. However, throughout the course of the project CEMICAMP team members maintained close ties with the PAISM coordinator. Activities were planned but there was lack of follow-through on the part of the PAISM coordinator for a variety of

reasons. The CEMICAMP team played an arbitration role where they were often requested to resolve conflicts among project participants.

The materials provided by the CEMICAMP team were perceived as valuable. The woman who provides educational activities in the community uses the information and training she obtained from CEMICAMP in her lectures and community work. The psychologist who provides educational sessions at the Maternity viewed CEMICAMP's teaching role as fundamental and that their help in assisting the health department to mobilize the necessary resources to undertake the project was crucial. CEMICAMP team members tried very hard to mitigate conflicts and resistance arising with physicians. Some project participants even felt that without CEMICAMP "it would not have been possible to do anything".

ITUIUTABA CASE STUDY

1. BACKGROUND

Ituiutaba is a municipality in Minas Gerais state with roughly 90,000 inhabitants and with 8 health posts and 7 private hospitals. With the increasing mechanization of agricultural activities the population of this municipality, which relies primarily on agriculture for income, has been decreasing in recent years. For this reason there is an excess of unused facilities and there are more specialized physicians in the city than necessary. The hospitals work in agreement with the public sector to provide some services not available in the public sector.

Ituiutaba was selected to participate in the implementation of Stage III because a physician working at the Centro de Saude da Mulher (Center for Women's Health or CSM) requested technical assistance from the Ministry of Health in the implementation of the Women's Health Program (PAISM) in the municipality, and in particular family planning. The Ministry, after having collaborated in the Stage I assessment recommended that the secretary of health and physician contact the CEMICAMP team for technical assistance. After receiving this request CEMICAMP invited a team from Ituiutaba, including the director of the Women's' Health Program to visit CEMICAMP and the Santa Barbara project. After this visit two representatives from Ituiutaba attended the final Stage II dissemination workshop after which the CEMICAMP team and the municipality arrived at an agreement to collaborate in a Stage III replication project.

2. BASELINE RESULTS

Results from the baseline diagnosis showed that health centers in the municipality were primarily providing prenatal care and gynecological consultations. Data on health services and family planning were unreliable. There were no prevention programs in place such as early cancer detection or for STDs; nor were there services for specific populations like menopausal women, adolescents or men. The quality of care was relatively low. Only six of the 8 health posts had gynecologists and in only two was there a gynecologist available every day. Women had to wait in line beginning very early in the morning to obtain a slot for a consultation. Sometimes the consultations were the same day as requested but at times such appointments were canceled after women had already waited a long time. A year before the initiation of the program, the municipality was making an effort to improve women's health services. They had opened a new health post, calling it the Center for Women's Health (CSM). The CSM concentrated mostly on breast cancer screening and breast pathologies and all laboratory tests were referred to this center. Technology to perform mammography was installed making the CSM the only place where this service was available in the municipality. They also offered gynecology consultations and some prenatal care but no family planning services.

Interviews with providers revealed that the Program for Women's Health (PAISM) had not been implemented. Requests for family planning and cancer prevention services were greater could be met by most of the health posts. Those health posts that offered family planning services offered only pills because it was the only method available. Occasionally some posts had condoms and IUDs and although diaphragms were sometimes available they were not offered. Most of the health posts were not well-equipped lacking necessary instruments for gynecological consultations and most lacked the instruments for insertion of IUDs. Educational activities were not implemented and IEC materials on reproductive health were not offered. Most of the providers had not been trained in family planning or the other components of reproductive health. Even auxiliary nurses providing vaccination learned their skills on the job with a very informal training.

Women complained that sometimes physicians were scheduled to give a consultation but sometimes they didn't come or arrived very late. Women generally thought that a gynecologist was needed in the health posts and they perceived the need for more gynecologists with more flexible hours. Their chief complaint revolved around the very long waiting times for a gynecological consultation. Women also discussed the need to improve the range of attention like incorporating cancer detection, laboratory exams and specific attention for adolescents. Most women had knowledge about the pill, condoms and rhythm. Some of them mentioned injectables, IUDs and coitus interruptus but most of those interviewed were using pills or already had obtained a tubal ligation.

3. THE INTERVENTIONS

The Process

The first activity that took place after the CEMICAMP team and the municipality agreed to collaborate was to implement an executive committee composed of health authorities, providers, and a variety of community representatives. This committee made decisions about how the project was to proceed. The community was particularly well-represented on the executive committee. One of the community representatives was designated as the spokesperson with the community. It was agreed that the CEMICAMP team would provide technical assistance and that their participation would be of low intensity. The research time visited Ituiutaba three times, the first time for the baseline diagnosis and a referral center team training. The second visit was devoted to a second training course, supervision, and to presenting the results of the baseline diagnosis. The third visit was a third training to reinforce the training of the providers who participated in the first training.

Specific Interventions

1. Training interventions: The most important intervention in this municipality was training of personnel. The initial training for 21 participants, in August 1997, included the CSM physicians, nurses, auxiliary nurses, social worker and psychologist as well as some participants from other health posts. The main objective of this training was to improve the quality of care at the CSM and to prepare it to become a referral center that would implement a systematic program for family planning and cancer detection.

A second training took place, organized by the municipality, because they had received requests from three small neighboring municipalities interested in implementing the program in their municipalities. This training course was given to personnel from Ituiutaba who did not take part in the first training, two staff from Capinópolis and two from another small neighboring municipality. In addition, the social worker and the psychologist from the CSM participated in this program so they would have the skills to later replicate such training. After this theoretical training course, two physicians and one nurse went to the family planning clinic at the University of Campinas (UNICAMP) to receive practical training.

A third training concentrating on sexuality and some aspects of adolescent reproductive health was requested by the social worker and the psychologist who handled educational activities in the referral center because they received a considerable number of requests for these services from users.

After the end of Stage III, one physician was trained at Santa Barbara and UNICAMP in the provision of vasectomy to return and organize a vasectomy program in Ituiutaba.

2. Referral center: The CSM was strengthened so that it could function as a municipal referral center. After training, the center began receiving referrals from the health posts for family planning and cancer detection to meet with the numerous requests for referrals in these areas. Educational activities were implemented on a regular basis. The fact that this facility already existed as a Center for Women's Health, and was in good condition and had adequate staffing, facilitated the process of upgrading its services.

   Antenatal care was discontinued in the referral center to enable the center to give more attention in family planning and cancer prevention. Antenatal cases were referred to the other health posts where the requests for these services was readily met. To support the successful implementation of the referral system, the health posts were trained to provide educational activities in family planning. They gave information, orientation and referral only. All family planning activities were concentrated in the CSM but women wanting to continue receiving attention in the health posts were allowed to do so. Referral was not compulsory.

3. Transfer of functions to nurses and auxiliary nurses: Based on successful experiences in Santa Bárbara, nurses and auxiliary nurses were trained in Pap smear collection and follow-up consultations for providing contraceptive methods (pills, condoms, injectables). This was done to increase the capacity of physicians to give attention to more women.

4. Contraceptive supplies: Improving the availability of supplies was an area identified as needing intervention. After the strengthening of the referral center, IUDs, injectables, pills, condoms and diaphragms began to be available there. Efforts were concentrated on the referral center whereas the other health posts continued to lack most methods and only the pill was available in some of them.

5. Management information system (MIS): Registration was problematic. Several forms were filled out, most capturing the same information and most also failing to capture some needed information. At the time of the Stage III seminar, the health authorities realized they were not acquiring sufficient data, so a computer was purchased to help remedy the situation.

6. Group education: First of all, educational activities were implemented in the CSM as a routine. In addition, counseling was also implemented. Also the personnel of the health posts and the family health program were trained to implement educational activities. In some posts where the personnel was not trained, educational activities were performed by the social worker and the psychologist of the referral center.

7. Improving the scheduling system: With the reorganization of services the availability of consultations increased and this allowed implementation of a walk-in scheduling system in the referral center where women are always attended the same day that they come for services.

4. RESULTS

Community Participation

Executive committee representatives participated actively throughout the project period. The Secretary of health always gave great importance to this project and always facilitated and supported community participation. The executive committee met almost every month. One person who led this participatory process was the social worker, who was trained in the first training, because she really understood the importance of a participatory approach.

Support from health and political authorities

The secretary of health took a strong leadership role by giving priority to the project. He acted as president of the executive committee and always participated in the meetings. He supported the practical training of three physicians and a nurse in Campinas. Despite strong commitment on the part of health authorities, health providers and the community, the project encountered problems in its coordination. The first coordinator had difficulties to assume the role of coordinator because it was difficult to coordinate the activities of his colleagues. For this reason he transferred this role to the CSM psychologist, who also had difficulties because physicians were resistant to accept the new guidelines. She became very active in this role and tried hard to maintain quality of care in the center and solve the problem of the lack of supplies. After some difficulties with the health secretary, she left the coordinator position and a nurse took it over.

Access

Before the implementation of the strategy family planning was almost non-existent in the municipality and afterwards all women requesting attention in family planning received both attention and information.

Concentrating reproductive health, particularly family planning, in the referral center and shifting antenatal care to the health posts significantly improved service access. The implementation of the walk-in scheduling system also significantly decreased waiting times. However, although the number of consultations available was always greater more than the number of patients, long waiting times were frequent because women came very early in the morning hoping to be seen first and then be dismissed. For some people, there is difficulty associated with public transportation to the CSM.

Quality of Care

Method Choice

Family planning was offered in the context of free and informed choice but with some constraints due to the lack of methods in the system (described below under Supplies). Injectables, pills, and condoms were missing because it was very difficult to obtain supplies because of bureaucratic problems. At the time of the evaluation, no surgical methods were available in the municipal system, but the program was planning to initiate vasectomy and the providers had been trained.

Information-giving

The implementation of educational activities in the CSM, by the psychologist and the social worker, improved information-giving dramatically. Both were trained and very committed to this work and women very much appreciated this aspect of service delivery. The provision of information given by physicians, however, did not improve. Little information is given in consultations which continue to be too short. IEC materials were not made available to the users to take with them although a lot of posters and materials were displayed on-site. In the referral center men were included in the educational activities from the beginning and this was perceived as a positive aspect of the program by all people interviewed.

Interpersonal relations

Interpersonal relations improved considerably after training, even for physicians, but some problems remain. Women had complaints about one of the physicians but other physicians received more favorable comments. Interviews and FGDs showed that the quality of care of the non medical personnel had improved significantly. The community praised this new kind, warm, and humane treatment.

Technical competence

Evaluation of technical competence showed that the technical competence of nurses improved but physicians still insisted in some behaviors. For example, some of them did not use the eligibility criteria, others continued putting barriers to the use of some methods, i.e. the IUD in adolescents.

Guidelines for infection prevention were not followed completely by all physicians (not always washed their hands between consultations, did not change the clothes, etc).

Follow up

Follow up was complicated by the lack of supplies: women were asked to return more frequently for resupply of pills than was otherwise necessary. The walk-in schedule however offered easier follow-up for side effects of contraceptive use because women could be seen the same day.

Constellation of Services

The range of reproductive health services expanded considerably, because of the addition of cancer detection, information, and screening of STD/RTIs. However, STD prevention is limited due to lack of condoms for long periods of time. The project also, independently of CEMICAMP's assistance, initiated some small surgical procedures in the CSM including minor cervical surgeries.

Supplies

Initially the availability of supplies was adequate but during the last year of the project, due to bureaucratic problems, supplies were lacking. One of the most important constraints to the success of the project was the lack of methods due to bureaucratic difficulties and difficulties in managing bids in the purchase of supplies. A change in norms at the national level, made the choice of suppliers and the allowable expenditures severely constrained and pharmaceutical companies are not interested in selling small amounts of products. This problem was not solved, in part because no one had a complete understanding of how to solve the problem or whose responsibility it was to do so. This particular difficulty caused political problems within the executive committee and among the health and political authorities, because the executive community blamed the Secretary of Health for the lack of supplies.

MIS

Records for continuity of care remained weak and the multiple forms that were being collected still did not capture needed information. CEMICAMP provided the project with the model forms used in Santa Barbara but these were not integrated into services.

Although the municipality had purchased a computer to help remedy the poor information system, the process of entering user information has been slow.

Perception of authorities, providers, users and other local people

There was a consensus that both the quality of and access to reproductive health services improved as a result of the project. The secretary of health felt that this project has had a positive influence on the family health program in the municipality. Although there were bureaucratic difficulties encountered during the project, a lack of communication between referral center staff and local authorities together with inefficient management, exacerbated these difficulties. Nonetheless, the program succeeded in identifying and mobilizing system funds that usually were not customarily used for these services or were going unutilized.

The increase in quality and better access/utilization of public sector services created some negative reactions among the physicians who perceived the program as competing with their private practices. This attitude logically arose in a community where the population is shrinking. The first coordinator and the Secretary of Health received pressure from private physicians who did not want improvements in the referral center. Some referral center physicians resisted shifting antenatal care to the health posts because they felt they risked losing potential candidates for private deliveries and tubal ligations. On the other hand, other providers working in the referral center appreciated their positions and there was little turnover which is a problem that normally plagues the public sector.

Women sometimes complained about the attention of some of the physicians, the continued long waiting times and the lack of supplies. But they said that did appreciate having access to free services with special reference to the cancer screening. Their most highly praised aspect of the service was the educational activities.

The political and financial support of the health secretary and the mayor allowed for the project's continuation. They felt it was a good program that could be better. When asked if the health secretary would do the project over again, he replied that if he would do it again the same way but that he would choose other people to participate.

Attention to special populations

Men

Personnel were trained to undertake the provision of a vasectomy program within the CSM. However, the program had not started by the end of the Stage III project. Men are invited to attend educational sessions offered in the health posts and at the CSM and therefore have access to information about family planning as a result of the project. FGDs with men showed that they recognized the importance of the referral center and educational activities. They wished for access to specific services for them. Men who had not participated in educational activities stated that they learned about contraception from their partners.

Adolescents

Before the evaluation the project coordinators asked CEMICAMP for a training course to implement a center for adolescents but this activity was not implemented. During the evaluation they stressed the need to having activities specifically directed to adolescents.

Role of CEMICAMP

According to the health officials, the CEMICAMP team played a very important role in the maintenance and survival of the project in addition to providing high quality technical assistance. However, project coordinators also felt that CEMICAMP's technical assistance could have been more intensive at least in the early periods. Providers and health authorities both felt that the project is now strong and sustainable. They think that technical assistance from CEMICAMP remains important but they consider that, under current circumstances, the project could survive even if the CEMICAMP team were to completely discontinue technical assistance.

According to providers, the CEMICAMP team was crucial for sustaining the project through very difficult moments. CEMICAMP is well-known and respected and the WHO seal also lent credibility to the project's image for the community and the authorities. CEMICAMP also helped mitigate resistance when physicians did not want to allow nurses to collect Pap smears and provide Pap results and breast examinations because they perceived turning these tasks over as a threat to their control.

Providers felt that the CEMICAMP team's presence had a catalytic effect in bringing about changes. In the end, CEMICAMP gave more technical assistance than was originally anticipated for this low intensity assistance municipality. In practice the coordinator and the project personnel continuously consulted the CEMICAMP team for help in resolving day-to-day problems that appeared throughout implementation.

The secretary and project personnel of the referral center embraced the project as a very important activity and have continued planning and implementing new activities, such as the vasectomy service.

Beyond Stage III

As a result of the project, Ituiutaba is in the position to play an important role in providing technical support to a reproductive health consortium of municipalities. These efforts were initiated in nearby Capinopolis. Although this replication process was not entirely successful it was a first attempt to expand the process and it is the health secretary's opinion that inadequate attention was given to this process. Capinopolis had, at the beginning, initiated family planning activities but both the physician and the nurse who had been trained by CEMICAMP left the program which lead to its discontinutation. Ituiutaba is in the process of building a new referral center with the intention of implementing adolescent services and equipping the facilities to become a training center in reproductive health.

ANÁPOLIS CASE STUDY

1. BACKGROUND

Anápolis, a large municipality of 300 000 inhabitants, is located in the state of Goias. Travel time from CEMICAMP to Anápolis, including car and plane, is a total of four hours. Due to financial and political problems, the 38 health posts of Anápolis provided minimal services between 1993 and 1996. Some gynecological consultations and prenatal care were offered, but other areas of women's health, including family planning, did not receive attention. The physician working in one of the health posts had previously received family planning training at UNICAMP. Because of his interest in family planning, women occasionally received contraceptive services, but he was an exception. He was highly motivated to improve women's health services, specifically family planning, and was instrumental in enlisting technical assistance from CEMICAMP. The system's deficiencies were key issues during the 1996 municipal elections. Having promised to revitalize municipal health services and to implement the Program for Integrated Attention to Women's Health (PAISM) during the elections, the new municipal government was committed to bringing about change.

Other key actor committed for improving women's health services during the election campaign was a deputy from the state legislature (hereafter referred to as "the Deputy"), who also was the wife of the successful mayoral candidate. She was aware of women's unmet needs for health services since 1988, and had actively spoken on behalf of women's needs during the election campaign and through her local radio program. The experience of listening to many women asking for her help during the election campaign, and as often happens in Brazil requesting for access to tubal ligation, strengthened her commitment to revitalize women's health services in the public sector. She was particularly concerned about the young ages of women asking for her assistance in obtaining tubal ligation.

Anápolis was selected as one of the municipalities for Stage III replication upon the request of the Coordinator for Maternal and Child Health from the Ministry of Health who had led the Stage I assessment. The Ministry of Health Coordinator was aware of the situation in Anápolis because the CEMICAMP-trained physician who provided family planning services in his health post was eager to see women's health services expand and had communicated this interest to the Ministry.

The Deputy as well as the CEMICAMP-trained physician attended the Stage II dissemination workshop held in June 1997 and visited the Santa Barbara project. Their strong motivation to initiate change in Anápolis was reinforced by the workshop and by their visit to Santa Barbara where they were particularly interested in the referral center.

2. BASELINE DIAGNOSIS

The municipality was eager to initiate the replication process. The baseline diagnosis took place shortly after the June 1997 dissemination workshop. Results showed that services in the municipal health network focused on pediatric care, general health care and dentistry. Availability of gynecological services was extremely limited, and to the extent that they were available pre-natal care received priority. There were no systematic family planning services, no cancer prevention or specialized services for STD/AIDS, adolescents or menopausal women. Providers concurred that the Integrated Women's Health Program was not implemented in the health posts but that demand for these services was high. Providers could not satisfy this demand because of the limited number of gynecologists in the municipal health network. As had been observed in Santa Barbara at the beginning of Stage II, appointment scheduling was not working well and was used as a means of containing demand.

Material and supplies for gynecological care and family planning were lacking and no IEC materials for reproductive health care were available. A lack of standardization of procedures and untrained staff in family planning and related reproductive health services characterized the health care system.

Seventy five percent of women interviewed at the health posts had a tubal ligation and twenty-five percent were using oral contraception. Most of them had paid for their contraceptive method and had little knowledge about other family planning options. Community women expressed a strong need for more doctors, shorter waiting times before the consultation, more laboratory tests and more opportunity to talk with the doctor. They felt it was important to have family planning services at the health posts as well as educational sessions and IEC materials related to reproductive health.

At the time of the diagnostic assessment, the Deputy invited some women to participate in focus group discussions about the women's health program. One focus group was held in a central location in Anápolis and the second one in a more distant location. A large number of women participated in the discussion groups: 400 women attended the first discussion group and 250 to the other. Among these women, few were selected for participation in smaller group discussions to initiate a "community dialogue" with others. The community dialogue was characterized by women sharing their complaints about the absence of family planning services and limited contraceptive supplies. Contraceptive supplies were only available in one of the health posts where the CEMICAMP-trained physician worked. Most women never had a pap smear. They had some knowledge about contraception, knowing for example that injectables exist, but they had no access to obtaining the method. A large number of young people participated in this community dialogue. The Deputy and municipal health authorities used this opportunity to introduce the plan to create a new center for women's reproductive health services.

3. THE INTERVENTIONS

The Process

As in Santa Barbara and other replication municipalities, creating an executive committee was an important component of initiating interventions. The committee included representation from the community, providers, and health authorities. In addition, representatives from the education and social service department, the evangelical and catholic churches were invited. The CEMICAMP team presented the diagnostic assessment results to the executive committee. Later, when the executive committee ceased to function, decisions about interventions were made by the Coordinator and the Deputy, taking into account the opinion of the providers and the community.

The CEMICAMP team supported the development of the Centro Integral da Mulher (CIM) through an initial one-week visit to Anápolis during which training was provided and the diagnostic fieldwork was conducted. Soon thereafter, during a second visit, the results of the diagnosis were presented at the Executive Committee meeting. One year later the team came for a three-day monitoring visit.; a final visit to Anápolis occurred in late 1999 for purposes of the evaluation. During the period of interventions the Coordinator and occasionally a nurse from the Center were in regular, weekly telephone contact with the CEMICAMP team.

Members of the Anápolis team visited CEMICAMP twice, first for the Stage II dissemination workshop - at which time the visit to Santa Barbara took place - and for the Stage III dissemination workshop. Two nurses and one psychologist came to CEMICAMP for practical training in the family planning clinic of the University of Campinas. The Coordinator also visited the CEMICAMP at least three times over this period of time when he was in the region on other business.

Specific interventions

1. Training: Training interventions were initiated with the comprehensive training program which was implemented in Santa Barbara and other municipalities (Endnote describing training, summarize from Santa B paper) All staff including receptionists of the Centro Integrado da Mulher (CIM) - which was designated as the referral center - were trained in the same training course. During subsequent visits to Anápolis, the CEMICAMP team reinforced this training in areas where deficiencies were observed. Training for new staff joining the CIM was provided by the psychologist and nurses under the guidance of the PAISM coordinator.

2. Referral Center: The CIM was newly created as part of the interventions. CIM is located next to a bus station in a structure which had previously served as a supermarket. With support from the mayor, the building was renovated and materials and supplies were obtained. Additional funding was acquired from the state level. CIM staffing was either newly recruited or transferred from existing

health posts. Recognizing the importance of educational activities, the remodeling took into account the need for educational space.

Interventions discussed below were implemented at the CIM ; not in the other health posts.

3. Definition of functions of the staff: At the time CIM was created, the coordinator, in collaboration with the research team and based on the experience of UNICAMP and SBO, defined the role and functions of the personnel designated to this center. The nurses were in charge of family planning activities -counseling, consultations of new users, and follow-up. Auxiliary nurses were designated to perform breast examination and pap smear collection. Physicians were in charge of IUD insertions until provision of IUDs was prohibited by municipal law in 1998. Physicians were also in charge of giving technical backstopping to nurses and providing consultations for menopausal women and other spontaneous medical consultations.

4. Supplies: Health authorities and the mayor made a commitment at the beginning of the project to buy contraceptive supplies. In addition to purchasing contraceptives, they procured oral contraceptive pills and condoms from the State Health Secretary.

5. Group Education: Educational sessions provided every day span three areas of reproductive health: 1)family planning; 2) breast and cervical cancer screening, for women not in need of contraception; 3) for menopausal women. Some attention to STDs is included in all of these sessions. In addition, sexuality education group sessions are organized once a week, in which individuals participate for four weeks. CIM has three rooms for these educational activities. Regular group education sessions were instituted including group sessions in sexuality. Posters in the waiting room advertised the availability of sexual education sessions. Client can express their interest for participation to the receptionist. Sexuality education groups were integrated by CIM team without support from CEMICAMP. The educational sessions are performed by one of the nurses or the psychologist. It is likely that the training component on the link between contraception and sexuality included in the basic training stimulated attention to this area.

6. Attention to menopausal women: Group education sessions conducted by the psychologist were instituted and women can now receive physician care for menopause problems. Before the creation of the referral center the physician who also provided family planning care in one of the health posts had organized a group of women to discuss issues related to menopause. He became instrumental in opening the referral center and assumed the role of coordinator. He invited these women to periodic group meetings at CIM. This was the starting point of a more regular program for menopausal women. Eventually the psychologist of CIM began to provide care on a regular basis for menopausal women. Attention to medical aspects, i.e. hormonal therapy, was also added.

7. Infertility services: Basic attention to infertility and referral to specialized services are available at the CIM.

4. RESULTS

Community Participation

Although community representatives were included in the executive committee, this committee functioned for only a short period of time. The Coordinator felt that many of the problems faced by CIM staff could have been solved if the executive committee had continued to function.

Even though community participation in decision making was therefore not fully realized, considerable effort was made to assess community needs and satisfaction. The Deputy was in frequent contact with members of the local community through her radio program. Once a year local women were invited to visit the CIM. During one of these meetings the deputy invited the women to link arms and surround the center, thereby giving it a "big hug". Furthermore, users of the CIM were invited to fill out an evaluation questionnaire indicating their reactions to the services as well as additional needs. Service users can pick up these questionnaires, which are clearly displayed, fill them out and put them in a suggestion box. CIM staff regularly evaluated these questionnaires and sought to address issues raised. The suggestion to provide regular services for menopausal women was made in response to such feedback from clients. During the evaluation, women requested that surgical methods be included in the range of methods offered.

Interference from the Catholic Church

The 'introduction' of family planning services through the CIM provoked strong reaction from a Catholic priest in Anápolis. He came to the center, asking "where is the surgery room where you kill babies and perform abortions" and distributed pamphlets to the community telling people not to vote for the deputy because she favors abortion. The evaluation revealed that this opposition was in part tied to a conflict between the Evangelical and the Catholic Church. The deputy belongs to the evangelical Church. Finally an end to the conflict was negotiated and the priest promised to cease his harassment. However, the political authorities in Anápolis had to commit themselves not to provide the IUD any longer. There now exists a municipal law in Anápolis - which is in conflict with federal law- that IUD insertions cannot be performed in the public sector.

Support from health and political authorities

Anápolis provides an example of unusually strong support from health and political authorities. The Deputy's strong commitment and her personal connection to the mayor guaranteed an unusually high level of support. However, the case also demonstrates the vulnerability of political leaders supporting women's reproductive health services to the pressures from the Catholic Church.

The health authorities consisting of the coordinator of the CIM and the health secretary were similarly supportive. The coordinator understood the strategic approach to contraceptive introduction developed by WHO and together with the health secretary provided consistent support to the project.

CIM's special status within the structure of municipal administration

CIM occupies a unique position within the structure of municipal administration. In order to assure that the center could draw on both municipal funds under the control of the mayor as well as on health funds, the center was created directly under the deputy's control. This special status has given the coordinator some autonomy which he would otherwise not have. The Coordinator has direct access to the Deputy and to the mayor. Simultaneously, this structure has also made him closely dependent upon the Deputy. In order to assure the sustainability of the center in the longer run, the coordinator and the Deputy are currently seeking to establish CIM as a foundation, which can receive funds from a variety of sources.

Access

The project achieved significant results in improving access to reproductive health services including family planning. Location of CIM near a bus stations made the center easily accessible. A rational system of appointment scheduling ensured that women can come to the center at any time during clinic hours and obtain services. Since the inauguration of the center in June of 1997 and the end of 1999, almost 30 000 new service users were seen. In the first six months of its existence, the center attended 5937 new patients. Some service users were bussed in from nearby municipalities which do not provide reproductive health services. The CIM team also provided services in smaller municipalities during cervical cancer screening campaigns.

The CIM has an adequate staff to meet the demand for services. Users spend a short time in the center because everything is well organized. Only new users need to wait for attending educational activities. While waiting to attend educational services among new user initially created client dissatisfaction, they soon realized that education was an important part of the consultation and found the wait worthwhile.

Quality of Care

Method Choice

As already indicated, political opposition had a strong negative impact on method choice leading to the withdrawal of IUD services. Because male and female sterilization were also not available, method choice remained restricted. The CIM cannot provide long-acting methods of fertility regulation. However, given that essentially no contraceptive services were available in the public sector service system of Anápolis prior to the implementation of CIM, method choice has in effect increased considerably. CIM provides oral contraception, LAM, the diaphragm, injectables, and condoms. In 1998 75 women used LAM and 25, the diaphragm. This shows that free and informed choice is in fact realized in

this setting. It is highly unusual to find these methods accepted by users of other family planning clinics.

When CIM was opened, all methods were available. Availability of methods then became more restricted because of the political situation and due to the periodic lack of supplies, as discussed below.

Information giving

Results show that group educational activities functioned well. Even at the individual level women receive good information because family planning services are provided by nurses and not by physicians. Some of the group educational activities reflect creative approaches. One of the social workers presented a puppet show to patients, soliciting their reaction to services and their needs.

Interpersonal relations

Relations between service users and the health team are uniformly cordial and friendly. The coordinator has the authority to dismiss staff and has indeed fired a physician whose work did not conform to expectations. In focus group discussions, women emphasized this good interpersonal relationship. They considered the staff to be very open. Observations showed good interrelationships as well.

Technical competence

More than 20 consultations were observed during the evaluation with the help of guidelines covering technical and interpersonal aspects of care. Also observed were exchanges between service users, the pharmacist and receptionist. All staff were found to be well prepared for their function and highly motivated. They knew their roles and were aware that all facets of the system constitute an important part in service provision. They understood that they need to be competent in establishing a good relationship. All of them demonstrated good ability to ask questions. They are skillful and attempt to identify user needs focusing not only on the reason for the consultation but on broader reproductive health needs. When a woman is consulting for family planning she is also asked about pap smears. Nurses were found to be good at counseling and information-giving during consultations to new and follow-up users. The information provided was technically correct. The psychologist provided accurate information during educational sessions in family planning and used interactive approaches. Most of the nurses carefully check whether women understood the instructions they were given. Educational sessions discuss the need for dual protection; however, during the consultation, nurses tend to ignore this message and tell women that one method is sufficient.

Provision of all methods except IUD insertion was observed. Providers maintained asepsis where appropriate, washed their hands and worked in a clean physical environment. Gloves were used and other norms of infection prevention were observed.
Providers used appropriate materials and techniques for pap smears and breast exams. For gynecological examination, disposable paper was used and changed for every woman.

Follow-up

Access to follow-up and re-supply is easy. Women are given a follow-up appointment at the time of their consultation. Follow-up for contraceptive services is provided in the education room in order to assure that follow-up is as simple as possible. Although this facilitates service delivery, it also means that at times needed physical examinations are not performed. For example, sometimes blood pressure control is called for but it is not done in the education room. Even though IUDs cannot be provided, IUD follow up continues to be offered at CIM.

Women indicated that they receive additional counseling and orientation at the time of follow-up. All providers talk about importance of follow-up and ensure that women leave the services with an appointment.

Constellation of services

The center is providing a broad range of services in women's reproductive health. In addition, observations during the process of evaluation revealed that providers do in fact address patient needs with a broad focus on multiple rather than single needs. For example, contraceptive needs are inquired about at the time of pap smear collection, and STD's are discussed in the process of contraceptive service delivery. However, it was also noted that given the shortage of contraceptive supplies, providers were hesitant to provide dual protection when it was requested.

Supplies

Shortage of supplies is a major problem. This problem arose in part from the rapid turnover of the nursing coordinator at CIM whose responsibility it is to order supplies. She orders supplies but finds it difficult to assure a regular flow of supplies because she does not receive an adequate amount from the administrator in charge of buying contraceptives for the municipality. A conversation with the mayor revealed that he is not aware of why the administrator does not buy more contraceptives.

The lack of contraceptive supplies has led to a loss of motivation. Providers also did not receive their salary for three months.

MIS

Registration of information is problematic at CIM. Three different types of registers are kept, one by the receptionist, one by nurses and one by the pharmacy. Their statistics do not provide consistent information. At the time of the evaluation the information system was in the process of being computerized.

Attention to special populations

Anápolis adolescents were attended to at CIM, but no special program for adolescents had been created. This is planned for the next year.

Perception of authorities, providers, users and other local people

The evaluation revealed that the Deputy considered the project an "extraordinary success". According to her, the objective of the project had been "to make women conscious of their body, able to select their own contraceptive method and to decide when to have children, how many to have and therefore to be happier". It was clear that the project had fulfilled her strong desire to help women in this community. She believed that she had done many good things but commented that if she had done "nothing else, this would be enough for all my life". Because political futures are always uncertain, she was keenly aware of the need to accomplish a great deal within a single administration time period. She felt it was fortuitous that her visit to the demonstration site in Santa Barbara coincided with the change in mayor thereby giving the project a minimum of four years of support.

Her initial reaction upon seeing the interventions in Santa Barbara was a concern that the intervention process appeared complex and overwhelming. She was afraid that there would not be enough motivated personnel in the public sector to undertake all the effort needed. She favorably commented on the coordinator's role in clarifying the interventions to her and in providing support. At the time of the opposition from the Catholic priest she felt so threatened that she almost abandoned her efforts to help the project. But she persisted.

The CIM Coordinator had an equally positive view of the project. He felt that "the response from the community is gratifying, and that the project has worked well". He also commented very favorably about the support from the health secretary, the mayor and other officials in the municipal administration.

Focus groups with local people and service users indicate that people are extremely satisfied with the services provided at CIM and comment about the integration of family planning with other aspects of reproductive health. Men commented that they would like to have a center for themselves also. Some people in the community are still unaware of the existence of the center, but generally it is well known. CIM gives schools the opportunity to organize student visits to CIM. Because of this the center is also known by adolescents. One important indicator of user satisfaction is that women from other municipalities started coming to CIM. And some municipalities organized vans to take them to the center.

The Role of CEMICAMP

Respondents interviewed in the course of the evaluation indicated that the role of the CEMICAMP team had been of fundamental importance in making change possible. Technical assistance from CEMICAMP is considered important because CEMICAMP has

credibility. Interviews with municipal authorities revealed that the CEMICAMP team assured accountability and this was positively viewed.

It was made clear that the CIM team felt they needed more technical support. They felt disadvantaged in this regard in comparison with Santa Barbara, the demonstration site which is located near CEMICAMP. For example, the CIM team wanted to introduce adolescent services but the CEMICAMP team was not in a position to provide the training. It was also expected that CEMICAMP would have developed an MIS system which they could copy. But this was not the case.

COMPARATIVE CASE STUDY ANALYSIS

1. Need/demand: In comparing the three case studies one is struck by the basic similarity among the municipalities in regard to the need and demand for services. Apart from ante-natal care, reproductive health services for women were largely unavailable at the beginning of the project. Provision of contraceptive services occurred sporadically and sterilization services were completely unavailable in the municipal health network. Women had difficulty gaining access to the services that were available, and generally had to make an appointment a long time prior to the actual consultation. Interviews in the community revealed that women were looking to the public sector health network to serve their reproductive health needs.

2. Local champions: All three municipalities had at least one local champion who took initiative to push for more systematic attention to family planning and related reproductive health services. Previous family planning training in CEMICAMP at the University of Campinas was the mechanism which led to the connection to the CEMICAMP team in two municipalities. In the other case the connection was made through the Ministry of Health which also had strong ties to CEMICAMP, in particular because of Ministry participation in the Stage I Assessment undertaken in 1993. Pre-existing interest in initiating more systematic attention to family planning services in the municipal health network was particularly strong in Anápolis. The fact that in all three cases the original impetus for change was local rather than external is an important factor in explaining the relative success of the project.

   Literature on the transfer of innovations has shown that one of the attributes of successful transfer is perceived dissatisfaction with the status quo. Clearly, there were "local champions" in all three municipalities who felt such dissatisfaction and were reaching out to institutions and individuals who might be able to help.

3. The Intervention Process: In all three municipalities the intervention process included attention to a participatory process and to a baseline diagnostic assessment. Both of these initiatives represented major innovations. An executive committee with broad based representation was created, and the CEMICAMP team presented results from its diagnostic assessment to this group. Municipal health networks typically function without regular programming and planning meetings of health authorities, providers and other staff. Participation from community representatives at such meetings was also highly unusual. The notion of conducting a needs assessment, let alone listening to the voices of local people in the community, were also not part of the working traditions of the municipal health service sector.

   In all three settings there was a remarkable degree of openness to these new ways of working. However, because participatory decision making processes are not part of the "organizational culture" of the health sector, it is also not surprising that in two municipalities this process was not sustained. In the municipality which succeeded in

continuing the tradition of holding executive committee meetings, strong initiative on the part of the coordinator of the referral center explains this success. Immediately prior to the evaluation (when Stage III was "officially" over), conflict between the health secretary and the referral center coordinator erupted because the health secretary felt that he had not been sufficiently involved in setting up the meeting's agenda. Thereafter the health secretary assumed authority for organizing the executive committee meetings. It is not known whether any further meetings have been held.

These results should not be entirely surprising. It is not easy to institutionalize participatory decision-making processes in organizational settings where they are not part of the ongoing institutional culture. This point also holds for the participation of community representatives. These innovations were initially well received, but they take a great deal of continuing support and nurturing until they become more deeply rooted and institutionalized.

4. The interventions: There is remarkable similarity in the interventions undertaken in the three municipalities: training, creation of a referral center, provision of IEC materials, introduction of systematic educational session, rationalizing a byzantine appointment scheduling system, incorporation of new service elements in reproductive health, increased attention to supply purchasing. This is not surprising for two reasons: First, the diagnostic assessment in all three settings revealed a basic similarity in community needs and patterns of deficiencies within the municipal health network. Second, the Santa Bárbara demonstration site provided observable evidence of the types of innovation that are feasible within the public sector. Municipal health authorities from the other regions were therefore readily convinced that they wanted to imitate what they had seen in the demonstration site.

   Providers in the municipal health network typically have no opportunity to receive training in family planning and related elements of reproductive health. Family planning training is either not covered in medical training or at best only in a most perfunctory manner. Thus even physicians are in need of basic training in the technical aspects of contraceptive service delivery and certainly in its interpersonal and counseling dimensions. Given the weak resource-base of the federal and state public health institutions, there are very few opportunities for on the job training. It is thus not surprising that the training interventions were so well received: they responded to a very basic need and they were provided by a dynamic team with a participatory, supportive approach.

   The institution of a referral center for reproductive health in all three municipalities is readily explained in terms of the limited resource base of the municipal health sector. Although some changes were also undertaken in the health posts of the municipality, the main attention of the change process focused on one municipal facility: the referral center. Again, the Santa Bárbara experience proved to have predictive value in anticipating what would be possible elsewhere: concentration on one centrally located institution where a relatively broad range of reproductive health services could be provided proved feasible; while attention to the health posts remained more peripheral.

5. Differences in the interventions: There were however also some differences in the type of interventions undertaken by the three municipalities. In Sumaré, vasectomy services were made available; in Anápolis, services for menopausal women, and sexuality education were introduced; in Ituiutaba, training was expanded to the health posts, to the Family Health Program and also to two small adjacent municipalities. These variations in the package of innovations arose out of variations in the local context.

   The municipal health network in Sumaré is closely linked to a state maternity hospital and above all, located in close proximity to the Santa Bárbara demonstration site where vasectomy services had been made available within the referral center. Given this close physical proximity, the physician who provides vasectomy in Santa Bárbara can attend patients in Sumaré as well. This explains why Sumaré could institute this new service with relative ease.

   Institution of services for menopausal women in Anápolis similarly arose out of a local resource. The physician who called for CEMICAMP's assistance, was already providing services to menopausal women on a small scale. It was therefore logical that when he became the coordinator of the newly created referral center, he would be keen on continuing and expanding this service.

   Finally, the request for training of adjacent municipalities arose out of the requests from health authorities in these areas to replicate the patterns undertaken in Ituiutaba.

6. Lasting but declining impact: All three municipalities experienced lasting impact in availability, access and quality of reproductive health services. However, all three municipalities also experienced varying degrees of declines in the availability and accessibility of services over time.

7. Introduction of family planning and expansion of contraceptive choice: In all three settings family planning services were successfully introduced as part of the project and a relatively impressive range of options existed subsequent to the project's initiation. Oral contraceptives, injectables, condoms and the IUD were available in the three referral centers. Vasectomy also became available in one setting, and LAM and the diaphragm were provided in Anápolis. In all three settings the overall situations with regard to contraceptive choice and family planning services remains better in all three settings than it was prior to project initiation.

   By far the best capacity to provide these services is maintained in Anápolis, where the referral center was established in a strategic location to provide easy access and where unusually strong support from both political and health authorities existed throughout the Stage III project period. However, even in this setting, two factors led to a decline in contraceptive options over time: lack of supplies and a political-religious conflict with the local Catholic Church. Lack of supplies arose from internal coordination problems while the exclusion of the IUD from services resulted from a serious conflict with the local priest. The continued vulnerability of family planning programs to religious influences in Brazil is amply demonstrated in this example.

Sumaré was the municipality where vasectomy services were introduced in the course of the project. Changes in the legal status of sterilization services facilitated this initiative. During the project period the previously ambivalent legal status of sterilization was clarified, establishing these procedures unequivocally as legal. Availability and accessibility of other contraceptive services in Sumaré saw a quick decline. Initially available both in the referral center and four health posts, provision by health posts of contraceptives services soon declined.

In Ituiutaba supply problems and internal conflict among coordinators of the municipal health service network reduced availability of contraceptive services, although this decline was not as extensive as in Sumaré.

8. The contraceptive supplies surprise: Based on the Stage I assessment and the Santa Bárbara project, supply problems were expected. However, it was also expected that these problems could be solved . And they were indeed solved, but initially only. The surprise was that the changes were not lasting and needed continued attention. Because the CEMICAMP team's limited capacity to provide technical assistance on an ongoing basis, supply problems were not consistently resolved and this had negative effect on project impact.

9. Introduction or expansion of other reproductive health services: In all three municipalities the project succeeded in initiating new services or improving existing reproductive health services in addition to those related to contraception.

10. Lasting significant impact on the availability of educational sessions: This is an area where the project registered major impact. Educational sessions were organized as part of the project and they have continued. The explanation for this success should be seen in the fact that these services are provided by nurses, psychologists and social workers whose professional socialization ensures attention to educational and client-centered approaches.

11. Limited impact on physicians' style of interaction with service users: Although referral center physicians are now providing a broader range of services than in the past, their style of interaction remains largely unchanged. Physicians spend little time with service users, and their attention to the provision of information has not been significantly enhanced. There are individual exceptions to this pattern, but they do not change the overall pattern.

12. Interventions mainly located at referral center: In each municipality one service facility was defined as a referral center - that is a facility for the provision of family planning and related elements of reproductive health care to which the other health posts/centers in the municipality should refer women with needs in these areas, or to which women could come directly. Project interventions were focused mainly on these referral centers.

13. Expanded functions of nurses and other staff: Evidence from the Santa Bárbara project demonstrated that expanding the functions of nursing and auxiliary staff significantly

enhances the service delivery capacity of the municipal health network. The case studies confirm that such expansion of staff function was a valuable innovation in the three municipalities. However, the case studies also show that physicians may oppose such expansion of nursing and auxiliary staff roles in order to protect their own interests.

14. Staff turnover: A relatively high level of staff turnover is a common feature of public sector health services in Brazil. Its detrimental impact on the success of the service innovations initiated was particularly visible in Sumaré. Staff turnover negates the effects of training innovations which, given the limited capacity of the technical support agency, are not easy to repeat.

15. Provider resistance to interventions: The three cases demonstrate that where innovations threaten the business and professional interests of physicians, they may encounter resistance. Physicians working in the public sector typically maintain a private practice as well and use their work in the public sector as a mechanism for the recruitment of private patients. Thus physicians benefit from their work in the public sector and paradoxically also from the fact that these services are often of low quality. A systematic effort to improve these public sector services thus constitutes a potential threat to their income and is therefore watched with concern.

    This was particularly apparent in Ituiutaba, a municipality which had experienced population declines and therefore had an excess of health facilities even in the public sector. Physicians were afraid that the quality of care improvements and the expansion of public sector reproductive health services might deprive them of private patients. Innovations intended to increase physician accountability are resisted most of all. For example, changes in the appointment scheduling which interfere with physicians' desire to rush through an allotted number of patients and then depart for their private practice, may succeed initially but gains tend to be easily lost over time.

16. The power of leadership and political support: Common sense suggests and research from the organizational sciences demonstrates that good leadership is the magic ingredient of program success. It is therefore not surprising that the three case studies show that both the overall accomplishments of the project as well as individual variation can in large measure be explained by the strength of local leadership. Anápolis is the strongest case in point. Strong prior commitment on the part of the CIM coordinator and the Deputy coupled with a supportive mayor and health secretary added up to an unusually strong leadership. All four remained in their posts over the project period thereby ensuring that initiatives could be brought to fruition and sustained.

    Leadership commitment was a precondition for involvement with the municipality. Thus it is not surprising that all three municipalities could count on a considerable amount of political commitment. However, in Sumaré, it became clear that strong commitment does not necessarily translate into good leadership and that electoral change tends to interfere with continuity of commitment and political support. Surviving political change takes time and effort. The Santa Bárbara experience has

shown that when the project is really institutionalized and has survived political change, then it becomes progressively immune to the vicissitudes of politics. But it takes a long time before such degree of institutionalization is reached.

17. Incomplete municipalization: Brazil has undergone an extensive decentralization of authority over the past several years, whereby major decision-making power has transferred to the municipal level. In some municipalities, however, the process of decentralization is not complete, leaving health authorities with more limited power. Such incomplete decentralization in Sumaré limited the health secretary ability to procure contraceptive supplies.

18. Role of the Church constrains contraceptive options: In Anápolis, hostility of the Church to the IUD was so strong that it could not be overcome even in the face of a strong political coalition consisting of the mayor, the health secretary and the Deputy. This is an important reminder that the Church is a major actor when it comes to the provision of contraceptive services in the public sector in Brazil.

19. Community response to service innovations: The community response to service innovations was positive in all three municipalities for obvious reasons. Innovations responded not only to an important public health need but also to a strong demand from local people. Given the severe lack of services in the past, women had relatively low expectations and any improvement was therefore welcome. Thus the favorable response of the community speaks to both the improvements in services as well as to the dismal state of reproductive health services for women prior to the project's initiation.

20. Technical Assistance : The technical assistance team acted as catalyst, researchers, problem solver, trainers, and monitors in all three municipalities. The role of the technical assistance team was vital in the transfer of innovations, and its services were in greater demand than could be met. It is clear that a greater capacity to provide technical assistance would have led to even greater success. It was also apparent that the effort to differentiate among high intensity and low intensity technical support could not be maintained. Although the dictates of research may lead one to establish such differences in design, the real world defies such artificial distinctions.

    Given the extent of the changes introduced, it is not surprising that outside support was so vital. The Santa Bárbara case illustrates that with time, change can become institutionalized. But the time required for this to happen is longer than typical project funding cycles.

    The importance of the demonstration project as a major influence on municipalities was clearly demonstrated in all three cases. Visits to the demonstration project were a key component of the Stage III strategy. Having an observable example, from which other municipal authorities could learn was essential in ensuring that they could move forward.

CONCLUSIONS ABOUT THE STAGE III EXPERIENCE

1. The investment in "scaling-up" brings significant returns: There is no doubt that the service delivery capacity of the three municipalities was significantly improved as a result of the Stage III program of work in Brazil. Formulating a third stage in the strategic process that was focused on systematic dissemination and replication of findings was proven to be an important stage in the implementation of the new approach. Without such systematic attention, the Stage II successes would have remained without larger impact.

2. Technical assistance needs are greater than expected: A great deal of effort went into the task, and it is clear that greater technical assistance would have had even greater returns. Even though a strong motivation to bring about change existed in each municipality, much technical assistance was needed to support the change process. Given the extent of the change that was undertaken, this is not surprising. Moreover, even though from the perspective of the CEMICAMP team the amount of assistance provided appeared formidable, the total amount of resources dedicated to this effort were not all that large. Furthermore, technical assistance should not be limited to reproductive health technical issues and requires that the team has a broad range of skills. The evolution of the project showed that the municipalities requested assistance from the CEMICAMP team on a series of topics that went beyond those identified at the beginning of the project, such as data management, administration of services, procurement, etc.

3. Stage III validated the triangular systems framework: As the evaluation of the Stage III Brazil project reaches its conclusion, it is valuable to also reflect upon the lessons that have been learned by the research team. This experience may be helpful to others who undertake a Stage III project. After six years of contributing to the development of the strategic approach and in implementing it, the research team in Brazil feels doubly persuaded by the value of the "triangular systems framework" which informs this work. One of the basic underlying assumptions of the systems framework is not only that the three critical components - users, services, technology - are important but that these three components need to fit together well if a program is to be successful. The importance of focusing on congruence as opposed to merely stating the relevance of each area was fully appreciated only at the end of the Stage III evaluation. Of course, we have spoken of the interrelationships between services and users, between users and technology, etc. However, what the Brazil team wants to stress is how valuable the process of working with "organization development" approaches has been and how deeply and richly it has affected their capacity to continue work in this field.

   On the other hand, evaluation at different stages of the process showed that the project's conceptual framework was not readily understood by municipal partners: Municipal coordinators took some time to realize how each part of the triangular systems framework fits together, and that attention to each is needed. Only recently, the framework "**started to make sense"**. For example, the supplies problem was earlier seen as an inevitable defect of the system that had little to do with the health program.

In the end they realized that they should look for solutions instead of expecting problems to magically be solved by the government.

4. Skills for data processing and ongoing evaluation require strengthening: Management of data proved to be one of the most important abilities that the municipalities lacked at the project's outset and nor were they able to acquire such skills by the project's completion. Gathering appropriate data is not a part of the purview of municipalities and nor do they use the data that exists, which is usually unreliable, for decisionmaking or planning of activities. Towards the end of the project the municipalities realized the importance of data collection and now are seeking solutions for this weakness. Closely related, the lack of reliable data is an obstacle to ongoing evaluation, which is now widely recognized as very important to maintaining or improving the quality of a program. In addition, the municipalities realized that the lack of reliable data also negatively impacts their capacity to secure funds from the municipality for health programming.

5. Replication versus policy diffusion: The Brazil Stage III strategy involved two components: replication of the Santa Bárbara innovations in three other municipalities and policy dialogues and workshops to ensure broader diffusion of the findings to relevant stakeholders in the policy and program arena. Most of the Stage III project emphasis was on replication because of the limited capacity of the Ministry of Health (MOH) and of state level health institutions to impact the service delivery process at the municipal level. The pay-off for the dialogues with the MOH, as well as the pay-off for continuing to provide support to the original demonstration site in Santa Bárbara are currently being demonstrated in the Campinas region of Sao Paulo State. The MOH is currently in a position to support family planning/reproductive health training in municipalities in the Campinas region. The MOH invited the Santa Bárbara project to a planning meeting declaring it a "model" for broader replication. This shows that both components of the Stage III strategy were essential. Santa Bárbara staff invited their CEMICAMP colleagues to the planning meeting, providing them an opportunity to witness a strong sense of ownership displayed by the Santa Bárbara staff of "their" project and "their" accomplishments.

6. The importance of longer time horizons: If CEMICAMP researchers had worked within the narrow budget time-frames provided by WHO, the longer-range benefits of both Stage II and Stage III would not have been apparent. The Santa Bárbara innovations became fully institutionalized long after the formal completion of the Stage II project. Without CEMICAMP's support to Santa Bárbara over quite a lengthy period of time, this might not have happened.

7. The dissemination of evaluation results will be very important: The evaluation results can be used to show health authorities how, with minor increases in resource allocations and an emphasis on training, collaboration, community participation, and a rationalization of resources, significant improvements on the quality of, and access to services can be obtained. The municipalities recognized that the results of this evaluation could prove very useful for acquiring additional resources for health programs.

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Facilitating Large Scale Transitions to Quality of Care in Family Planning Programs: An Idea Whose Time Has Come

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Abstract

In the reproductive health field, investigation of the transfer of knowledge gained from demonstration and pilot projects to large public sector programs has not typically been considered a relevant domain for research or other investigation. This paper argues that it is time for change. Drawing on a variety of social sciences literatures, two frameworks for understanding critical attributes for successful expansion of small-scale innovations are presented. Seven key lessons are developed using examples from the family planning field where "scaling up" was an explicit objective including the early Taicung Study of Taiwan, the Chinese Experiment in Quality of Care, the Bangladesh MCH-FP Extension Project, the Navrongo Project in Ghana and the Reprolatina Project in Brazil. The paper argues that unless small innovative projects concern themselves from the outset with the question of how innovations can be put to use on a larger scale they risk remaining irrelevant for policy and program development.

I. Introduction

At the beginning of the 21st century, the international family planning field looks back on both major accomplishments and shortfalls. Programs have shown a measure of success in regions of the world where earlier little hope had been held, especially among those persuaded by structural and demand-side interpretations of demographic change. On the other hand, family planning programs have drawn increasing criticism for their lack of attention to quality of care and to reproductive health needs more generally. The new framework articulated at the International Conference on Population and Development in 1994 in Cairo (ICPD) mandates that family planning programs adopt a reproductive health approach, address social and gender inequalities, and ensure adherence to appropriate levels of quality of care. The challenge for the 21st century will be to demonstrate how this shift can be accomplished on a large scale, especially in resource-constrained public sector settings.

A key toward accomplishing the ambitious ICPD agenda lies in understanding the transfer of reproductive health innovations from small-scale projects to large-scale programs. Impressive pilot, demonstration and experimental projects from different parts of the world have shown that quality of care can be attained and a range of reproductive health needs addressed even in settings characterized by extreme poverty (Phillips et al. 1988). Many such projects have been cited in the recent effort to document progress five years after the Cairo Conference (Population Reference Bureau 1999; Haberland et al. forthcoming), although the results of many others are confined to the "gray literature" of project documentation and thus largely unnoticed. Such small-scale projects are significant. However, they generally fail to address the question of how the innovations they have

tested can be expanded or "scaled-up" so that they benefit programs on a regional or national scale.

In the family planning field the use of research findings and related experience from small-scale interventions for broader policy and program development has received little attention. In fact, it is not commonly acknowledged as a "problem" requiring scientific research. This article begins to address this gap by drawing attention to important insights about scaling-up that can be derived from a variety of literatures and field experiences.

Although the family planning literature has not paid systematic attention to issues of scaling up, there are exceptions. In several major examples a concern for "scaling-up" was part of the experimental or pilot project from the very beginning. One of the first major family planning experiments in the world, the Taicung study, was deliberately designed to inform national policy and program development in Taiwan. Freedman and Takeshita (1969) and Cernada (1982) specifically analyzed how research results in Taiwan were integrated into actual program experience. Second, the Extension Project, organized by the International Centre for Diarrhoeal Disease Research in Bangladesh, was a planned endeavor designed to transfer lessons from the successful Matlab maternal and child health and family planning project to the national program. The process of transfer was systematically examined (Phillips et al. 1984; Haaga and Maru 1994). Third, the strategic approach to contraceptive introduction, pioneered by the World Health Organization (Simmons et al. 1997), has dedicated a major stage of work to the utilization of research findings for policy and program development. For example as an extension of this program of work, the Reprolatina Project in Brazil is studying the process of how successful innovations tested in four municipalities can be made more generally available throughout the country.

If one looks more broadly beyond the family planning literature to related areas of reproductive health (Gonzales et al. 2001), and beyond that to the international literature on hunger eradication, income generation, child survival and nutrition, one notes that in the 1990s attention to scaling up increased considerably (Edwards and Hulme 1992; Uvin 1995; Uvin and Miller 1996; Uvin 1999; Clark 1990, Marchione 1999; Lovell and Abed 1993; Wils 1995; Sternin et al. 1999). Much of this emerging literature arises out of a broader interest in the role of non-governmental organizations in the development field. This body of work has provided a range of important lessons about scaling-up and has also attempted to present typologies of how NGOs have dealt with growth in their programs and projects.

Given the rising interest in the topic, it is important to stimulate a process of systematizing this area of inquiry so as to derive more general understandings and principles that can guide scaling-up initiatives. This paper seeks to make a beginning by drawing on several social science disciplines in an effort to develop broader frameworks for conceptualizing the transfer of innovations from pilot projects to larger, public sector programs. Several social science literatures can inform discussions on scaling-up. Most prominently among these are: 1) a body of scholarly work which explicitly studied the diffusion of innovation and the transfer of knowledge (Glaser 1983; Rogers 1995; Havelock 1971); 2) the political science literature related to policy formation, agenda setting and the diffusion of innovations within political systems (Kingdon 1984; Mintrom 1997; Walker 1969); and 3) literature from the management and organization sciences (Paul 1982; Rondinelli 1983; French and Bell 1995; Perrow 1978; Lawrence and Lorsch 1969; Donaldson 2001).

Because the literature on the transfer of knowledge/diffusion of innovation tends to be unknown in the international health and development field, we highlight some of its central ideas in Section II of this article. We show that this literature is relevant for the family planning/reproductive health field, alerting us both to attributes which encourage successful transfer and to the difficulties likely to confront broader replication of quality-of-care innovations. Pertinent insights from the political and organization sciences as they apply to the international scaling-up experience are discussed in Section III in the context of seven key lessons. Scaling-up, which in the NGO literature is defined as "increasing impact" (Edwards and Hulme 1992, p. 14), is defined here as the deliberate transfer of quality of care innovations tested in pilot or experimental projects to large-scale public sector health/family planning bureaucracies.

II. Relevant Insights from the Literature on the Diffusion of Innovation

In the decades following the Second World War interest in the application of knowledge and especially in the diffusion of technology was strong. Technological innovations were multiplying, social science and applied research were thriving and issues of social change - both in industrialized and non-industrialized societies - attracted a great deal of attention. The diffusion of innovations, planned change and the dissemination and utilization of research were the subject of many publications. For example, the bibliography of a major review of the literature on the diffusion of knowledge and the implementation of planned change by Glaser et al. (1983) consists of 167 papers; Rogers' bibliography in his volume on the diffusion of innovations (1995) comprises 66 pages. Between 1964 and 1986 the Center for Research on the Use of Scientific Knowledge at the

University of Michigan was dedicated to these issues. Similarly, in the family planning field interest in this subject was illustrated by the organization of a conference on the utilization of family planning research (Echols 1974 as cited by Cernada 1982), and other professional meetings and activities. Although still pursued in the social sciences, these issues have become less prominent than they were in the 1960s, 1970s and early 1980s.

The key question addressed in this body of work is how to ensure that new products, ideas or exemplary practices will be put to use on a broad scale. The literature on the transfer of knowledge and innovations has identified a variety of factors that affect the successful transfer of knowledge. Distinctions are made among factors pertaining to:

1) the innovation itself, that is the innovative product, process or practice;
2) the change agency, resource or sending system from which the innovation originates;
3) the potential users or the user system - sometimes also referred to as the receiving system;
4) the means of transmitting knowledge, also referred to as the dissemination-utilization strategy or the linkage process; and
5) the larger social system within which the transfer of innovation occurs.

In seeking to identify the determinants of the effective use of knowledge, several authors have established lists of variables or attributes which can be used in assessing the potential of innovations to be implemented in particular settings. These factors are derived from a variety of sources: case studies, clinical experience and research projects which have used behavioral models of change and learning theory.

Figure 1 provides an overview of elements of the innovation/knowledge transfer framework, along with key attributes that were found to assure success in such knowledge transfer. The large oval represents the social, cultural, political and economic environment

or context within which the resource system and the user system are located (for a discussion of the importance of this larger socio-political context see Chunharas 2001). The small rectangle to the left within the oval depicts the innovation as well as the resource system (or change agency) which has tested the innovation. The small rectangle to the right side of the oval designates the user system, that is the organization or program context within which the innovation is to be replicated and expanded. Connecting these two rectangles is an arrow, representing the linkage process defined as the strategies for the communication, diffusion or dissemination of the innovation. The arrow is pointing in both directions to highlight the importance of a two-way communication process to ensure that the transfer of knowledge succeeds.

Connected to the innovation, to the user system and to the linkage process are three boxes outside of the oval. These identify major attributes of each component which, according to the literature, contribute towards successful translation of new ideas, products and exemplary processes into larger scale practice. Below we indicate what the literature has identified as some the major attributes of success[1]. Simultaneously we reflect briefly on the practical implementation realities likely to be encountered as one proceeds to expand successful small-scale innovations in family planning and related aspects of reproductive health in developing countries.

Attributes of the innovation: Innovation is defined as "an idea, practice, or object that is perceived as new by an individual or other unit of adoption" (Rogers 1995, p.11). As Rogers points out, it matters little whether the idea, practice or objective is new, or whether it is only perceived to be so. If it is perceived to be new, it is considered an innovation.

Glaser identified seven key characteristics of the innovation itself which were found to facilitate its wider application (Glaser and Taylor 1973 as cited in Glaser et al. 1983; see Figure 1). Innovations must be:

(1) based on sound evidence or espoused by respected persons or respected institutions in order to be credible;
(2) observable to ensure that potential users can see the results in actual practice;
(3) relevant to address persistent or sharply felt problems;
(4) of relative advantage over existing practices so that potential users are convinced that the costs of implementation are offset by benefits;
(5) easy to install and understand rather than complex and complicated;
(6) compatible with the potential users' established values, norms and facilities
(7) be testable or triable without committing the potential user to complete adoption without seeing results[2].

It is logical that these seven characteristics facilitate the transfer of innovations, but it is unlikely that in practice they will all be present. In the case of innovations derived from research, it is probable that the evidence will be sound and that the innovations will be supported by respected persons or institutions. After all, sound evidence is what research seeks to obtain. Typically the proposed innovations are also observable in pilot, demonstration or experimental projects and they can be tested by the user system before large-scale adoption. However, other attributes on the above list may not be present. Policy makers or other decision makers may not always see the advantage of the innovation, may consider it too complex or costly, or the innovation may conflict with established norms, practices or resources in the potential user system. For example, when innovations are tested in non-governmental settings rather than in the public sector, policy makers may argue that they are irrelevant.

Policy makers usually have a preference for technological solutions, expecting that "magic bullets" will provide effective solutions to pervasive problems. New approaches to preventive health or emphasis on what has been referred to as the "software" dimensions of quality of care receive less attention because they are less visible or demonstrable. For example to program managers and policy makers, expanding contraceptive choice typically means bringing in new contraceptive devices and distributing them rapidly throughout a service delivery system. It does not suggest improving counseling, information giving or technical standards of care. Technological solutions are also easier to install and understand than the more systemic innovations needed to create the managerial foundation within which services of higher quality can be delivered. Policy makers want simplicity, whereas researchers may conclude that relatively complex change is needed.

Moreover, improving the quality of services usually requires that patients are treated with dignity and respect, that their concerns are listened to and that they are given the information and support they need. The public sector bureaucracies charged with implementing reproductive health care are rarely characterized by such client-orientation. Providers and field-staff are more likely to be authoritarian and non-supportive of client needs.

Furthermore, public sector management systems tend to be punitive rather than problem solving in their approach to supervision and generally do not sufficiently support their frontline staff. Small scale demonstration or experimental projects often create an organizational environment in which energies are largely directed towards achieving formally established human service goals. Large-scale, complex bureaucracies usually do

not succeed in doing this (Misra et al. 1982; Phillips et al. 1985). Other concerns tend to predominate: an interest in additional sources of income, career advancement, political concerns, power struggles, etc (Perrow 1978).

Attributes of the potential user system: The literature found that successful transfer of innovations is facilitated when:

(1) the user system perceives a need for the innovation, considers it beneficial, and congruent with its central ideas and concepts;
(2) the user system has the appropriate implementation capacity, values and openness;
(3) the timing and circumstances are right;
(4) there is leadership and internal advocacy; and
(5) the resource and user system are similar in characteristics (homophily) and in close physical proximity[3].

For an innovation to be adopted, the user system must be sufficiently dissatisfied with the status quo, must generally be open to the idea that change is desirable and possible, and must be willing to accept outside help. The innovation must be perceived as relevant to the pressing problems faced by the potential user system and there must be absence of major resistance to its central concepts and ideas.

These requirements often stand in contrast to the actual circumstances found within the potential user organizations that will have to scale-up pilot programs. The quality of care and reproductive health innovations tested in small-scale interventions address problems that are sharply felt by the global reproductive health profession, by individual researchers and even by individuals within the user system. But these problems are not necessarily given priority or considered pressing problems by key decision makers within the user system. Their agendas are often oriented in different directions.

It seems obvious that the user system needs to have the appropriate openness, values and capacity to implement an innovation. In practice, the organizations or programs expected to scale-up quality of care and reproductive health innovations are extremely limited in their capacity to implement such change. Physical and human resources are often limited. Equally important, the organizational culture of these institutions often does not support the human service orientation and philosophy inherent in the quality of care and reproductive health approaches suggested (Simmons 1980).

The work of Havelock and Lingwood (1973) and Rogers (1995) has emphasized the importance of 'homophily' - the similarity in the characteristics of the resource organization and the user system - as critical attributes determining the successful transfer of innovations. Here again one must observe that researchers and policy makers are by definition dissimilar in their orientations. Policy makers and program managers need quick and timely solutions; researchers require sufficient time to undertake a systematic process of study design, data collection, analysis and synthesis. Scientific rigor requires a process of rational steps and methodical documentation of findings and analysis. Political rationality proceeds according to a different logic and a much faster pace.

This review has shown that the innovations tested on a small-scale do not necessarily have the attributes which, according to the literature, predict easy and successful transfer of knowledge into large-scale practice. The innovations themselves often do not fit readily into the organizations into which they should be transplanted and the people on both sides of the divide may be quite dissimilar from one another. These contradictions suggest that if the transfer of knowledge and innovations is to succeed, careful and sustained attention must be devoted to the linkage strategy.

Attributes of the linkage strategy: Key attributes of the linkage strategy which have been found to predict successful transfer are:

(1) Clear messages in which the advantages of the innovation are made visible;
(2) Personal contact and informal communication;
(3) Early involvement of members of the user system;
(4) Adaptation of the innovation to the local context;
(5) Technical assistance and a supportive approach;
(6) Sufficient time to implement new approaches; and
(7) Strong diffusion channels.

For innovations to be adopted more widely, they must be presented simply and clearly and their advantages must be made apparent. Although seemingly obvious, this often is a problem in the transfer of research results into larger practice settings. The literature emphasizes what is already known all too well: The language of research is often unintelligible to policy makers and program managers (Orosz, 1994). Researchers have a trained incapacity to communicate in practical, clear, succinct language.

Even though written materials obviously are relevant, research on the transfer of innovations has consistently demonstrated the power of interpersonal contact, both formal and informal. For example Rogers has argued that "People learn about new ideas, products and processes not necessarily through a rational and directive information seeking process, but often through serendipity and personal contact" (Rogers 1995, p. 18). Mass media create personal awareness of the innovation but interpersonal channels of communication are more effective in persuading individuals to accept new ideas or practices (Rogers 1995; Gladwell 2000). And Glaser notes that "Conferences in which research findings and exemplary practices are presented and discussed in depth with practitioners are more influential than publications or other one-way processes" (Glaser 1983, p. 305). The dominant mode of research dissemination in the health and family planning field remains

focused on written materials and publications of various sorts despite extensive evidence that publications or guidelines by themselves are insufficient.

The literature stresses the involvement and participation of members of the user system as an important ingredient of success in the transfer of innovations. Researchers should involve managers in the development of the research design and the focus of research, and carry out the research through collaborative teams (Glaser 1983; Davis and Howden-Chapman 1996). Transfer of innovations should be viewed as a two directional rather than a one-directional process. This is important because communication with an active involvement of potential users assures that potential obstacles became shared concerns (Glaser 1983). It also assures that there can and will be appropriate adaptation of the innovation to suit the needs and capabilities of the user system.

In the early years of the transfer of innovation research the assumption prevailed that innovations would be either adopted or rejected; in practice it turned out that they were often modified or "reinvented" (Rogers 1995, p. 174-80). Such adaptation may be helpful in simplifying the innovation or flexibly suiting it to the adopters' needs. Reinvention may also assure that innovations are viewed as local products. However, it is also essential that in the course of such adaptation the integral components of the innovation are not lost.

Technical assistance, a supportive approach on the part of the resource system and sufficient time to implement innovations were additional characteristics of effective transfer strategies (Glaser 1983). The literature is clear that success usually requires strong diffusion channels, a fair amount of time, and an overall strong linkage process. Unfortunately, in reproductive health as well as other fields, dissemination and utilization of research results

has been all too often an afterthought, not considered the responsibility of the researcher, and not something to which precious time need be devoted.

In sum, a variety of factors maintain and reinforce current practices and prevent innovations from taking root in larger program settings. Researchers and others wishing to promote the utilization of research must incorporate concern for the transfer of their innovations from the very outset. A sustained effort is often needed to ensure that research innovations are transferred to practice settings. Not all the factors facilitating successful transfer will ever be present in a given situation. Attributes of success identified in the literature allow us to appraise the likelihood that a given innovation might be transferred with ease or with difficulty. Certainly, the fewer the determinants of success present, the stronger the linkage process must be.

This summary of attributes of successful program diffusion suggested by the social science literature leads to an important baseline conclusion: The transfer of innovations in quality of care and other aspects of reproductive health should not be considered a simple or mechanical process. These innovations cannot flourish in the organizational environment that characterizes most public sector programs; they require change in organizational culture and orientation. Scaling-up quality of care innovations in reproductive health therefore must be considered an **institutional change task** of major proportions.

III. Seven Key Lessons for Scaling Up

After this relatively pessimistic appraisal of how easily quality of care innovations from pilots can be transferred, we now turn to actual scaling up examples from the family planning and related reproductive health literature and experience to see what lessons they can impart. In doing so, we simultaneously draw on insights from the political and organizational sciences because, as Satia and colleagues (1985) argued, the constraints to rapid scaling up will not be predominantly resource constraints but institutional and organizational factors[4]. Literatures from the political and organizational sciences assist in understanding scaling up as an institutional and political process in which strategic interventions can produce success.

A complete review of what can be learned from either the family planning or the political and organization sciences would be too formidable a task to undertake within the confines of one paper[5]. Instead we present examples that illustrate central issues and provide seven key lessons for scaling up (Table 1). Much of what is discussed reinforces and expands on lessons from the literature on research utilization and the diffusion of innovation. At the same time it reassures us by demonstrating that systematic attention to the process of scaling up can yield positive results even in difficult environments.

Using the insights from the family planning experience and the policy and organization sciences we elaborate a second framework (Figure 2). The innovations with which we are concerned relate to providing access to quality reproductive health services for men, women and adolescents, to user orientations, gender and reproductive rights perspectives and empowerment. Figure 2 builds on Figure 1, offering a conceptual framework that

identifies key elements in the resource system and the user system that facilitate scaling up of innovations involving improvements in quality of care. It also identifies a process of participatory organization development that enables potential change agents in both the user and the resource system to work together to scale up innovations. The innovation, the resource system and the user system are again placed inside an oval which represents the social, cultural, political and economic environment within which scaling up takes place.

Lesson One: Do not rely on spontaneous transfer - make scaling up a concern from the time pilots are initiated

Skeptics might argue that sustained attention to the utilization of research is unnecessary. There is ample evidence, they could assert, that research-based innovations, as well as others, spread spontaneously from individual to individual and from innovative program settings to others. Indeed, the diffusion of innovation research undertaken in various fields, including demography and political science, demonstrates that innovations can spread on their own. Walker's research (1969) on American politics has shown, for example, that policy innovations have often been initiated by key or leading states and subsequently imitated by others without guidance from anyone. In the population field, study of the fertility transition has shown that fertility control spread in Europe without any deliberate policy or program initiative (Coale and Cotts-Watkins 1986). Innovations in community-based family planning and primary health care initiated by the Navrongo Health Research Centre (NHRC) in Ghana have been spontaneously replicated by other regions of the country by health officials who visited the project [6]. A quality of care pilot project undertaken by the State Family Planning Commission of China in one county in each of six provinces has generated much interest among other counties in these provinces

to replicate these innovations, without deliberate efforts by the leaders of the project to generate such interest. Other provinces and regions of the country have shown considerable interest in becoming part of the pilot project (Zhang Erli 1998; Gu Baochang 1998).

The spontaneous transfer of research innovations from experimental settings to larger program units is indeed an important process. As the literature indicates, it is likely to occur when the innovations address a clearly felt need within the program, or where there is a focusing event that draws attention to this need (Shiffman, 2000). In China, for example, a heavy-handed and tightly administered population control program increasingly encounters complaints from local people showing that the program is becoming incompatible with the climate of individual initiative and entrepreneurship encouraged by economic reforms. The program is also likely to become redundant in regions where fertility preferences are already low and couples have access to other sources of contraception than those provided by the government. Changing the program to be more service-oriented and incorporating a range of reproductive health services also addresses the needs of managers who would like to see their program be more in line with the international consensus established at ICPD and the 1995 Beijing Women's Conference (Simmons et al. 2000).

However, even in areas where a strongly felt need for change - or other factors - generate such spontaneous transfer, it is important to ensure that the essence of the innovation remains intact as expansion takes place. In Ghana, conversations with regional directors of health in the country have revealed that in areas where the diffusion of the Navrongo model has progressed in an unguided spontaneous way, only one major element of the approach is being replicated: posting a community health nurse at the village level.

Such spontaneous replication misses the point that the success of the model has depended in large measure on the mobilization of community leaders and elders and on a participatory approach which involved these leaders in program implementation (Nazzar et al. 1995). Incomplete or superficial transfer of reproductive health innovations will not produce the desired results[7].

But there is an even more important reason why we must pay systematic attention to scaling up: Without such attention, small-scale research innovations remain mostly irrelevant for policy and program development. Spontaneous and complete diffusion of such innovations is extremely rare, precisely because the quality of care innovations often are not congruent with the institutional practices of public sector programs. A process of learning is needed about what works and what does not, and about what needs to be adapted or changed as innovations are implemented on a larger scale. To ensure that such learning occurs and is widely shared among relevant stakeholders, scaling up must be intentional, directed, and supported.

In fact experience from the family planning field suggests that a concern for scaling up should guide the very design of pilot projects (Cernada 1982; Simmons et al. 1997, Pyle 1980). As described earlier, the literature on the diffusion of innovation argues that it is essential to involve those who will later implement results on a broader scale in the early stages of the project planning process. Another way of planning for scaling up from the outset is to test innovations under realistic institutional conditions and within the resource constraints of public sector programs.

Lesson Two: Acknowledge the political nature of the task and value incremental change

Most observers know that public sector bureaucracies, especially those in resource poor societies, are complex political organizations, frequently more occupied with power struggles and other political concerns than with the provision of good reproductive health services. By implication, one should recognize that any attempt to scale-up service-oriented innovations is likely to encounter political and other structural barriers resisting the suggested change. However, these understandings are usually discussed informally, in private conversation. They are rarely part of the official, professional or even academic discourse. Consequently, scaling up, if considered at all, is treated as a technical task that is approached from the perspective of training needs, personnel or physical resource requirements.

Exceptions are Cernada's review of Taiwan's early experience with the utilization of research (1982), Haaga and Maru's review of the effects of operations research on program changes in Bangladesh (1996) and Pyle's analysis of why an integrated health and nutrition project was not scaled-up (1980). Haaga and Maru concluded:

> Policy advice that is consonant with existing power relations (between layers of the hierarchy, or among functional units) is the easiest to implement. Policy advice that disrupts long-standing relationships is especially liable to remain mere declaration. (p. 85)

It is indeed important to acknowledge that the transfer of research innovations into larger program settings implies working in intensely political environments. Proposed innovations, particularly those likely to bring about major shifts in the way services are

provided and managed, often threaten to interfere with existing power relations. As a consequence large-scale expansion may succeed only partially.

This point is well documented in an example from the Extension Project's effort in Bangladesh in the late 1980s to assist with nationwide recruitment of community-based female family planning workers. When comparison of worker-to-population ratios between the Matlab project and the government family planning program revealed that the more favorable ratios in Matlab explained a fair amount of its success, the government embarked upon large-scale recruitment of additional female workers. The Extension Project, whose major goals was to transfer lessons from Matlab to the government program, provided technical assistance in this effort, using recruitment criteria which had been pre-tested in Extension Project sub-districts. Results demonstrated that it was possible to insist that such rational recruitment criteria as residence in the work area and educational qualifications were largely enforced (Haaga and Maru 1996; Simmons 1987). By contrast, monetary kickbacks to officials involved in recruitment could not be stopped. Such payments are as deeply rooted as they are deleterious for implementing results-oriented programs.

Understanding the political dimensions in the large-scale transfer of innovation allows one to set realistic expectations about the extent to which large bureaucratic systems can be expected to change. The Extension Project demonstrated that much can be accomplished in spite of the pervasive presence of dysfunctional power relations. The cumulative benefits of such incremental change must not be underestimated, although as we noted above, if replication is too incomplete, it may not lead to the desired quality of care improvements in reproductive health services.

Lesson Three: Benefit from policy windows and policy entrepreneurs

Insights from the political science literature on the policy process provide a more optimistic interpretation of the above point. The argument there is that leadership and internal advocacy for the proposed change are indeed essential, but that does not mean that all key decision makers have to be in favor. It is often sufficient for key individuals, referred to as "policy entrepreneurs", to be supportive of the change in order to move it forward (Kingdon 1984; Mintrom 1997).

The political science concepts of 'policy entrepreneurs' and 'policy windows' are helpful in realizing that the potential for success in the transfer of innovations must be viewed as dynamic rather than static. When policy windows are open, they provide an opportunity for researchers and others to draw attention to the value of the innovations tested in smaller research projects, and to the need for their broader application in larger settings. When they close, the potential for impact declines. The ICPD is an example of how a global conference created a policy window that makes research-based quality of care innovations in family planning relevant for policy and program development.

Election of officials committed to improving public health services also provides an important policy opportunity. One should recognize, however, that such a policy window is likely to remain open only as long as the supportive cohort of politicians stays in power. When they are replaced, new leaders typically start new initiatives rather than continue those of their predecessors. The process of transferring quality of care innovations in reproductive health can therefore come to an abrupt halt or require intensive effort to be integrated into the program of action of the newly elected political team. To be sustainable,

the transfer of quality of care innovations in public sector bureaucracies must have gathered sufficient institutional strength to survive when policy windows close. They also must receive strong and continuing support from the resource system, which can play a catalytic role in ensuring program survival in the face of electoral or other political change (Díaz et al. forthcoming; Díaz and Simmons 1999).

Policy entrepreneurs are advocates who are willing to "invest their resources in return for policies they favor" (Kingdon 1984, p. 215). These advocates have a claim to be heard because they are experts or leaders of interest groups or because they occupy a position of authority in the government hierarchy. They are politically well-connected and persistent. They are found in different formal or informal positions, in or outside of the government and can be influential in moving an issue into a position of prominence on the policy agenda. "Policy entrepreneurs are able to spot problems, they are prepared to take risks to promote innovative approaches to problem solving, and they have the ability to organize others to help turn policy ideas into government policies" (Mintrom 1997, p. 40).

Any scaling up initiative will benefit immensely from the support of policy or program entrepreneurs. An example is the Deputy Minister of Health of Ghana. He has taken great interest in the results of the community-based family planning and health service model developed and tested by the Navrongo Health Research Center. He sees this model as providing a mechanism for bringing primary health care to local communities - an ideal that he has held since the 1970s and especially since the Alma Ata declaration. Being senior and close to retirement, the Deputy Minister is not only a person with expertise, a formal position of authority and many connections, but someone who does not have to be concerned about his political or professional career. As a result he can devote his full

attention to the pursuit of policy priorities. He considers provision of primary health care an urgent necessity, and views the Navrongo model as a solution to this problem. With such a policy entrepreneur in place, the dissemination and scaling up process has been rapidly initiated in Ghana. However, it must be emphasized that scaling up will benefit from the creation of coalitions so that the initiative does not depend on a single individual (Pyle, 1980).

Lesson Four: Insist on phased implementation while simultaneously addressing broader dissemination of central ideas

Policy entrepreneurs willing to champion the cause of program innovations are major assets. However, the discrepant time perspectives of policy makers and researchers still remains a problem. Policy entrepreneurs will have the short-term time horizons of the politician and little patience for a slower, incremental process of research and expansion [8]. Successful development projects, by contrast, use a process of phased implementation that allows learning through gradual expansion and concurrent adaptation (Paul 1982; Rondinelli 1983).

Gradual expansion of research-based innovations is extremely important because in many instances the determinants of success in experimental projects are incompletely tested or understood. For example, the Matlab project tested a community-based family planning service model showing that such a strategy can have significant impact on desired outcomes. In implementing the model, however, the project deliberately isolated itself from local political pressures that might have negatively affected its ability to design an effective management and monitoring system (Phillips et al. 1988). As a result, only partial conclusions about broader use of Matlab results for national program development could be

derived. The project demonstrated that community-based and user-oriented services will succeed with local people, but not how such a strategy could be implemented in a complex, bureaucratic, and resource poor national program. Answers to those questions could only be obtained from the Extension Project which was later organized within the constraints of the public sector program.

In Ghana, the current interest to scale-up the Navrongo model presents a similar predicament. Navrongo has demonstrated that a community-based and participatory model of service delivery could make major inroads in a traditional and economically deprived setting. However, even though the project is functioning within the public sector, essential management systems such as supervision and the information systems were strongly supported by the research team of the Navrongo Health Research Center. The push for nationwide expansion, under the leadership of the Deputy Minister, came before these complex managerial dimensions of the innovation were functioning without the support of the research team. Therefore, it was not possible to give evidence-based advice to the scaling-up effort on how the public sector health system could be reoriented so as to provide supportive supervision, or what management information system would work within the context of the national program. A process of phased expansion of research innovations provides time to adapt and learn how these complex managerial problems can be handled in national bureaucracies. Phased implementation also allows for the possibility of "re-inventing" (Rogers, 1995) or adapting innovations to variable conditions.

The Ghanaian example also shows, however, how the contradiction between the pressure for quick expansion and the need for gradual scaling-up and adaptation might be reconciled. The current plan for expansion combines attention to national dissemination of

the key lessons from the Navrongo experiment through consensus-building involving national and regional health leaders and a process of guided expansion of the model to a limited number of districts. Seeking to work within a win-win framework, this approach allows for the possibility that national and regional policy makers and program managers move ahead with necessary consensus-building and preparation for large-scale implementation. The model also makes it possible for individual regional health directors to proceed with replication on their own. At the same time the Navrongo Health Research Centre is undertaking a process of phased implementation in a limited number of districts. The expectation is that work in these limited settings will make it possible to complete a learning process that can subsequently be fed into further expansion of the model.

Lesson Five: Scale up where there are points of strength

The transfer of small-scale innovations to larger systems is enhanced by capitalizing on points of strengths. Large, complex national programs - no matter how resource poor or otherwise constrained - are always characterized by considerable internal variation in their capacity to organize effective services. Although the overall commitment to improve quality of services or expand access and availability may be limited, individuals within these systems may nonetheless be extremely motivated to move forward. For example, it has been argued that:

In all settings, no matter how complex, some scope exists for change. …Over the years we have observed again and again that some units within severely resource-constrained programs flourished, while others lagged behind. In each case, the commitment, orientation, and work style of the individual managers made the difference,

demonstrating that much can be accomplished, even in settings functioning within severe social, financial, and bureaucratic constraints. One of the reasons these managers were effective is that they exerted normative influence, eliciting a moral and emotional involvement with the quality of care objectives of the program (Simmons and Simmons, 1992, p. 24).

Internal differentiation exists not only with regard to staff motivation and morale but also with regard to other organizational characteristics. These include results orientation, flexibility, staff competence, and problem-solving focused supervision which have been discussed as important determinants of scaling up (Satia et al. 1985; Cernada 1982; Pyle 1980).

Building on points of strength is likely to lead to successful transfers. These in turn make it possible to solidify the model, to gain experience, build support and create demonstrable results that can motivate interest in expansion to other regions. Such an approach is currently adopted in the Chinese experiment, which initiated the transition to quality of care in pilots located in the economically advanced regions of the country. It also informs the Reprolatina Project in Brazil which seeks to expand successful innovations by working only with municipalities which have given clear evidence of motivation and initiative.

Concern to provide improved services for a country's poorest regions could lead scaling-up efforts to concentrate major resources there. If strong commitment to the proposed innovation exists in these regions, and "quality of care champions" can be identified, this would be an effective approach. If such commitment does not exist, it may

be more appropriate to work initially in areas of greater strength. Once there are multiple examples of how transfer of quality of care innovations is successfully replicated in several areas/regions within a program, these can then serve as "benchmarks" allowing policy makers and program managers to observe how such change was accomplished, thereby building a momentum for further expansion[9]. Such a strategy was pursued in China. Leaders of the quality of care project felt that prior to expansion to poorer provinces, national policy commitment to quality of care needed strengthening. Doing so involved demonstrating success, which could be most easily accomplished in the more developed part of the country. Once national policy commitment was ensured, new quality of care pilots are now being initiated in poorer, western provinces (Zhang Kaining, 2001). This example also serves to emphasize the point that scaling up refers not only to the expansion of service innovations but to the building of policy support for quality of care in reproductive health services [10].

Lesson Six: Use participatory organization development and ensure long-term support from resource systems

Mainstreaming quality of care innovations in public sector bureaucracies requires instituting management practices that support these innovations. "Organization development" (OD) is an applied behavioral science discipline which can be used for this purpose. OD has been defined as "a long-term effort, led and supported by top management, to improve an organization's visioning, empowerment, learning and problem-solving processes, through an ongoing, collaborative management of organization culture, …utilizing the consultant-facilitator role and the theory and practice of planned change" (French and Bell 1995). It is a process of working collaboratively with people in

organizations, helping them diagnose existing problems, design interventions and evaluate their effectiveness [11]. Experience in Bangladesh (Phillips et al. 1984) and Brazil has shown that use of OD can be instrumental in promoting the transfer of innovations and the transition to quality of care in reproductive health services more generally.

Organization development practitioners start with the assumption that substantial improvements in management processes, culture, strategies and structure cannot be accomplished in a short period of time. Such change requires a commitment to a **process** of organizational improvement. Transferring quality of care innovations to public sector bureaucracies can only succeed if there is such a commitment to required institutional needs and to the time investment required (Phillips et al. 1991). A "program" rather than a "project" perspective is needed as well as donor support for such a longer-term time perspective [12] . However, we do not wish to imply that these institutional changes require the infusion of massive external resources. To the contrary, the pilot programs discussed here have undertaken quality of care innovations with minimal additional resources. Moreover, the additional resources needed were mostly generated from within the bureaucratic system into which innovations were introduced (Díaz et al. 1999; Zhang et al. 1999). Cost analysis of the widely discussed Matlab project showed that the relatively high quality services provided by this project were not more expensive than those provided in the much weaker public sector (Simmons et al. 1991).

Emphasis in the organization development approach on a cycle of diagnosis, intervention and evaluation highlights the importance of information feedback to decision makers. Clear, parsimonious and expeditious feedback about the operations of existing

programs or health needs, ideally presented in concise indicators, are an essential ingredient in the successful transfer of innovations (Kingdon, 1984; Cernada 1982).

A key characteristic of organization development is that OD consultants (in our framework - members of the resource system) establish an egalitarian relationship with members of the organization with which they work. Their role is to help organization members identify new opportunities and solve their own problems (French and Bell 1995). As noted in Figure 2, members of the resource system must be experienced trainers who can impart the values which produced the successful innovations to others and be familiar with the principles of organization development and service delivery research.

Moving to greater quality of care in reproductive health services constitutes a major new opportunity for public sector health bureaucracies. To emphasize the egalitarian nature of the relationships and the need for local ownership by health authorities we prefer to use the term "participatory organization development"[13]. To ensure effectiveness and the local relevance of innovations, a participatory process also includes involvement of community members (Díaz et al. 1999).

In Brazil, the Reprolatina Project is currently scaling up quality of care innovations previously tested in four municipalities to other municipalities. Participatory organization development is undertaken as a collaborative effort between health authorities, providers, community members and members of the resource team. It focuses on: 1) collaborative assessments of local health service needs; 2) training in sexual and reproductive health; 3) restructuring of services to allow greater attention to reproductive health; and 4) improvements in supervision, supplies management and information systems. In addition,

local training/intervention capacity is being developed to ensure that innovations can subsequently be expanded to other municipalities within the region. The effectiveness of "shadow" replication teams, which continue to expand innovations in other areas once the original training/intervention team withdraws, has been documented in the scaling-up of dairy cooperatives in India (Paul, 1982). As innovations expand to more and more municipalities, networking among participating municipal partners serves to reinforce and sustain the movement to greater quality of care.

Lesson Seven: Appreciate the principle of contingency and the need for adaptation

One of the most insightful lessons from the organization sciences is that there is no single best way to organize anything. This lesson is derived from contingency theory which states that what works best organizationally depends on the particular context in which organizations function [14] (Lawrence and Lorsch 1969; Donaldson 2001). Contingency theory encourages us to think of organizations as systems of interrelated elements, where change in one aspect has to be evaluated within a larger context (Katz and Kahn 1978). Such "systems thinking" is a major component of the strategic approach to contraceptive introduction in which attention to scaling up is heavily emphasized (Simmons et al. 1997).

Contingency theory suggests that service delivery innovations may be feasible in one region of a country but may need to be adapted to work well in another. For example the principle of proximity identified by the social science literature on the diffusion of innovations might be used to argue that the resource system should always be located close

to the user system. This worked well in Taiwan, for example, where the research and implementation teams were housed within the same organization. Scaling up benefited from the close association of these two systems (Cernada 1982). One should be careful not to over-generalize, however. The Taiwan experience was successful because there was extensive capacity and motivation in the government system. Where such capacity is absent, too close an association can also entangle the resource team in bureaucratic red tape and inaction.

Reflecting the principle of contingency, the organization development approach used by the Reprolatina Project insists that in each new participating municipality, a diagnostic assessment needs to be undertaken. This assessment serves to familiarize the resource team and key members of the user system with the practical realities of service implementation in the location. It also provides an opportunity to assess how service innovations successfully implemented in other regions of the country need to be adapted to the particular context. Such a focus on local needs and realities is also essential for health authorities and political leaders who want to ensure that new initiatives fit their policy agendas and perceived needs.

The principle of contingency is so important that it almost calls into question use of such language as the "transfer" of innovations. General principles are transferable, but as Rogers pointed out, innovations have to be re-invented in each location so that they can be locally owned. This suggests that we should use the term "transfer" of innovations with caution.

IV. Conclusion

Referring to small-scale innovations in health and family planning as pilot or demonstration projects implies that such efforts will lead us somewhere, or demonstrate something that is relevant beyond a limited setting. Yet there are many pilot projects which lead nowhere, and many demonstrations that do not produce action on a broader scale. Experimental projects often provide good scientific data about what interventions have beneficial effects on fertility, mortality or reproductive morbidity. But too often the science ends there. The predominant underlying assumption has been that the demonstration of success by itself would lead to the transfer of innovative approaches to large-scale programs and policy development. In the family planning field, investigation of the transfer of knowledge from small projects into large-scale programs has not typically been considered a relevant domain for research or other scientific investigations.

In this paper we have argued that it is time for change. Pilots, demonstrations and experimental projects are immensely valuable. But they must be designed not only to test what works to improve health or reduce fertility; they should from the outset be concerned with the question of how the innovations can be put to practical use on a large scale. Rigorous study and analysis should not end with the pilot or experiment. It should be extended to the process of transferring innovations into larger programmatic settings, even though this review of relevant literature has suggested that this will be a difficult task. The task is daunting because a large gap exists between the attributes of user systems which predict success and the prevailing condition in large scale bureaucracies charged with implementing reproductive health services. However, much can be learned from past and current experience with scaling up projects and insights from the organization and political

sciences proved helpful in formulating seven strategic lessons. A focus on transferring innovations from small-scale projects to larger public sector programs is an idea whose time has come.

Endnotes

1 The number of attributes identified is immense. Only a few key attributes are selected here for discussion. For a meta-review of this literature see Glaser (1983).

2 Other authors identified other, somewhat overlapping attributes. For a fuller discussion see Glaser 1973, and Rogers 1995.

3 Several of these factors were originally formulated by Davis 1971 and by Davis and Salasin, 1975 (as cited by Glaser 1983). Proximity and homophily were emphasized by Havelock and Lingwood (1973) and by Rogers (1995), and leadership by Glaser (1983).

4 However, D'Alessandro et al, 1995, provide an example to the contrary showing that although nationwide introduction of insecticide-treated bednets in The Gambia would produce significant reductions in child mortality, the effort was not affordable.

5 For an earlier review of literature on organizational factors and political, economic, and socio-cultural processes see Glaser et al. 1983.

6 Frequent visits to the Navrongo field site by health officials produced spontaneous replication of some aspects of the model in other regions of the country. Because such replication was haphazard and incomplete a formal project seeking to scale up the model in the country as a whole was initiated under the name "Community-Based Health Planning and Services Initiative" by the Ministry of Health.

7 The expansion of the WARMI methodology from Bolivia to Peru experienced a similar problem (Gonzales et al. 1999).

8 Experience in Taiwan showed that research results did not get implemented when findings were not yet available at the time that critical program decisions had to be made (Cernada 1982).

9 For a discussion of benchmarking see: Boxwell, 1994.

10 For a discussion of various types of scaling up see Uvin (1995; 1996; 1999)

11 The WARMI project in Bolivia (Gonzalez et al. 2001) used a "Community Action Cycle" consisting of auto-diagnosis, planning, implementation and participatory evaluation - which is similar to organization development as described here.

12 For a similar point see also Gonzales et al. 2001.

13 The importance of this point was also extensively discussed in the social science literature on the diffusion of innovation (Havelock 1971).

14 This point was also made in the research utilization literature. Glaser (1983) argues "One who plans to undertake a particular utilization effort must keep in mind the many considerations and circumstances affecting the particular case….each application of any principle that may evolve from a summation of individual studies of innovation is *contingent* on various characteristics that pertain to that application (p.11).

References

Boxwell, Robert J. 1994. *Benchmarking for Competitive Advantage.* McGraw Hill, New York.

Cernada, George P. 1982. *Knowledge into Action: A Guide to Research Utilization.* Baywood Publishing Company, Inc, Farmingdale, New York.

Chunharas Somsak. 2001. "Linking Research to Policy and Action" in *Forging Links for Health Research: Perspectives from the Council on Health Research for Development.* Eds. Victor Neufeld and Nancy Johnson. International Development Research Centre, Ottawa, Canada.

Clark, John. 1991. *Democratizing Development.* Earthscan Publications, London

Coale Ansley J, and Susan Cotts-Watkins (Eds). 1986. *The Decline of Fertility in Europe.* Princeton University Press, Princeton, New Jersey.

D'Alessandro U, Olaleye B O, McGuire W, Langerock P, Bennett, S, Aikins M K, Thomson M C, Cham M K, Cham B A, Greenwood B M. 1995. "Mortality and morbidity from malaria in Gambian children after introduction of an impregnated bednet programme". *The Lancet.* Vol 345:479-83.

Davis Peter and Philippa Howden-Chapman. 1996. "Translating research findings into health policy". *Social Science and Medicine,* 43(5):865-872.

Díaz, Margarita, Simmons Ruth, Díaz Juan, Gonzalez Carlos, Makuch Maria Yolanda, and Bossemeyer Debora. 1999. "Expanding contraceptive choice: Findings from Brazil". *Studies in Family Planning*, 30(1):1-16.

Díaz Margarita and Ruth Simmons. 1999. "When is research participatory? Reflections on a Reproductive Health Project in Brazil". *Journal of Women's Health,* 8(2): 175-184.

Díaz Margarita, Simmons Ruth, Díaz Juan, Cabral Francisco, Bossemeyer Debora, Makuch Maria Yolanda, Ghiron Laura. Forthcoming 2001. "The Santa Barbara Project: Action research to improve municipal reproductive health services in Brazil" in: Responding to *Cairo: Case Studies of Changed Practice in Reproductive Health and Family Planning* (working title). The Population Council Press, New York New York.

Donaldson, Lex. 2001. *The Contingency Theory of Organizations (Foundations for Organizational Science).* Sage Publications, Thousand Oaks, California.

Echols, J. eds. 1974. 'Making Population-Family Planning Research Useful: The Communicator's Contribution' Conference Summary Report, East-West Communication Institute, Honolulu, Hawaii, April, 1974.

Edwards Michael and David Hulme, Eds. 1992. *Making a Difference: NGOs and Development in a Changing World.* Earthscan, London, England.

Freedman, Ronald and J Yuzuru Takeshita. 1969. *Family Planning in Taiwan: An Experiment in Social Change*". Princeton University Press, Princeton, New Jersey.

French Wendell L, and Cecil Bell. 1995. *Organization Development - Behavioral Science Interventions for Organization Improvement*. Prentice-Hall, Englewood Cliffs, New Jersey.

Gladwell Malcolm. 2000. *The Tipping Point: How Little Things Can Make a Big Difference.* Little, Brown. Boston, Massachusetts.

Glaser Edward M and S Taylor. 1973. "Factors Influencing the Success of Applied Research" *American Psychologist*, 28:140-146.

Glaser Edward M. 1983. *Putting Knowledge to Use: Facilitating the Diffusion of Knowledge and the Implementation of Planned Change*. Jossey-Bass Inc., San Francisco, California.

Gonzales Fernando, Arteaga Elizabeth, and Lisa Howard-Grabman. 1999. "Scaling Up the WARMI project: Lessons learned". In Barton R. Burkhalter and Victoria L. Graham, eds. 1999. Presented Papers: High Impact PVO Child Survival Programs, Volume 2. Proceedings of an Expert Consultation, Gallaudet University, June 21-24, 1998. CORE Group/BASICS Project/USAID, Arlington, VA.

Gu Baochang, personal communication 1998. Gu Baochang, at the time a researcher at the Center for Population Information and Research.

Haaga John and Rushikesh Maru. 1996. "The effect of operations research on program changes in Bangladesh." *Studies in Family Planning,* 27(2):76-87.

Haberland Nicole, Bruce Judith, et al. Forthcoming 2001. *Responding to Cairo: Case Studies of Change Practice in Reproductive Health and Family Planning* (working title). The Population Council Press, New York New York.

Havelock Ronald G. 1971. *Planning for Innovation through Dissemination and Utilization of Knowledge.* Center for Research on Utilization of Scientific Knowledge. Institute for Social Research, University of Michigan, Ann Arbor.

Havelock Ronald G and DA Lingwood. 1973. *R&D Utilization Strategies and Functions: An Analytical Comparison of Four Systems*. Center for Research on Utilization of Scientific Knowledge. Institute for Social Research, University of Michigan, Ann Arbor.

Katz Daniel and Robert L. Kahn. 1978. *The Social Psychology of Organizations.* John Wiley and Sons. New York.

Kingdon John W. 1984. *Agendas, Alternatives and Public Policies*. Little, Brown, Boston, Massachusetts.

Lawrence Paul R, and Jay William Lorsch. 1969. *Organization and Environment.* Irwin, Inc. Homewood, Illinois.

Lovell Catherine and F.H. Abed. 1993. "Scaling-up in Health: Two Decades of Learning in Bangladesh", in John Rohde, Meera Chatterjee and David Morley, eds. *Reaching Health for All.* Oxford University Press. Delhi.

Marchione Thomas J. ed. 1999. *Scaling Up, Scaling Down - Overcoming Malnutrition in Developing Countries.* Gordon and Breach, Australia.

Mintrom, Michael. 1997. 'Policy Entrepreneurs and the Diffusion of Innovation'. *American Journal of Political Science,* 41:738-770.

Misra BD, Ashraf A, Simmons Ruth, Simmons George. 1982. *Organization for Change: A Systems Analysis of Family Planning in Rural India*. University of Michigan, Center for South and Southeast Asian Studies. xxiv, 444 p. Ann Arbor, Michigan.

Nazzar Alex, Adongo Philip B, Binka Fred N, Phillips James F, Debpuur Cornelius. 1995. "Developing a culturally appropriate family planning program for the Navrongo experiment". *Studies in Family Planning*, 26(6):307-24.

Orosz Eva. 1994. "The impact of social science research on health policy". *Social Science and Medicine* 39(9):1287-93.

Paul Samuel. 1982. *Managing Development Programs: The Lessons of Success* Westview Press, Boulder, Colorado.

Perrow Charles. 1978. "Demystifying organizations" in Rosemary C. Sarri and Yeheskel Hasenfeld (eds.), *The Management of Human Services*, Columbia University Press, New York, pp.105-120.

Phillips James F, Simmons Ruth, Simmons George B, Yunus M. 1984. "Transferring health and family planning services innovations to the public sector: An experiment in organization development in Bangladesh." *Studies in Family Planning*, 15(2):62-73.

Phillips James F, Simmons Ruth, Huque AA Zahidul, Koblinsky Marjorie A, Koenig Michael A. 1985. "Implementation based policy development: A progress report on the MCH-FP Extension Project paradigm, field strategy, and impact". Unpublished.

Phillips James F, Simmons Ruth, Koenig Michael A, Chakraborty J. 1988. "Determinants of reproductive change in a traditional society: Evidence from Matlab, Bangladesh'. *Studies in Family Planning,* 19(6):313-34.

Phillips James F, Simmons Ruth, Simmons George. 1991. "The Institutionalization of Operations Research", in Seidman Myrna and Marjorie C. Horn (eds). *Operations Research: Helping Family Planning Programs Work Better.* Wiley-Liss, Inc. New York.

Population Reference Bureau and the Population Council. 1999. *A Guide to Research Findings on the Cairo Consensus.* Monograph.

Pyle David F. 1980. "From Pilot Project to Operational Program in India: The Problems of Transition". *In Politics and Policy Implementation in the Third World* Ed Merilee S. Grindle. Princeton University Press, Princeton, NJ.

Rogers Everett M. 1995. *Diffusion of Innovations, 4th ed*. Free Press, New York.

Rondinelli Dennis A. 1983. *Development Projects as Policy Experiments.* Methuen, London, New York.

Satia Jay K, Mavlankar D, Indu Menon. 1985. "Scaling up for child survival - key issues", in *Collection of Concept Papers, Case Studies and Experience Sharing.* Regional Workshop on Scaling up for Child Survival Activities, August 20-23; Indian Institute of Management, Ahmedabad, India.

Shiffman, Jeremy. 2000. "Agenda setting and reproductive rights into the 21st century". Paper presented at the IUSSP Seminar on Family Planning Programs in the 21st century, Dhaka, Bangladesh January 17-20, 2000.

Simmons George B, Balk Deborah, Faiz KK. 1991. "Cost-effectiveness analysis of family planning programs in rural Bangladesh: Evidence from Matlab". *Studies in Family Planning,* 22(2)83-101.

Simmons, Ruth. 1980. "A Human Service Perspective on the Organization of Primary Health Care" in Health Sciences Faculty (eds.) *Human Resources for Primary Health Care in the Middle East*, American University of Beirut, Lebanon.

Simmons Ruth, Phillips James F, Koenig Michael A, Huque AA Zahidul. 1987. "Implementation-Based Policy Development in Bangladesh". Paper presented to the Annual Meeting of the Population Association of America. April 30- May 2, 1987. Chicago, Illinois.

Simmons Ruth and George Simmons. 1992. "Moving toward a higher quality of care: Challenges for Management". In *Managing Quality of Care in Population Programs.* Anrudh K. Jain (Ed). Kumarian Press, West Hartford, CT.

Simmons Ruth, Hall Peter, Díaz, Juan, Díaz Margarita, Fajans Peter, Satia Jay. 1997. "The strategic approach to contraceptive introduction." *Studies in Family Planning*, 28(2):79-94.

Simmons Ruth, Baochang Gu, Ward Sheila. 2000. "Initiating Reform in the Chinese Family Planning Program". Paper presented at the Annual Meeting of the Population Association of America, Los Angeles, California. March 21-24, 2000.

Sternin, Monique, Jerry Sternin and March David. 1999. In Marchione, ed: *Scaling Up, Scaling Down - Overcoming Malnutrition in Developing Countries.* Gordon and Breach, Australia.

Uvin, Peter. 1995. "Fighting Hunger at the Grassroots: Paths to Scaling Up". *World Development*, 23(6):927-940.

Uvin Peter and David Miller. 1996. "Paths to Scaling-up: Alternative Strategies for Local Nongovernmental Organizations". *Human Organization,* Vol 55. No. 3. 344-354.

Uvin Peter. 1999. "Eliminating Hunger After the End of the Cold War: Progress and Contraints. In Marchione, ed. *Scaling Up, Scaling Down - Overcoming Malnutrition in Developing Countries,* Gordon and Breach, Australia.

Walker Jack L. 1969. "The diffusion of innovations among the American states". *The American Political Science Review.* 63, 880-899.

Wils Frits. 1995. "Scaling-up, Mainstreaming and Accountability: the Challenge for NGOs". In Edwards Michael and David Hulme, eds. *Non-Governmental Organisations: Performance and Accountability beyond the Magic Bullet.* Earthscan, London.

Zhang Erli, Baochang Gu, and Zhenming Xie (eds.) 1999. *Assessment Reports on the SFPC's First Pilot Counties/District on Quality of Care in Family planning (1995-1998)*. (In Chinese) Beijing: China Population Press.

Zhang Erli. 1998. Personal communication. Zhang Erli at the time Director of Statistics and Planning of the State Family Planning Commission of China was the head of the quality of care project.

Zhang Kaining. 2001. Personal communication. Zhang Kaining at the time Director of Yunnan Reproductive Health Research Association, Director of the Institute for Health Sciences - Kunming Medical College, and Member of the Gender Advisory Panel, UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction.

Table 1. Seven Lessons for the Scaling Up of Quality of Care Innovations

Lesson One:	Do not rely on spontaneous transfer - make scaling up a concern from the time pilots are initiated
Lesson Two:	Acknowledge the political nature of the task and value incremental change
Lesson Three:	Benefit from policy windows and policy entrepreneurs
Lesson Four:	Insist on phased implementation while simultaneously addressing broader dissemination of central ideas
Lesson Five:	Scale up where there are points of strength
Lesson Six:	Use participatory organization development and ensure long-term support from resource systems
Lesson Seven:	Appreciate the principle of contingency and the need for adaptation

Figure 1. Components of the Innovation Diffusion /Knowledge Transfer Framework and Key Attributes of Success

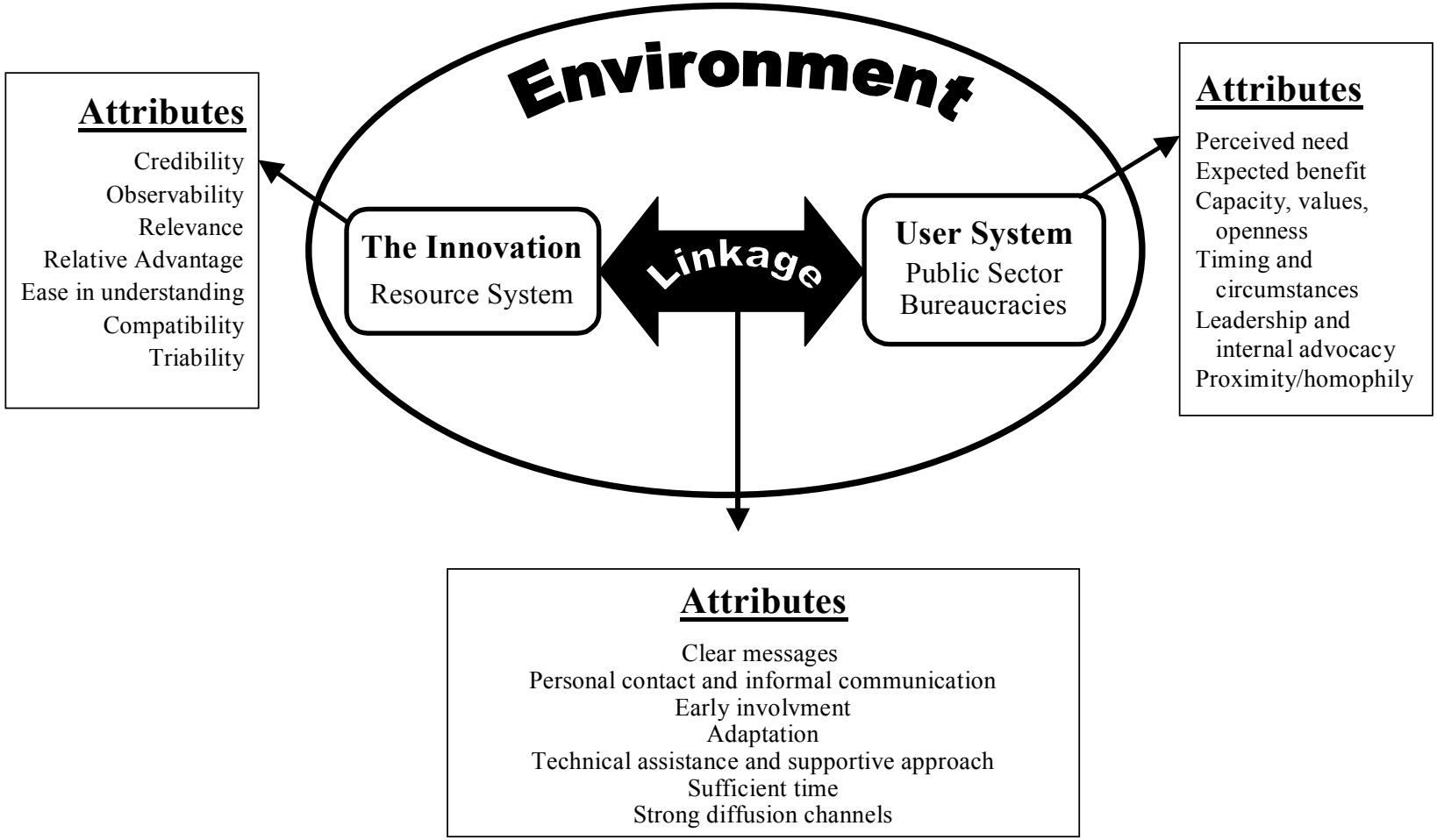
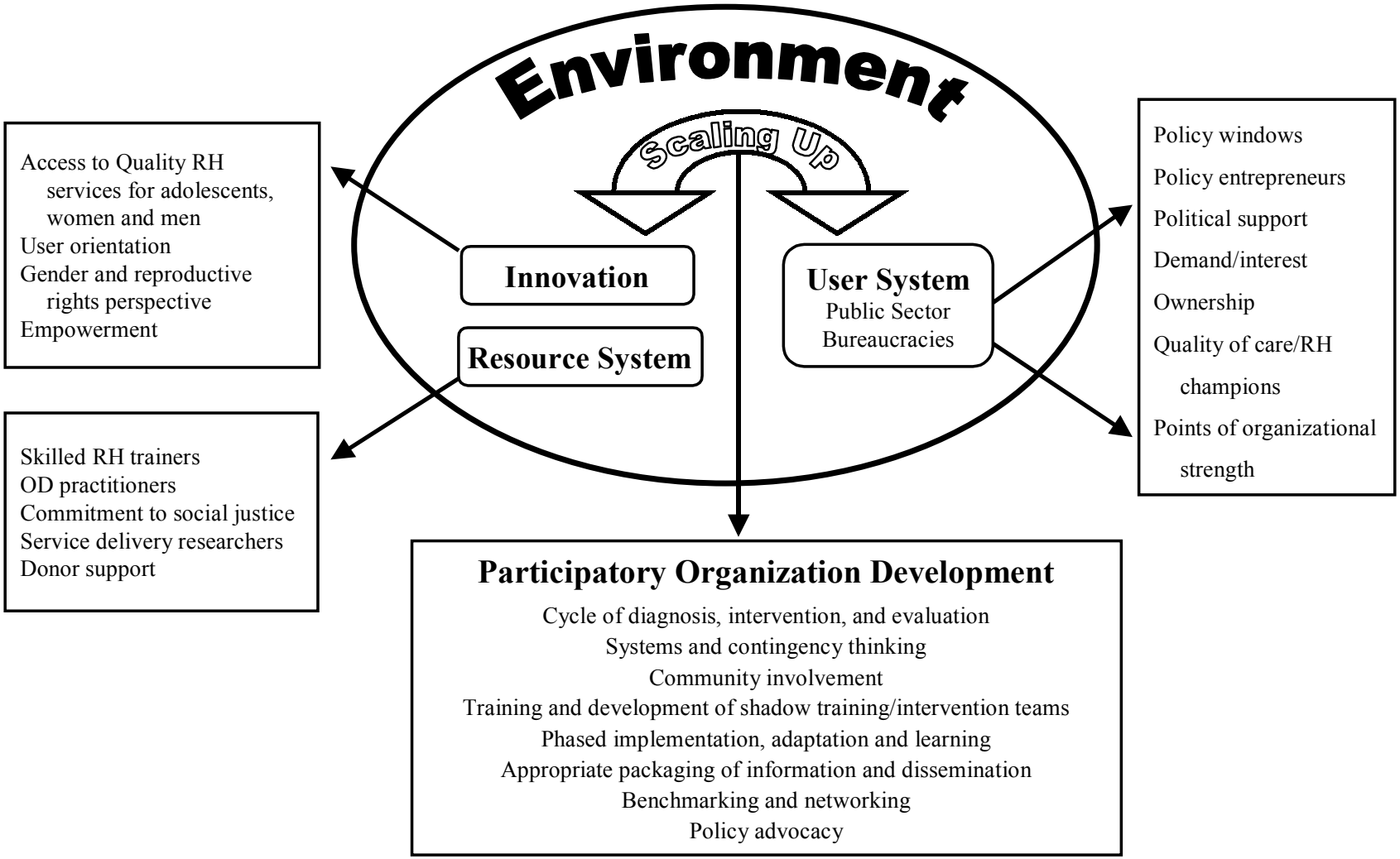


Figure 2. Participatory Organization Development (OD) Framework for Scaling Up Reproductive Health/Quality of Care Innovations



3.4. Principais Lições Aprendidas

Uma das principais lições aprendidas foi que a educação e sua integração com a saúde foram cruciais para o sucesso alcançado com a implementação da estratégia. Devido à sua importância serão abordados no capítulo 4.

Certamente, outras lições foram aprendidas durante o processo, que podem ser de grande utilidade para outros grupos que queiram implementar ações que objetivem a melhoria da qualidade da atenção em saúde sexual e reprodutiva, ou de outras áreas da saúde, listadas a seguir:

- *A Flexibilidade da Estratégia e seus Componentes*

  Com a experiência acumulada durante a implementação da estratégia aprendemos, em primeiro lugar, que a metodologia é muito flexível e possível de se adequar a outras áreas da medicina. De fato, essa metodologia já tem sido aplicada também na área de atendimento obstétrico em outros países (Bolívia) e na área de doenças sexualmente transmissíveis e Aids (Brasil).

  Outro fato importante a salientar é que, embora o ideal seja aplicar a estratégia integralmente, seus componentes, especialmente as Etapas I e II, podem ser individualmente úteis. O diagnóstico estratégico, Etapa I, tem sido aplicado em outros países que não implementaram o processo integralmente e já demonstraram ser de grande utilidade para o planejamento de atividades em saúde reprodutiva, saúde materna e doenças sexualmente transmissíveis e Aids.

  Aproveitando a experiência pioneira adquirida no Brasil e somada à de outros países, a Organização Mundial da Saúde preparou um manual para implantação do diagnóstico estratégico que pode ser de grande valor em outros países que queiram fazer a mesma coisa (WHO, 2001).

A metodologia utilizada na Etapa II, pesquisa de ação participativa, também tem demonstrado ser uma metodologia de grande utilidade em qualquer área da saúde (Maguire, 1987).

As características da pesquisa participativa, que inclui ações orientadas para a solução de problemas, a participação e modificação das intervenções de acordo com os resultados obtidos, tornam-na aplicável em situações nas quais o objetivo seja por exemplo a melhoria de um sistema com a utilização dos conceitos de desenvolvimento organizacional.

- *Apropriação e Vontade Política*

Estes dois conceitos, que estão intimamente ligados, são fundamentais para o sucesso da implementação da estratégia.

Uma das características da implementação de projetos com apoio financeiro e técnico internacional é que, ao seu término, em geral as atividades não prosseguiam. Uma das razões para isso é o fato de os pesquisadores locais não deterem o comando nem serem os “donos” do projeto.

A implementação da estratégia participativa, a partir de seu planejamento, busca que os pesquisadores locais apropriem-se do projeto e assumam sua autoria e direção. A assistência técnica e financeira é crucial, embora seja imprescindível que a assistência técnica inclua o desenvolvimento de competência técnica e a capacidade inclusive de buscar, dentro e fora do município, recursos que permitam garantir a continuidade do programa. Isso faz que, desde a implantação, as pessoas do local percebam com muita clareza que a responsabilidade final pelo sucesso ou fracasso da estratégia é deles e que sua equipe deverá continuar com as atividades quando já não mais contarem com financiamento e apoio técnico.

Conseqüentemente, a assistência técnica deve buscar o fortalecimento institucional e o desenvolvimento das capacidades técnicas e administrativas.

Por outro lado, a vontade política para apoiar a estratégia é extremamente importante. As atividades de saúde vêm sendo progressivamente descentralizadas, e os municípios estão adquirindo mais independência na implantação dos programas. Sem o apoio explícito das autoridades municipais, que devem prover os recursos necessários, é difícil, senão impossível, a manutenção das atividades.

A apropriação da estratégia torna mais factível a obtenção de apoio contínuo, porque as autoridades geralmente estão mais predispostas a colaborar em projetos nacionais. A apropriação e a institucionalização da estratégia favorecem a manutenção do apoio político, que por sua vez é crucial para a sustentabilidade dos programas.

- *Participação – Implementação do Comitê Executivo*

Este conceito também está intimamente ligado à apropriação e favorece a manutenção e a continuidade da implementação da estratégia.

A implementação da estratégia, diferentemente de outros projetos que também têm como objetivo a melhoria da qualidade, sempre buscou obter a participação de todos os profissionais no processo de implementação, desde o seu planejamento.

Nesse projeto, para garantir a participação e a representatividade de provedores, autoridades e principalmente da comunidade, foi criado o Comitê Executivo, definido no projeto como uma instância de representação e decisão

criada para dar apoio ao projeto de melhoria da qualidade de atenção em saúde sexual e reprodutiva.

O Comitê Executivo permitiu que não só os pesquisadores mas os prestadores de serviços locais, autoridades e comunidade, pudessem conhecer melhor a realidade dos serviços, fazendo sugestões baseadas no diagnóstico. Esse processo democrático, realmente participativo, sem dúvida necessita de apoio político das autoridades desde a implantação, o que deve ser ativamente buscado e mantido.

Os objetivos do Comitê Executivo são garantir a representação e a participação dos diversos segmentos envolvidos, principalmente da comunidade usuária, no processo de tomada de decisões do Programa de Saúde Sexual e Reprodutiva, no sentido de assegurar seu controle social.

O papel do Comitê é:

- representar os diferentes segmentos da comunidade e do sistema de saúde;
- discutir os resultados do diagnóstico/avaliações e definir ações e prioridades;
- colaborar na busca de apoio e recursos mediante a mobilização social;
- disseminação do programa no âmbito da comunidade;
- Integrar os diversos atores e instituições para discutir questões da saúde sexual e reprodutiva. Exemplo: educação e saúde.

A seguir mostra-se a estrutura do projeto.

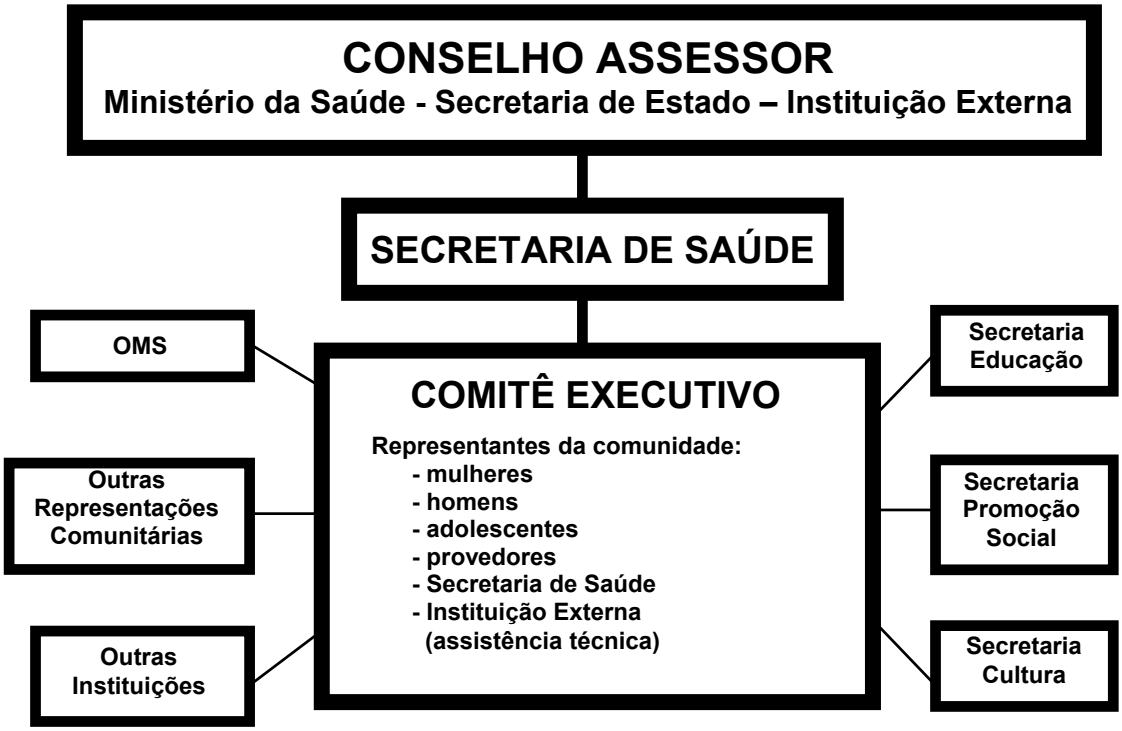


FIGURA 2: Organograma do Projeto

A participação contribuiu de maneira fundamental para a apropriação do processo por parte das instituições locais e, conseqüentemente, pôde auxiliar também na manutenção do apoio político.

Particularmente, a participação da comunidade desde o planejamento das atividades também foi essencial em dois aspectos: primeiro, permitiu uma adequada priorização das atividades, já que a comunidade está mais qualificada para determinar quais são suas reais urgências. Em segundo lugar, a participação comunitária mostrou-se como o verdadeiro pilar da sustentabilidade. O exemplo mais claro disso foi a manutenção do programa de vasectomia de Santa Bárbara d'Oeste, num momento de transição política no qual as novas autoridades não consideravam prioritário o projeto. A

demanda da comunidade e a satisfação com o serviço foram cruciais para convencer as autoridades da necessidade de mantê-lo ativo.

- *A Importância do Diagnóstico Prévio no Desenvolvimento das Atividades*

A importância do diagnóstico estratégico, alicerce fundamental da estratégia, parece não precisar de justificativa. No entanto, a repetição de diagnósticos locais em cada um dos municípios onde foram implementadas as intervenções tem sido discutida por alguns pesquisadores tanto no Brasil quanto em outros países.

As razões defendidas pelos que se opõem à realização sistemática de diagnóstico prévio em todos os municípios baseiam-se na constatação de que os resultados obtidos em cada município são muito parecidos e também muito semelhantes aos apontados pelo diagnóstico geral do país.

Ainda reconhecendo que este fato é real, pelo menos em parte, o diagnóstico inicial em cada município teve uma importância decisiva na implementação da estratégia pelas seguintes razões:

1. O diagnóstico representou a primeira instância de participação e contribuiu para a apropriação do projeto pelos pesquisadores e prestadores de serviços locais. O pessoal local colabora no diagnóstico, aprende a fazê-lo, apropria-se dos resultados e participa da discussão das intervenções que poderão resolver os problemas encontrados. Esse envolvimento faz que a equipe local assuma um compromisso mais forte com o projeto, ao se sentirem “autores” dele, desde sua implantação. Além disso, contribui para o bom entendimento da metodologia do projeto, favorece o trabalho em equipe e permite um melhor entrosamento entre os profissionais locais e a equipe de pesquisa.

2. O diagnóstico local dá legitimidade aos achados. Embora os resultados sejam, habitualmente, muito semelhantes nos diversos municípios, o fato de terem sido coletados localmente faz que se tornem mais críveis. É comum que nas reuniões preliminares de negociação, diretores e prestadores de serviços tenham dificuldade de acreditar que em seu município a situação seja semelhante àquelas encontradas em outros municípios, especialmente no que se refere à qualidade de atenção, tempo de espera, tempo real dentro da consulta etc.

   Em todos os municípios que participaram da implementação da estratégia, os diretores e provedores reconheceram que o diagnóstico de base foi fundamental para se entender a situação real do município, além de aumentar o grau de compromisso com a melhoria da qualidade de atenção.

3. Embora os problemas sejam de fato muito semelhantes em todos os municípios, há diferenças notáveis entre eles em relação ao seu potencial de solução. A participação da equipe local no diagnóstico permite-lhes visualizar mais claramente quais são os problemas que podem ser resolvidos em tempo relativamente curto, porque no município há capacidade instalada para isso. Por outro lado, possibilita também a identificação dos recursos que se devem agregar ao sistema. Por exemplo, em alguns municípios existe o número adequado de enfermeiras e/ou trabalhadoras sociais e local apropriado para implantar atividades de educação e de orientação. Nesses casos, a decisão administrativa de implementá-lo e a capacitação são suficientes. Em contraste com isso, em outros há necessidade de se contratar pessoal e arranjar o local previamente, o que torna o processo mais lento e complexo.

   Por essas razões, ainda que a realização do diagnóstico requeira recursos e tempo antes do início das intervenções, trata-se de um custo justificável, porque as intervenções serão mais apropriadas e o pessoal local terá um

conhecimento mais amplo dos problemas e um compromisso maior com sua solução.

- *Supervisão Contínua*

A supervisão é uma atividade fundamental para a manutenção da qualidade de atenção. Todos os municípios participantes tinham, pelo menos em teoria, um serviço de supervisão contínua e, antes do diagnóstico, achavam que era inútil falar do assunto porque isso já estava implementado há muito tempo.

O diagnóstico permitiu, em todos os municípios, em maior ou menor grau, constatar que a supervisão era uma instância burocrática, que embora estivesse definida no organograma era uma função quase inexistente ou, quando existia, era para punir, chamar a atenção, mas nunca para auxiliar, elogiar as pessoas ou para manter a comunicação entre as pessoas.

Primeiro, porque o número de supervisores era mínimo e essas pessoas não haviam sido preparadas para atuar como tal. Sua função se limitava praticamente a detectar problemas (falta de funcionários, equipamentos em más condições de uso etc.) e informar os superiores sobre as várias questões, não tendo em geral autonomia para tomar decisões envolvendo sua solução. Além disso, o/a supervisor/a cumpria uma série de funções alheias ao seu cargo.

A lição aprendida é que a supervisão tem que ser contínua e de apoio. Não deve ser encarada como uma instância de controle e nem punitiva, mas sim uma continuidade da capacitação, de maneira a contribuir para o fortalecimento dos/as provedores/as com a finalidade de que alcancem autonomia e eficiência na realização de suas funções.

Reconhecemos que, nesse sentido, nosso sucesso tem sido limitado. Preparar pessoal para executar essa tarefa adequadamente não é fácil. Em primeiro lugar, a pessoa deve ter alto preparo técnico e características pessoais que lhe permitam cumprir bem a função, além de capacitação específica, requisitos difíceis de preencher.

Em geral, o pessoal que tem sido capacitado para exercer essas funções inevitavelmente deve cumprir outras tarefas, o que faz que a supervisão não seja realizada com a freqüência e a intensidade requeridas.

- *Avaliação Contínua*

Nada mais fácil de ser aceito pelas autoridades dos municípios que a avaliação contínua. Todos concordam com sua importância, especialmente para detectar problemas precocemente e planejar intervenções adequadas oportunamente.

Por outro lado, esse é um processo muito difícil de implementar. O pessoal dos serviços de saúde habitualmente trabalha contra o tempo, tentando terminar logo suas tarefas, porque os médicos têm pouco tempo disponível e tudo tem que ser feito no período em que há médicos no posto.

Com isso fica muito difícil conseguir que os documentos necessários para levar a cabo uma avaliação razoável sejam preenchidos adequadamente. Os médicos dizem que não têm tempo, e o pessoal auxiliar argumenta que para eles é mais difícil preencher tais documentos, alegando que não entendem muito bem o que o médico fez. Por isso, eram preenchidos unicamente os documentos mínimos exigidos pelo SUS, para poder garantir os fundos federais para o município.

Na Etapa II, em Santa Bárbara d'Oeste, foi instituído um sistema de registro de dados que permitia fazer uma avaliação mais acurada do atendimento em

saúde reprodutiva. Ele se mostrou relativamente fácil de manter, e os médicos colaboraram no preenchimento do formulário, sem que isso significasse uma sobrecarga de trabalho.

Apesar do sucesso da experiência, o sistema de avaliação contínua não foi implementado com sucesso nos municípios participantes da Etapa III, que seguiu funcionando somente em Santa Bárbara d'Oeste. Os diretores dos serviços reconheceram a importância da avaliação contínua, mas não conseguiram implementá-la.

Parte do problema residiu no fato de que nos municípios não havia tradição de utilizar a avaliação para a tomada de decisões. Em geral, até agora, os municípios têm trabalhado cumprindo metas que lhe são alheias, habitualmente ditadas pelas secretarias estaduais ou pelo governo federal. Além disso, a maioria dos municípios não tinha equipamento de informática adequado ao sistema de registro contínuo de informação.

Agora, com a descentralização, os municípios têm maiores responsabilidades no planejamento e é evidente a necessidade de se ter uma avaliação contínua mais precisa.

Por isso, atualmente, estamos no processo de desenvolvimento de um sistema mais simples mas que permita o registro de todas as informações necessárias ao planejamento das atividades futuras, ao mesmo tempo que os municípios serão preparados para sua utilização.

O crescente avanço da tecnologia, com equipamentos cada vez mais acessíveis, faz com que a implantação de sistemas de avaliação seja mais factível, desde que o pessoal esteja devidamente capacitado.

- *Enfoque no Sistema de Saúde como um Todo*

O enfoque no sistema é a chave da estratégia. O conceito, sintetizado no triângulo, expressa que para introduzir uma nova tecnologia num sistema de saúde, ou lidar com as que já estão disponíveis, de forma que tenham um impacto positivo e melhorem a qualidade dos serviços, é preciso levar em conta, de maneira integrada e harmônica, as necessidades das/os usuárias/os, as características dos equipamentos disponíveis e a capacidade dos serviços para oferecer essa tecnologia. A circunferência na qual está inserido o triângulo representa o contexto social, econômico e político da sociedade à qual os serviços de saúde estão destinados, cuja importância é fundamental.

A implementação da estratégia tem confirmado que esse enfoque é fundamental para o sucesso de qualquer programa que pretenda melhorar o acesso e a qualidade dos serviços de saúde sexual e reprodutiva.

A experiência mostrou que, mesmo quando o objetivo do programa era a implementação do planejamento familiar, ao se trabalhar com esse enfoque holístico, houve melhorias em todos os outros componentes da saúde sexual e reprodutiva, como detecção precoce do câncer ginecológico, atendimento pré-natal e ginecológico etc., e melhorou o sistema como um todo, no sentido de humanizar o atendimento e de melhorar as relações entre provedores e usuárias.

Por outro lado, alguns programas de introdução de métodos, em que esses fatores não foram levados em conta, não tiveram o impacto esperado e, a longo prazo, acabaram fracassando. O exemplo mais típico, já relatado anteriormente, é a introdução do DIU na Índia: após um grande sucesso inicial, com grande aceitação do método pela população, ela passou a rejeitar o método. A prevalência de seu uso continua muito baixa no país até hoje. Isso

ocorreu porque não se considerou adequadamente a necessidade das usuárias nem a capacidade dos serviços.

Em nossa experiência, as tecnologias oferecidas, as necessidades da população e os procedimentos utilizados na implementação da estratégia, nos diversos municípios, têm sido muito semelhantes. Entretanto, os resultados têm diferido, fundamentalmente, porque a capacidade dos serviços e o contexto social, político e econômico apresentaram importantes diferenças entre si. Em alguns municípios, ainda que existissem todos os outros fatores favoráveis ao sucesso da implantação da estratégia, a dificuldade às vezes instransponível, por razões políticas ou econômicas, de se manter um estoque adequado de toda a gama de métodos anticoncepcionais diminuiu o impacto positivo do projeto.

- *Utilização de uma Metodologia Baseada no Desenvolvimento Organizacional*

O desenvolvimento organizacional, seja no âmbito industrial ou no comercial tem feito o sucesso de muitas companhias. Não cabe aqui fazer uma análise exaustiva do tema, mas convém salientar a importância que tiveram a metodologia da pesquisa participativa e o modelo de desenvolvimento organizacional na implementação da estratégia.

Uma das características fundamentais do desenvolvimento organizacional é trabalhar em ciclos de diagnóstico, planejamento e implementação de intervenções, com avaliação contínua. Além disso, no processo, dá-se ênfase à aprendizagem de métodos que levem a uma melhoria do funcionamento da organização.

Todas as atividades educativas, outro fator fundamental, adquirem pleno valor quando são inseridas num modelo de desenvolvimento organizacional, alcançando efeitos positivos, importantes e duradouros.

- *Assistência Técnica Externa*

O processo de expansão da implementação do processo dentro em alguns municípios e sua replicação em outros requer que uma instituição ou sistema o estimule e mantenha.

A capacitação técnica, definida por Freire, *"*é mais do que treinamento, porque é busca de conhecimento, é apropriação de procedimentos" (Freire, 1992, p. 88).

A duração da assistência técnica é variável porque ela incorpora uma capacitação que está inserida no sistema, isto é, um tema conduz necessariamente a outros, e esse processo requer tempo, até que o grupo de cada município tenha adquirido a capacidade de lidar com o processo, mantendo-a atualizada, domine a metodologia do desenvolvimento organizacional, mobilize e administre adequadamente os recursos e tenha aprendido a avaliar e implementar novas ações.

Atualmente, dois municípios estão dando continuidade ao processo de maneira completamente independente e ainda colaboram na sua implantação em municípios vizinhos. Nesse contexto, o significado de assistência técnica, quanto tempo ela requer, como a descontinuar e/ou manter são interrogações ainda não respondidas.

4. O Componente Educativo: Elemento Fundamental para a Melhoria da Qualidade de Atenção

4.1. Principais Características

A implementação da estratégia com vistas à melhoria da qualidade de atenção no planejamento familiar e outros componentes da saúde reprodutiva previa uma aprendizagem da nova metodologia, a incorporação de novas informações que levassem à participação das pessoas, a fim de que elas pudessem mudar seu serviço de saúde e seu entorno de acordo com suas necessidades e direitos.

Dessa forma, a educação foi uma das ferramentas mais importantes para provocar o processo de mudanças necessárias à melhoria da qualidade de atenção na área da saúde sexual e reprodutiva, que era afinal o objetivo deste projeto.

A análise dos princípios-chave da estratégia mostrou que a apropriação do processo pelos grupos locais, o trabalho colaborativo e a participação comunitária apareciam como pilares fundamentais para seu sucesso. Isso representou o primeiro grande desafio para a implementação da estratégia: tanto os provedores de serviços, no sentido mais amplo, quanto a comunidade não estavam preparados para participar das mudanças que deviam ser implementadas. O diagnóstico tinha mostrado que a maioria dos profissionais não estava tecnicamente bem preparada e, ainda mais, na sua prática evidenciava-se um conceito centrado na figura do profissional de saúde que privilegiava os aspectos “curativos”. As usuárias eram atendidas de uma maneira segmentada, de acordo com a queixa ou problema que apresentavam, não conheciam seus direitos e tinham dificuldade de acesso aos serviços de saúde. Uma frase muito significativa, dita por uma usuária, ilustra bem essa situação: “Conseguir uma consulta é como ganhar na loteria”.

O diagnóstico também deixou claro que a grande maioria dos funcionários dos serviços estava desmotivada e, em geral, não estavam preparados para trabalhar de maneira colaborativa e participativa, só fazendo o mínimo necessário. Por outro lado, o diálogo entre autoridades, provedores e comunidade era quase inexistente, e não havia interesse, motivação e nem compromisso para tentar melhorar a situação.

Isso fortaleceu a idéia de que, sem um importante processo educativo, tanto voltado para os profissionais de saúde quanto para a comunidade, haveria poucas possibilidades de êxito na implementação da estratégia.

Entretanto, tínhamos clara consciência de que esse processo educativo teria que ser diferente dos que habitualmente vinham sendo realizados. Para obter os resultados esperados, era importante juntar os referenciais teóricos da saúde com os da educação e aprender com as experiências anteriores.

A análise de alguns programas e/ou ações educativas permite constatar que embora muitas vezes as pessoas recebam informações, nem sempre elas resultam em conhecimentos ou preparo ou, segundo a Teoria de Ausubel, não resultam em aprendizagem significativa (Novak, 1981).

No estudo realizado para minha dissertação de mestrado (Díaz, 1994), detectou-se que os jovens universitários tinham informação, mas a prática não era coerente com a informação. Entre os muitos fatores que podem explicar esse fato, que se tem repetido em outras pesquisas realizadas posteriormente (Cemicamp e Fundação Odebrecht, 1999 a, b, c), está a maneira como esses programas educativos são realizados, que faz que eles não consigam atingir resultados significativos.

Essa motivação, presente ao longo de todo o desenvolvimento deste trabalho, estimulou-me a revisar e analisar de maneira especial o processo educativo e suas

características fundamentais, como uma maneira de contribuir não só para tornar proveitosa a implementação da estratégia em outros países, como também para melhorar o processo de expansão dessa experiência em larga escala e, de um modo geral, os resultados dos programas de educação em saúde em nosso país.

Entenda-se componente educativo como uma referência às diferentes atividades educativas desenvolvidas ao longo do projeto e que em alguns momentos são chamadas de atividades de “sensibilização” e “capacitação”. A avaliação mostrou que essas ações educativas foram, junto com outros elementos, fundamentais para a participação dos diferentes atores do sistema de saúde – a própria comunidade usuária dos serviços, provedores e autoridades de saúde – na proposta de melhoria da qualidade de atenção em saúde sexual e reprodutiva. O compromisso que todas as pessoas assumiram foi a força que motivou as mudanças e que tem permitido superar as dificuldades e manter a continuidade do programa.

Muitos profissionais que têm visitado os municípios que implementaram a estratégia, incluindo dois avaliadores externos que a OMS enviou, tem perguntado o que foi realizado neste projeto que o torna diferente dos outros? O que ele tem de especial que tem conseguido incorporar tanto assim os profissionais, e mesmo as autoridades, de maneira a ser evidente a motivação e satisfação, tanto das pessoas que trabalham, como daquelas que são atendidas pelo sistema de saúde?

Para responder a essas interrogações e solidificar a importância que o componente educação teve, selecionamos algumas características que, no nosso entender, o tornam especial.

Essa divisão didática foi feita com o propósito de enfatizar alguns aspectos do processo educativo, tendo presente a compreensão de que a educação é um processo dinâmico e permanente como a própria vida, conforme visão de educação apresentada anteriormente.

- *A Capacitação como um Processo*

Em muitos projetos nos quais trabalhamos anteriormente, a capacitação era uma ação pontual dirigida somente a alguns profissionais, que focalizava principalmente a informação e, em alguns casos, o desenvolvimento de habilidades específicas, como a colocação de um dispositivo intra-uterino.

Em nosso projeto, entendemos a capacitação como um processo educativo com uma intenção definida de mudança cultural, de transformação da realidade do sistema de saúde, com base numa clara noção de direitos. Esse processo inicia-se com o próprio diagnóstico de necessidades, etapa em que os profissionais percebem qual é a situação das unidades de saúde e as necessidades das/os usuárias/os, junto com os quais começam a visualizar e discutir as possibilidades de mudanças. Os provedores também começam a pensar em seu papel social e em suas funções, ocasião em que também avaliam o preparo que receberam e de que recursos dispõem para o desempenho dessas funções. O diagnóstico, desenvolvido igualmente de maneira participativa, facilita a identificação das dificuldades encontradas pelos provedores e permite a detecção das necessidades de capacitação das diversas pessoas que compõem a equipe de saúde. Nesta etapa já se trabalha com o sentido de despertar o interesse das pessoas, estimulando-as a ter um olhar crítico, a falar, dialogar e aprender.

Tanto nesta etapa quanto nas posteriores (o curso propriamente dito e as atividades de supervisão), o processo de capacitação, como qualquer outro no âmbito do planejamento educacional, leva em conta o posicionamento do educador/capacitador ou facilitador do processo de ensino-aprendizagem. Nossa equipe de capacitação discutiu e definiu a noção de “pessoa” e de “mundo”, a intencionalidade, nossa metodologia e papel.

Considerando fundamental o papel do “educador”, posteriormente será reservado um espaço para sua abordagem.

Admitidos como base do projeto tais conceitos e marcos de referência, a capacitação, de acordo com nossa compreensão, visa desenvolver nas pessoas, principalmente, autonomia e solidariedade. Nesse contexto, o processo de capacitação focaliza não somente os aspectos cognitivos, mas também os culturais, emocionais, afetivos e o desenvolvimento de aptidões e habilidades.

De uma maneira didática, muitas vezes separamos esses aspectos, embora eles estejam absolutamente integrados, uma vez que fazem parte da pessoa e cada um determina ou influencia os demais.

De modo geral, no aspecto cognitivo, a capacitação sempre deve considerar as informações que a pessoa já tem para facilitar a incorporação de outras, novas, que possam resultar em significados diferentes. No plano afetivo e emocional, deve levar em conta a experiência, vivências anteriores, expectativas futuras das/os participantes, bem como a auto-estima, a habilidade para reconhecer e lidar com os sentimentos mobilizados ao longo do processo.

A capacitação visa não somente desenvolver habilidades técnicas, como por exemplo medir um diafragma ou fazer uma orientação, mas preparar a pessoa de maneira que ela possa conquistar sua autonomia, como por exemplo, habilidade para investigar, questionar, argumentar, comparar opiniões, assumir compromissos, etc.

Nosso conceito de capacitação alinha-se com os quatro pilares da educação para o século XXI listados no relatório que a Comissão Internacional sobre Educação para o Século XXI preparou para a UNESCO (Delors, 2001). São eles:

- **Aprender a conhecer**, isto é, adquirir os instrumentos da compreensão;
- **Aprender a fazer**, para poder agir sobre o meio envolvente;
- **Aprender a viver juntos**, a fim de participar e cooperar com os outros em todas as atividades humanas; e
- **Aprender a ser**, via essencial que integra as três precedentes.

O relatório afirma que essas quatro vias do saber constituem uma só, dado que há entre elas múltiplos pontos de contato, de relacionamento e de permuta. Também assinala que, embora aprender a conhecer e aprender a fazer sejam quase indissociáveis, em geral as ações educativas orientam-se basicamente para o aprender a conhecer e menos para aprender a fazer, e que o ideal seria que os quatro pilares fossem incorporados no processo educativo, para mudar essa visão puramente instrumental da educação e se passasse a considerá-la em toda a sua plenitude ou seja, realização da pessoa que, na sua totalidade, aprende a ser.

Isto significa que a educação deve contribuir para o desenvolvimento integral da pessoa: espírito e corpo, inteligência, sensibilidade, sentido estético, responsabilidade pessoal, espiritualidade. O ser humano deve ser preparado para elaborar pensamentos autônomos e críticos e para formular seus juízos de valor e poder tomar decisões e agir por si próprio nas diferentes circunstâncias da vida (Delors, 2001).

De acordo com esses pilares, nossas atividades educativas visam fazer que a pessoa desenvolva sua autonomia no sentido de identidade, auto-estima, autoconceito, projeto de vida, auto-realização e solidariedade no mais amplo sentido de sociabilidade e ética, relações e apoio ao outro. Do ponto de vista da educação, solidariedade significa compartilhar conhecimentos, desafiar os preconceitos, a discriminação e, principalmente, lutar contra a ignorância (Brasil, Ministério da Saúde, 1997).

Solidariedade, no pensamento de Paulo Freire (2001), significa*:* “compromisso histórico de homens e mulheres, como uma das formas de luta capazes de promover e instaurar a ‘ética universal do ser humano’” (p. 13).

Tendo em conta que as pessoas são diferentes e portanto têm histórias, vivências, expectativas e ritmos distintos, pensamos que a capacitação deve ser um

processo contínuo que permita sua participação no desenvolvimento de suas potencialidades e de seu crescimento pessoal, de maneira a conquistar sua autonomia e, com solidariedade, possam transformar as unidades de saúde, participar da elaboração das políticas públicas e transformar a sociedade de um modo geral.

- *O Papel do/a Educador/a*

  Há muitos fatores envolvidos no processo de ensino-aprendizagem. Um deles é o do/da educador/a, que pode atuar facilitando ou não o processo de formação, de desenvolvimento da autonomia.

  Paulo Freire (2001) descreve em seu livro *A Pedagogia da Autonomia* que saberes são necessários à prática educativa, leitura crucial para qualquer educador se auto-avaliar e refletir sobre como está se desenvolvendo o processo de educação no qual esteja envolvido. Ele destaca que "formar" é muito mais do que puramente "treinar" o educando no desempenho de destrezas.

  Segundo Freire, assim como em outras práticas, por exemplo, cozinhar ou velejar, é importante que a pessoa tenha alguns saberes e que a prática vá modificando-os ou ampliando. Dessa maneira, afirma que: "a reflexão crítica sobre a prática se torna uma exigência da relação Teoria/Prática sem a qual a teoria pode ir virando blábláblá e a prática, ativismo" (pág. 24).

  Os três aspectos discutidos por ele são:

  - Que não há docência sem discência;
  - Que ensinar não é transferir conhecimento; e
  - Que ensinar é uma especificidade humana.

Ele discute alguns saberes que em sua opinião deveriam ser conteúdos obrigatórios da formação docente – que ensinar exige: rigor metódico, pesquisa, respeito aos saberes dos educandos, senso crítico, estética e ética, reflexão crítica, respeito à autonomia, humildade e tolerância, alegria e esperança, exigindo ainda a convicção de que a mudança é possível. Também diz que ensinar exige segurança, competência profissional, compreensão de que a educação é uma forma de intervenção no mundo, que exige: liberdade e autoridade, consciência ao tomar decisões, saber ouvir, disponibilidade para o diálogo e querer bem aos educandos.

Identificando-nos com seu pensamento e baseados em nossa experiência, acreditamos que um/uma educador/a da área de saúde sexual e reprodutiva deveria:

- Gostar de educar: o/a educador/a deve ser uma pessoa comprometida com sua área de atuação na sociedade, ser um agente de transformação e ter coragem para conscientizar e estimular um processo de mudança. Entenda-se conscientização não apenas como conhecimento ou reconhecimento, mas como opção, decisão, compromisso.

- Facilitar o processo de ensino-aprendizagem: o/a educador/a deve ter humildade para reconhecer que "ninguém sabe tudo e ninguém ignora tudo. Todos sabemos algo e ignoramos algo" (Freire, 1993, p. 55). Para facilitar o processo, devem ser usados métodos e técnicas apropriadas, mas principalmente, é preciso que haja diálogo. O/a educador/a deve ter uma postura aberta e confiar na capacidade e no processo individual e grupal para criar, descobrir, aprender, crescer e transformar.

- Ajudar as pessoas e o grupo a construir sua própria autonomia, o que significa uma postura de respeito não paternalista.

- Facilitar a construção, num curso ou num programa, do vínculo afetivo entre os membros do grupo e da equipe de trabalho, especialmente quando se trata de assuntos como sexualidade, papéis do homem e da mulher, anticoncepção etc., já que esses temas afetam e mobilizam os/as provedores/as. Eles precisam se sentir num espaço em que haja confiança, para que possam refletir, opinar, falar sobre tais assuntos. Habitualmente é preciso passar por um processo de mudança interna para mudar externamente. Por exemplo, é preciso que as mulheres trabalhadoras da saúde mudem internamente as relações de poder. Elas precisam ser "empoderadas"[5] para possibilitar a mudança externa e assim facilitar a ocorrência dessas mudanças em outras mulheres (as usuárias).

  Para construir o vínculo afetivo, o/a educador/a precisa ter disponibilidade interna, conhecer as pessoas, reconhecer as diferenças e respeitá-las. É fundamental que domine as técnicas de comunicação interpessoal e saiba como "cuidar" do grupo e das pessoas com intencionalidade, para que esse conjunto de pessoas desenvolva uma rede de vínculos e consiga trabalhar em grupo, cuja força lhes permitirá superar as dificuldades e frustrações. Ao mesmo tempo, é importante que cada profissional, individualmente, seja livre e autônomo em sua maneira de ser, pensar e agir.

  Vínculo, segundo Margarida Serrão e Maria Clarice Baleeiro (1999), é a relação que se constrói entre as pessoas na convivência grupal. Ela tem um papel fundamental em qualquer ação que vise mudanças, já que funciona como o elo de uma corrente que liga os indivíduos, favorecendo a duplicação do modo de sentir e perceber a si mesmo e o outro.

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[5] Empoderamento é a tradução não dicionarizada do termo inglês *empowerment*. Denota o processo pelo qual as mulheres ganham poder interior para expressar e defender seus direitos, ampliar sua autoconfiança, identidade própria e auto-estima e, sobretudo, exercer controle sobre suas relações pessoais e sociais.
HERA: Health, Empowerment, Rights & Accountability. Empoderamento das Mulheres. p.1.

As autoras descrevem uma série de condições que os/as educadores/as precisam ter em conta para possibilitar a construção de vínculo, como: disponibilidade interna, aceitação das diferenças individuais, escuta e acolhimento oferecidos a todos, cuidado com o bem-estar do grupo, o imaginário do grupo, as relações pré-existentes etc.

- Ser referência: o/a educador/a deve funcionar como um ponto de referência ao longo do processo. Deve estar disponível para escutar, ajudar, motivar, informar, facilitar a reflexão e também para estabelecer limites para o grupo. Nesse sentido, é muito importante que o/a educador/a mantenha coerência entre teoria e prática. Por exemplo, recomendar aos provedores que respeitem as usuárias significa que o/a educador/a deve respeitar os/as educandos/as durante o curso.

  Como parte dessa referência, o papel do educador é manter a filosofia e os marcos de referência do projeto ou programa.

  Para que o/a educador/a possa desempenhar bem seu papel, é importante que ele/ela também mantenha uma postura de busca permanente, procurando sempre aprimorar o processo de formação, e uma postura de reflexão crítica sobre sua prática.

- *Marcos de Referência*

Um dos pontos críticos dos cursos que se destinam a preparar as/os profissionais é que eles não especificam os marcos de referência e até, às vezes, apresentam uma incoerência entre o discurso e a prática.

Por exemplo, os programas de planejamento familiar, tanto os que se destinam a preparar profissionais quanto os que são dirigidos às/aos usuárias/os, não

abordam a sexualidade como tema central, mas privilegiam as informações sobre anatomia e fisiologia do corpo e os métodos anticoncepcionais.

> Desse modo, ensinar como evitar uma gravidez usando um método anticoncepcional tem sido mais importante que refletir com a mulher, por exemplo, sobre seu direito de dizer sim ou não a uma relação sexual, de decidir por si própria se quer ou não engravidar, ou de reconhecer o seu corpo não só como fonte reprodutora, mas também como fonte de prazer e propriedade sua. (Díaz, 1999, p. 234)

Procurando manter a coerência para alcançar os objetivos propostos, os principais marcos de referência do projeto foram igualmente incorporados no processo de capacitação:

- *Enfoque Estratégico da OMS* – proporciona a visão do sistema de saúde como um todo, e do contexto sociopolítico, cultural e econômico em que está inserido.

- *Componente de Participação* – entendida como a representação efetiva de provedores, autoridades e principalmente da comunidade nos processos de tomada de decisão e em todas as atividades do projeto.

- *Contexto dos Direitos Sexuais e Reprodutivos* – são o ponto de partida e o ponto de chegada e significam: a) facilitar o exercício dos direitos sexuais e reprodutivos; b) diminuir as desigualdades de gênero que trazem sérias conseqüências à saúde sexual e reprodutiva de mulheres e homens.

Além disso, para a capacitação, baseamo-nos em alguns dos princípios pedagógicos descritos na publicação do Foro Latino-Americano "La Incorporación del Enfoque de Género en la Capacitación, Implementación y Evaluación en los Programas de Salud Sexual y Reproductiva", que tive a oportunidade de coordenar (Díaz e Spicehandler, 1997). Esses princípios são: processo, participação, facilitação, desconstrução e reconstrução, reconhecimento da diversidade do contexto cultural, compreensão da

subjetividade, individualização, intenção de mudança e integração com pesquisa e avaliação.

- *Seleção dos Participantes*

Outro ponto crítico é a seleção das pessoas que devem participar do curso de capacitação ou formação. Muitas vezes a escolha é feita por razões de amizade, por imposição, porque a chefia considera que uma determinada pessoa necessita aprender (castigo), ou enviam alguém que tem tempo para participar do curso.

Em experiências anteriores, quando o curso não era organizado em conjunto com o programa, os/as educadores/as não participavam da seleção dos/das participantes, nem faziam parte do programa, inclusive desconhecendo muitas vezes os próprios objetivos do programa. Dessa maneira, os objetivos da capacitação não tinham a intencionalidade de ir além dos objetivos de aprendizagem do curso, e com isso não se dava seguimento às atividades realizadas pelos profissionais que dele participaram. Ou seja, o foco se situava em alguns conteúdos teóricos e não num modo de os incorporar na prática, processo que muitas vezes não é desenvolvido pelos profissionais como se espera. Diferentes avaliações realizadas têm mostrado que a inadequada seleção dos/das participantes resulta em um número significativo de pessoas que na prática nunca aplicam o aprendido, porque mudam de área, se aposentam, ou porque já desenvolviam atividades administrativas e foram “capacitados” para atender usuárias, por exemplo. Enfim, um sem-número de razões apontam para o fato de que a seleção das pessoas é crucial.

Nossa experiência mostrou que a seleção deve começar com as pessoas que já estão motivadas a participar. Elas próprias vão iniciar o processo e atrairão outras pessoas que também vão se interessar. Também é importante pensar nelas como parte de um grupo. Quando o grupo é muito heterogêneo e/ou

quando há muita desigualdade de poder (chefe e auxiliar de limpeza), o manejo e a constituição do grupo tornam-se mais difíceis.

Também é importante identificar e considerar as necessidades reais dos/as participantes e, com base nisso, formular claramente os objetivos do processo educativo a curto e longo prazo. A partir dessa informação, deve-se identificar os conteúdos do curso.

A seleção dos/das participantes e o conhecimento das informações sobre eles é fundamental não somente para a elaboração do programa, mas para a escolha das técnicas e materiais educativos que serão utilizados para facilitar o processo de ensino-aprendizagem.

- *Materiais Educativos*

Esta é uma das ferramentas cruciais de apoio ao processo de ensino-aprendizagem, tanto em relação aos provedores, quanto à comunidade.

Em minha experiência de trabalho na área da saúde sexual e reprodutiva, no Brasil e em outros países da América Latina, tenho constatado que tanto os materiais produzidos para os cursos, e principalmente os utilizados com as usuárias (pôsteres, vídeos, álbum seriado, folhetos), são elaborados por uma equipe alheia ao programa e sem participação da população a quem se destinam. Além disso, são amplamente reproduzidos e distribuídos, sem que haja um pré-teste ou preparo necessário à sua utilização.

Com base nesses dados, como parte do projeto, foram elaborados alguns materiais destinados a servir de apoio às atividades educativas implementadas. Para isso, seguimos o método empregado na elaboração de materiais do Program for Appropriate Technology in Health - Path (1992).

Tanto em relação a um novo material quanto aos já existentes, consideramos que devemos ter claros os marcos de referência. Por exemplo, se o programa e o curso de formação têm como objetivo diminuir as desigualdades entre os gêneros, e nos folhetos mostram-se desenhos que perpetuam os papéis tradicionalmente determinados pela sociedade para homens e mulheres, estamos sendo contraditórios. Se esses desenhos fossem usados para um trabalho de reflexão, eles seriam adequados, mas o problema é que são usados sem essa percepção, portanto, a contradição deixa de ser trabalhada.

Também aprendemos que só ter bons materiais não é suficiente. É necessário também aprender como usá-los, quando e com quem.

- *Metodologia Participativa*

O processo educativo é um processo de ensino-aprendizagem no qual, como dizia Paulo Freire, quem ensina aprende ao ensinar e quem aprende ensina ao aprender. *"*...ensinar não é transferir conhecimento, mas criar as possibilidades para a sua própria produção ou a sua construção" (Freire, 2001, p. 25).

Contudo, é fundamental o método que se usa para ensinar e, logicamente, o educador que manipula esse método, a posição em que ele se coloca e as condições que cria para que as pessoas sejam realmente sujeitos de seu processo de construção e reconstrução do conhecimento.

Nos últimos anos tem sido incorporada nos cursos uma série de "técnicas" de trabalho em grupo, também chamadas de "dinâmicas de grupo", com o objetivo de facilitar a participação das pessoas no processo, permitindo a criação de um ambiente de aprendizagem e melhorando as relações entre os/as participantes e a dinâmica ou movimento do grupo.

Entretanto, observamos que às vezes também são usadas técnicas participativas e vivenciais, mas dentro de uma concepção de educação incoerente com a "real" participação e sem que se esteja preparado para lidar com elas. Têm-se observado resultados desastrosos com as pessoas que participam dessas experiências, criando, muitas vezes, resistências para futuras atividades desse tipo.

Em nossa experiência, procuramos ser muito rigorosos com o método usado, mantendo a flexibilidade de uma metodologia participativa, libertadora e comprometida com o empenho em mudar a realidade da saúde pública no país.

- *Supervisão: uma Etapa do Processo*

A supervisão, tradicionalmente, tem sido realizada e vista pelas pessoas como uma ação punitiva que se baseia na crítica, que visa "controlar" as pessoas, colocando nelas e não no processo seu foco, além do que baseia-se no passado e não no futuro, que em geral é uma ação esporádica não planejada como parte do programa.

E esse constitui um dos grandes desafios que não conseguimos vencer completamente: mudar esse conceito de supervisão. Entendemos a supervisão como uma etapa do sistema de gerenciamento de um programa. É também uma etapa que dá continuidade às atividades de capacitação. Consiste em um seguimento sistematizado, contínuo e analítico do processo de melhoria da qualidade de atenção que inclui ações e intervenções destinadas a alcançar os objetivos propostos (das pessoas individualmente e do programa).

Os principais objetivos da supervisão incluem:

- auxiliar a equipe de saúde no processo de mudança para melhorar a qualidade de atenção e ajudar a manter a motivação;

- avaliar como está sendo realizado o processo de implementação das ações;
- garantir os marcos de referência do programa, identificando que aspectos ou ações não estão sendo desenvolvidos conforme o estabelecido e auxiliando, ao fornecer as informações necessárias à busca de soluções;
- facilitar o diálogo e a comunicação entre as pessoas, de maneira a fortalecer o trabalho em equipe;
- verificar o registro das informações e coletar dados que ajudem principalmente na avaliação do processo, assim como possibilitar que a equipe use essas informações para uma retroalimentação contínua.

Consideramos que o planejamento de uma estratégia de supervisão e a formação de profissionais que possam atuar como supervisores/as é condição que garante melhores resultados. Neste ponto, novamente o processo educativo é crucial, no sentido de preparar profissionais para desempenhar essa função. Eis algumas das características que deve ter a pessoa que realizará a supervisão:

- ter participado do curso de capacitação;
- conhecer bem o programa e seus objetivos;
- ter claro o papel que desempenhará e seus limites;
- saber lidar com os “instrumentos” de supervisão;
- conhecer e usar as técnicas de comunicação;
- ser assertivo/a;
- ter facilidade para estabelecer relações profissionais;
- estar disponível e ter tempo para elaborar e cumprir o plano de supervisão.

- *Avaliação: Processo Contínuo*

Há várias definições sobre avaliação e muitas maneiras de realizá-las.

A avaliação é um processo contínuo e participativo que deve permitir não só que se possam medir os resultados, como também orientar o foco para o processo, visando à aprendizagem, retroalimentação, identificação de novas necessidades e elaboração de propostas.

Baseados nessa experiência, poderíamos nos inscrever na definição de avaliação de Michael Patton (1994), “Developmental Evaluation”, que traduziremos como “Avaliação do Desenvolvimento”, que ele inicia analisando sinônimos do termo “develop” como: melhorar, criar, formar, mudar etc., afirmando que em geral o termo “desenvolvimento” carrega uma conotação negativa em alguns setores.

Ele define avaliação de desenvolvimento como *“*o processo de longo prazo, em relações de parceria engajadas no desenvolvimento de programas” (Patton, 1994, p. 312).

Ainda segundo Patton, a avaliação de desenvolvimento não é um modelo. É uma relação na qual se compartilha um propósito: o desenvolvimento. Nessa relação, o avaliador, que é parte da equipe, contribui com o conhecimento sobre a avaliação de programas e alguma experiência para ajudar a estabelecer o sistema de supervisão e retroalimentação. O papel da pessoa que atua como “avaliador” é facilitar as discussões sobre a maneira de avaliar o que está acontecendo e participar junto com o restante da equipe das decisões sobre o modo de aplicar os resultados para a próxima etapa.

Para nós, pesquisadores, um dos aspectos difíceis foi incorporar outras pessoas, provedores e a própria comunidade no processo de avaliação, porque isso requer o domínio de alguns conhecimentos específicos e alimentávamos o preconceito de que era difícil transferir esse tipo de informação. Percorremos um longo caminho de aprendizagem e reflexão sobre

as relações de poder entre os membros da equipe de saúde, com a comunidade, entre os/as pesquisadores e a equipe.

Aprendemos que isso é possível. Aprendemos também que quando a participação de todos os envolvidos no sistema de saúde se dá ao longo de todas as etapas de implementação de um programa, desde o diagnóstico (que já é uma avaliação), o processo de implementação, a supervisão e a avaliação propriamente dita, sem dúvida, a equipe "aprende" a desenvolver autonomia para elaborar e implementar propostas e organizar um programa de boa qualidade. Por exemplo, em Santa Bárbara d'Oeste, a implementação do programa de saúde sexual e reprodutiva resultou em um aumento importante no número de consultas. No primeiro ano houve um aumento de 22.6% em relação ao número total de consultas na área de saúde sexual e reprodutiva e de 47.5% dois anos após a implementação.

Considerando somente as consultas no âmbito do planejamento familiar houve um aumento de 114% no primeiro ano e, dois anos após a implementação, o número de consultas era quatro vezes maior que no início do projeto (Díaz *et al.*, 1999). Entretanto, um dos resultados que mostra a sustentabilidade das ações realizadas é o processo de expansão realizado no próprio município, pela equipe local.

Uma das ações foi a implementação de um Centro de Referência em Saúde Sexual e Reprodutiva, que atende pessoas que se consultam sobre planejamento familiar e detecção precoce de câncer cérvico-uterino em esquema de agenda aberta, com ações educativas participativas. Também foi aberto um espaço para a participação do homem no planejamento familiar, oferecendo vasectomia e o programa de adolescentes.

A população avaliou muito bem a atenção desse Centro e reivindicou a necessidade de uma unidade na zona Leste, por uma questão de facilidade de acesso.

Foi implementado o segundo Centro de Referência, com recursos locais, e o primeiro Centro de Referência atuou como "Centro Capacitador" para a equipe do segundo Centro.

Além disso, a equipe local conseguiu mobilizar recursos para outros projetos, como "pré-natal humanizado", violência contra a mulher etc., o que sem dúvida tem contribuído para continuar melhorando a qualidade de atenção nessa área.

- *A Capacitação como Desenvolvimento Organizacional*

Se analisarmos as principais características e objetivos do processo de capacitação que foi realizado ao longo do projeto, à luz das principais características que distinguem o desenvolvimento organizacional, encontramos uma grande semelhança.

De maneira didática, faremos uma rápida comparação:

1. O D.O. focaliza cultura e processos	**1.** A capacitação visa uma mudança de "cultura" e dos processos (no sistema de saúde e na sociedade)
2. O D.O. estimula a colaboração entre os líderes da organização e os membros	**2.** A capacitação focaliza os provedores, chefias e as autoridades de saúde, promovendo o trabalho colaborativo e participativo, incluindo também as pessoas da

	comunidade
3. As equipes de todas as classes são particularmente importantes para alcançar as tarefas e são alvos para as atividades de D.O.	**3.** A capacitação incorpora todas as pessoas do sistema de saúde e facilita a identificação de papéis e funções para alcançar os objetivos do programa.
4. O D. O. focaliza o lado humano e social das organizações e, ao mesmo tempo, também intervém nos aspectos tecnológicos e de estrutura	**4.** A capacitação incorpora nos provedores uma visão holística e integral das pessoas e, ao mesmo tempo, prepara-as para lidar com os aspectos técnicos (manejo de tecnologia) e administrativos (de organização) do sistema
5. Participação e envolvimento na solução de problemas e tomada de decisões por todos os níveis de uma organização.	**5.** A capacitação segue os marcos de referência do projeto, no qual é crucial o aspecto de participação e envolvimento de todos dos atores na identificação de problemas e nas decisões acerca das soluções.
6. O D.O. focaliza a mudança de todo o sistema e vê as organizações como um complexo sistema social	**6.** A capacitação focaliza todo o sistema de saúde e vê o programa de saúde sexual e reprodutiva de uma maneira holística
7. Os praticantes de D.O. são facilitadores, colaboradores e co-aprendizes, com a clientela.	**7.** Os/as capacitadores/as são facilitadores, colaboradores e co-autores do processo de mudanças, junto aos provedores e à comunidade.
8. Uma grande meta do D.O. é tornar	**8.** Um dos objetivos da capacitação é

as pessoas capazes de resolver problemas por si próprias, ensinando as habilidades e conhecimentos por meio de um método de aprendizagem contínuo.	tornar as pessoas autônomas e solidárias, utilizando um processo contínuo de ensino-aprendizagem e focalizando aspectos cognitivos, afetivos e de habilidades.
9. O D.O. confia num modelo de pesquisa com extensa participação dos seus membros.	**9.** A capacitação utiliza uma metodologia participativa e está inserida no projeto de pesquisa participativa, no qual a ação e a educação são componentes básicos da mudança.
10. O D.O. busca a melhoria de ambos, indivíduos e organizações. Tenta criar soluções de “ganhar-ganhar”, como prática nos programas de D.O.	**10.** A capacitação procura a melhoria de profissionais, serviços e comunidade. Mediante a capacitação, as/os participantes aprendem a visualizar que, ao considerar tanto a perspectiva das usuárias como a dos provedores, os resultados são altamente satisfatórios para ambos.

Revisando a literatura internacional, com o objetivo de comparar o que nós aprendemos sobre o processo de capacitação em planejamento familiar, encontramos que em 1998 surgiu uma nova abordagem para a organização dos processos de capacitação nesta área, onde as autoras analisam algumas das limitações encontradas, as quais guardam muitas semelhanças com as identificadas em nossa experiência (Bradley *et al*., 1998)

Algumas delas são:

- que a capacitação organiza-se separadamente do sistema de supervisão;
- há falta de seguimento;
- os conhecimentos e habilidades adquiridos não são aplicados no trabalho das pessoas;
- os cursos de capacitação focalizam muito as pessoas e pouco o serviço em que elas trabalham;
- a seleção é imprópria;
- os conteúdos e tempo para os cursos são inadequados;
- a capacitação é centralizada e muito específica, incapaz de atender à demanda de serviços mais integrais;
- os serviços precisam ser interrompidos para que os provedores possam freqüentar os cursos.

Considerando as novas propostas dessas autoras e nossa própria aprendizagem, torna-se necessário dispor de mais avaliações sobre esses processos educativos que possam contribuir para melhorar a nossa prática.

4.2. A Integração de Educação e Saúde

Falar de integração entre educação e saúde pressupõe que há uma separação, e propor uma integração poderia significar uma aceitação de que ambas podem juntar-se para se completar, mas que continuarão separadas.

Essa contradição é um dos primeiros aspectos que, em minha opinião, precisaria ser discutida.

Minha visão de educação e de saúde e, portanto, de vida, de mundo e de pessoa, é que elas não poderiam estar separadas. Com isso não estou propondo uma disciplina “educação e saúde”, embora ela possa existir, mas sim sugerindo que a

educação deveria perpassar toda a formação dos profissionais da saúde, assim como a saúde deveria ser parte da formação dos educadores.

Certamente isso implica uma compreensão dos conceitos de educação e saúde diferente da que na prática se utiliza na formação dos profissionais de saúde.

Ao longo deste trabalho foram levantados aspectos críticos da atuação dos profissionais de saúde, entretanto, penso que é necessário relacionar essa atuação com sua formação, com as políticas de saúde, enfim, com os modelos de saúde e de educação inerentes ao sistema político e econômico de nossa sociedade.

Fazendo um rápido exercício de reflexão sobre a falta de educação na saúde, é possível constatar que as faculdades de medicina, por exemplo, fazem educação sem ter os subsídios teóricos da educação, fazem parte do mundo das ciências, que tem um conhecimento técnico específico do qual o ser humano depende para curar doenças e evitar a morte.

Este “saber” lhe outorga “poder”, e é nessas relações de poder que se dão as relações com o restante das pessoas que não fazem parte desse mundo. Se a educação (libertadora e visando à autonomia) estivesse incorporada no ensino dos profissionais da saúde e esse “saber” fosse compartilhado, diminuiriam as relações de poder.

Em relação a compartilhar conhecimentos, não estou querendo dizer que as pessoas deveriam aprender a fazer cirurgia ou colocar um dispositivo intra-uterino, compartilhar conhecimentos significa, por exemplo, que as pessoas deveriam receber informações sobre seu estado em linguagem simples, que as bulas deveriam estar escritas de um modo que as pessoas que não dominam a linguagem técnica pudessem ter acesso a informações úteis para elas. Observa-se, no entanto, que a bula e outros materiais com propósitos supostamente

informativos deixam a pessoa ainda mais confusa e com medo, o que em vez de ajudar muitas vezes prejudica.

A incorporação da visão libertadora da educação na saúde e da saúde (não doença) na educação, contribuiria para o verdadeiro exercício de cidadania, ou seja, as pessoas deveriam assumir o compromisso de cuidar de si mesmas, contando com os serviços das unidades de saúde (saneamento básico, limpeza, banheiros etc.). Atualmente a população não tem consciência de que os serviços pertencem à população e que ela deve contribuir para mantê-los. É importante discutir com a comunidade que o exercício dos direitos significa também assumir compromissos.

Cabe aqui a interrogação sobre como conseguir juntar ou integrar o que está separado.

Uma das experiências de nosso projeto, que se propôs a integrar não só as ações da educação e da saúde, mas também as Unidades de Saúde e as Escolas, foi o Programa de Adolescentes, implementado no município de Santa Bárbara d'Oeste e, posteriormente, implementado em outros municípios incluídos no projeto.

Na expansão do Programa de Adolescentes para outras cidades, foram capacitados, juntos, profissionais de saúde e professores das escolas. Também foi capacitado um grupo de adolescentes destinado a atuar como agentes voluntários de saúde nas escolas, no centro de saúde e na comunidade, fazendo educação de seus pares.

O fato de os adolescentes e educadores conhecerem a unidade de saúde e os profissionais que ali atuam tem facilitado o acesso das/os adolescentes e o trabalho conjunto de prevenção de gravidez não planejada e de doenças sexualmente transmissíveis. A capacitação também permitiu que os educadores adquirissem confiança para trabalhar esses assuntos em sala de aula. Cada

profissional aprendeu a identificar os limites de sua atuação. Por exemplo, o professor não deve fazer diagnóstico mas pode facilitar o diálogo, a discussão, a incorporação das informações e a construção de um projeto de vida em que os próprios adolescentes assumam o compromisso de lutar por uma vida melhor. Os profissionais da saúde entenderam que a consulta é também um espaço educativo. É uma das ações educativas mais importantes, na qual os adolescentes devem ser tratados como pessoas, como sujeitos de direito.

No diagnóstico verificou-se que os/as adolescentes não procuravam a unidade de saúde para solicitar métodos anticoncepcionais por não serem bem recebidos. Frases como "você ainda é muito criança para isso", "sua mãe já sabe que você está aqui?" ou "você deveria estar brincando com bonecas" foram relatadas pelas adolescentes que, por falta de atenção e orientação e não de informação, engravidaram sem que tivessem planejado.

A integração da educação com a saúde também se deu entre as Secretarias de Educação e da Saúde, permitindo uma utilização mais racional dos recursos em benefício da população adolescente.

A partir dessa experiência foi possível vislumbrar alguns caminhos: primeiro, reconhecer a mencionada separação entre as duas áreas e a denúncia sobre suas conseqüências na vida das pessoas e, segundo, levar essa questão para ser discutida em diferentes instâncias e fóruns, principalmente nas próprias universidades, para influenciar a formação dos profissionais.

Além disso, na prática com os profissionais atuantes, facilitar a avaliação crítica a partir do que acontece na realidade. Por exemplo, por que nas escolas, quando precisam falar do risco de gravidez e de doenças sexualmente transmissíveis, eles chamam um profissional da saúde? Por que se aborda a reprodução separada da sexualidade?

Avaliando a prática e revendo a realidade, pode-se mudar. O encontro, o diálogo de profissionais das duas áreas podem desconstruir e reconstruir a concepção de saúde e de educação atualmente em vigência em nossa sociedade.

Essa é uma das tarefas pendentes e um dos grandes desafios: conseguir integrar educação e saúde, não somente na discussão dos conceitos, mas também nas ações, de maneira a se promover a melhoria da qualidade de saúde e de vida das pessoas.

4.3. Projeções: Incorporação dessa Abordagem nas Faculdades

A implementação da nova estratégia no Brasil é um processo longo, complexo, que exigiu um grande esforço e um alto grau de compromisso de todos os participantes. Isso é um fato já aceito quase unanimemente no campo do desenvolvimento organizacional. Por exemplo, Klinmahorm e Ireland (1992) afirmam que "...não parece apropriado nem útil encarar a expansão das intervenções como um produto que possa ser completado num tempo fixo.... É um processo que se completa num tempo longo e indefinido" (p. 68).

No Brasil, a duração do processo foi variável nos diferentes municípios, mas levou a resultados positivos em todos eles, de acordo as avaliações, interna e externa, realizadas.

Entretanto, o grande desafio é a manutenção dessa nova metodologia participativa nos municípios, assim como a expansão da experiência para outros municípios, mantendo a filosofia e os marcos de referência utilizados.

Esse é o principal objetivo do projeto que estamos realizando atualmente, uma proposta que foi desenvolvida pela autora em colaboração com a Dra. Ruth Simmons, da Universidade de Michigan, e o representante do Population Council no Brasil, Dr. Juan Díaz, ambos participantes da implementação da estratégia no

Brasil. O projeto, denominado “Projeto Reprolatina”, foi aprovado pela Fundação Gates, que fez uma doação para apoiá-lo por cinco anos (2000 – 2004).

As principais estratégias para a expansão são a formação de Centros de Educação e Capacitação e a criação de uma rede eletrônica de comunicação por meio de um “web-board” (comunicação interna entre os municípios participantes) e um site www.reprolatina.net, que já está disponível na rede internacional.

Este projeto está atualmente sendo apoiado pelo Ministério da Saúde, que também participou da implementação do enfoque estratégico desde o início. O apoio do Ministério está centrado, atualmente, no suporte que dá aos Centros de Capacitação para que atuem como multiplicadores do processo. Além disso, o Projeto Reprolatina está colaborando com algumas Secretarias de Educação, no Estado de Minas Gerais, com apoio da Fundação Odebrecht, na implementação de Programas de Adolescentes (integrando educação e saúde), a partir da experiência do Programa de Adolescentes implementado na Etapa II, em Santa Bárbara d’Oeste. O componente fundamental é a capacitação de educadores, de profissionais de saúde, de adolescentes e de pais.

Os primeiros resultados do novo projeto tem nos mostrado bons resultados e também algumas limitações. Entre as limitações, também encontradas na etapa anterior, está a mudança de governo e a contínua troca de profissionais, o que torna o processo ainda mais lento.

O processo de avaliação contínua, as leituras, as discussões da equipe, etc., têm me levado a fortalecer a idéia de levar essa nova abordagem também para as universidades.

Se fizermos um rápido reconhecimento do que acontece atualmente com a formação nas faculdades dos profissionais de saúde, observaremos um ensino alienado e não comprometido com a saúde pública.

Os profissionais habitualmente nem sequer conhecem os lugares onde moram as pessoas que eles atendem, não conhecem o que pensam, como vivem, quais são suas expectativas, enfim, estão distantes da população. Além disso, as experiências de projetos como o nosso não são divulgadas nem conhecidas, e muito menos são utilizadas no ensino.

Habitualmente também se valoriza muito mais a tecnologia do que os aspectos humanos como as relações entre as pessoas, a comunicação, a motivação etc.

Tem sido muito gratificante a experiência de alguns cursos de que participam professores da faculdade de medicina, e eles têm se expressado assim: *"*se eu tivesse participado de um curso como este, minhas pacientes seriam mais bem atendidas e meus alunos aprenderiam de modo diferente".

Visualizo uma transformação real nos serviços de saúde e nas políticas de saúde, uma vez que os novos profissionais que estão se formando conheçam e participem de experiências como esta. Penso que os profissionais têm que sair de dentro da universidade para conhecer a realidade social e cultural e dialogar com as pessoas com que se relacionarão. Ao mesmo tempo, penso que as faculdades têm que abrir as portas e talvez organizar esse tipo de Comitê Executivo com a participação de todas as pessoas que fazem parte do sistema de saúde, principalmente da comunidade usuária. Diminuindo essas distâncias, possibilitando o diálogo, facilitando o espaço de participação, unindo e somando esforços, apostando nos profissionais que estão em formação e estendendo seu conhecimento para a própria comunidade, poderemos construir um sistema de saúde mais atuante e uma sociedade melhor.

Reconheço que não é uma tarefa fácil, mas também penso que é possível. O importante neste momento é colocar o assunto em discussão, para que as pessoas nos diferentes espaços falem, identifiquem novas possibilidades e

principalmente se posicionem e se comprometam com as mudanças necessárias para melhorar a qualidade da saúde sexual e reprodutiva e a qualidade de vida das pessoas.

Referências Bibliográficas:

ÁVILA, M.B.; CORRÊA, S. O movimento de saúde e direitos reprodutivos no Brasil: revisitando percursos. In: GALVÃO, L.; DÍAZ, J. (Org.). **Saúde sexual e reprodutiva no Brasil.** São Paulo: Hucitec, Population Council, 1999. p. 70-103.

AVSC INTERNATIONAL. **Cope: client-oriented, provider-efficient services**. New York, USA: AVSC International, 1995.

BARRETO, V. **Paulo Freire para educadores**. 3ª Edição. São Paulo: Arte e Ciência, 1998. 138 p.

BEMFAM - SOCIEDADE CIVIL BEM-ESTAR FAMILIAR NO BRASIL. **Brasil: pesquisa nacional sobre saúde materno-infantil e planejamento familiar – Brasil, 1986.** Rio de Janeiro, 1987. 234p.

_____. **Brasil: pesquisa nacional sobre demografia e saúde - 1996.** Rio de Janeiro, 1997. 182 p.

BERQUÓ, E.S. **Sobre o declínio da fecundidade e a anticoncepção em São Paulo (análise preliminar).** Campinas: Nepo/Unicamp, 1986. 51p.

_____. **A anticoncepção e a população brasileira na virada do século.** São Paulo: Nepo/Unicamp, 1987. 17p.

BERQUÓ, E.S.; ARAÚJO, M.J.O.; SORRENTINO, S.R. O caso brasileiro. In: **Fecundidade, saúde reprodutiva e pobreza na América Latina.** São Paulo: Cebrap/Nepo/Unicamp, 1995. V. 1, 199p.

BRADLEY, J; LYNAM, P.F.; DWYER, J.C.; WAMBWA; G.E. Whole-site training: a new approach to the organization of training. **AVSC working paper,** v.11, p. 2-16. 1998.

BRANDÃO, C.R. Pesquisar – participar. In: _____ (org). **Pesquisa participante**. 7ª Edição. São Paulo: Brasiliense, 1988. p. 9-16.

BRASIL. **Constituição da República Federativa do Brasil**. São Paulo: Imprensa Oficial do Estado, 1988.

BRASIL. Ministério da Saúde – Programa Nacional de DST/Aids. **Educação em saúde escolar para prevenir DST/AIDS e drogas.** 1997.

BRASIL. Ministério da Saúde. www.saude.gov.br

BRASIL. Secretaria de Educação Fundamental. **Parâmetros curriculares nacionais: terceiro e quarto ciclos: apresentação dos temas transversais**. Secretaria de Educação Fundamental. Brasília: MEC/SEF, 1998. 436 p.

BRUCE, J. **Fundamental elements of the quality of care: a simple framework.** New York: Population Council. Programs Division. Working Papers nº 1, 1989. 90p.

CABRAL, F.; DÍAZ, M. Relações de gênero. In: SECRETARIA MUNICIPAL DE EDUCAÇÃO DE BELO HORIZONTE; FUNDAÇÃO ODEBRECHT. **Cadernos afetividade e sexualidade na educação: um novo olhar**. Belo Horizonte: Gráfica e Editora Rona Ltda, 1998. p. 142-150.

CARTA DE OTTAWA. Ottawa 21 de novembro de 1986. Disponível em: http://www.saudeemmovimento.com.br/profissionais/legislation/index.htm. Acesso em: 30 agosto 2001.

CECATTI, J.G. **Análise da mortalidade materna no município de Campinas, no período de 1985 a 1991.** 1992. 113 f. Tese (Doutorado em Ciências Médicas) - Curso de Pós Graduação em Ciências Médicas, Universidade Estadual de Campinas, São Paulo.

CEMICAMP; FUNDAÇÃO ODEBRECHT. **Relatório da avaliação externa do projeto de educação afetivo-sexual. Belo Horizonte,** 1999a. 116p.

_____. **Relatório da avaliação externa do projeto de educação – um exercício de cidadania. Salvador,** 1999b. 136p.

_____. **Sucessos e desafios da educação sexual de adolescentes da rede pública estadual de ensino do Rio de Janeiro. Projeto Educarte,** 1999c. 130p.

CONFEREÊNCIA INTERNACIONAL SOBRE POPULAÇÃO E DESENVOLVIMENTO – CIPD. **Relatório da conferência internacional sobre população e desenvolvimento**. Tradução revisada por: Sônia Correa. Cairo, Egito, 5 a 13 de setembro de 1994. Brasília: FNUAP; CNPD, s/d. 199 p.

DADOS DO SUS. Nascidos vivos – Brasil. Disponível em: http://www.tabnet.datasus.gov.br/cge/tabcge.exe?SINASC/cnv/nvuf.def. Acesso em: 17 julho 2001.

DELORS, J. **Educação: um tesouro a descobrir**. Relatório para a UNESCO da Comissão Internacional sobre Educação para o século XXI. 5ª Edição. São Paulo: Cortez; Brasília, DF: MEC: UNESCO, 2001. 288 p.

DÍAZ, M. **Condutas sexuais e atitudes que constituem fatores de risco para gravidez não desejada e AIDS em estudantes universitários:** um desafio para

a educação sexual. 1994. 78 f. Dissertação (Mestrado em Educação) – Curso de Pós Graduação em Educação, Universidade Estadual de Campinas, São Paulo.

DÍAZ, M.; SPICEHANDLER, J. Foro Latinoamericano. **La incorporación del enfoque de género en la capacitación, implementación, investigación y evaluación en los programas de salud sexual y reproductiva.** Washington: ICRW, 1998. 36p.

DÍAZ, M.; SIMMONS, R.; DIAZ J; GONZALES, C; MAKUCH, M.Y.; BOSSEMEYER, D. Expanding contraceptive choice: findings form Brazil. **Studies in family planning,** v. 30, n. 1, p. 1-16, 1999

DIAZ, M. e SIMMONS, R. When is research participatory? Reflections on a reproductive health project in Brazil. **Journal of women's health,** v. 8, n. 2, p. 175-184, 1999.

DIAZ, M. Educação sexual e planejamento familiar. In: RIBEIRO, M. (org.). **O prazer e o pensar: orientação sexual para educadores e profissionais de saúde**. V. 2. São Paulo: Gente, 1999. p. 229-240.

_____. Final Technical Report: **Evaluating the project 96323 "Brazil stage III: researching the utilization and dissemination of findings from a project on the improvement of contraceptive choice within the context of reproductive health"**. Campinas: Cemicamp, 2000. 82 p.

FAMILY CARE INTERNACIONAL. **Acción para el siglo XXI. Salud y derechos reproductivos para todos.** New York, 1994. 53p.

FAÚNDES, A.; HARDY, E. From birth control to reproductive health. **International Journal of Gynecology & Obstetrics,** v.49, p. 55-62, 1995.

FAÚNDES, A.; RODRIGUEZ-GALANT, G.; AVENDANO, O. The San Gregorio experimental family planning program: changes observed in infertility and abortion rates. **Demography**: 836-845, 1968.

FERREIRA, A.B.H. **Novo dicionário Aurélio da língua portuguesa**. 1ª Edição, 15ª Impressão. Rio de Janeiro: Nova Fronteira. s/d. 1499 p.

FREIRE, P. **Extensão ou Comunicação**. 10ª Edição. Tradução de Rosisca Darcy de Oliveira. São Paulo: Paz e Terra, 1992. 93 p.

_____. **Professora sim, tia não: cartas a quem ousa ensinar**. São Paulo: Olho d'Água. 1993. 127 p.

_____. **Educação como prática da liberdade**. 23ª Edição. São Paulo: Paz e Terra, 1999. 158 p.

_____. **Pedagogia do oprimido**. 29ª Edição. São Paulo: Paz e Terra, 2000a. 184 p.

_____. Aprofundamento Teórico. Revista Presença Pedagógica, Belo Horizonte, Jan/Fev 1995. Entrevista concedida a Neidson Rodrigues. In: SECRETARIA DE ESTADO DA EDUCAÇÃO, GOVERNO DO ESTADO DO RIO GRANDE DO SUL. Caderno temático da constituinte escolar: conhecimento científico e saber popular. Porto Alegre, RS: Secretaria de Estado da Educação, 2000b. cad. 7. p. 6-8.

_____. **Pedagogia da autonomia: saberes necessários à prática educativa.** 17ª Edição. São Paulo: Paz e Terra, 2001. 165p.

FRENCH, W. L.; BELL, C.H. **Organization development: behavioral science interventions for organization improvement.** International sixth edition. New Jersey: Prentice-Hall, 1999. 343p.

GALVÃO, L. Saúde sexual e reprodutiva, saúde da mulher e saúde materna: a evolução dos conceitos no mundo e no Brasil. In: GALVÃO, L. e DÍAZ, J. (Org.). **Saúde sexual e reprodutiva no Brasil.** São Paulo: Hucitec, Population Council, 1999. p. 165-179.

GARCÍA, R.D.; STYCOS, J.M.; ARIAS, J. Prólogo. In: _____ (Ed.). **El Dilema de la población em America Latina.** Cali, Colombia: Universidad del Valle, 1968. p. 11-15.

GIROUX, H. Teoria crítica e prática educacional. In: _____. **Teoria crítica e resistência na educação**. Petrópolis: Vozes, 1986. p. 21-24.

GLOBAL WORKING GROUP MEETING, 1998, Bellagio. **Informed choice in international family planning service delivery. Strategies for the 21st century**. New York: AVSC International, 1999. 50p.

GYSLING, J. Salud y Derechos Reproductivos: Conceptos en Construcción. In: VALDÉS, T. e BUSTOS, M. (Ed.). **Sexualidad y reproducción: hacia la construcción de derechos.** CORSAPS/FLACSO. Santiago, Chile: Salesianos, 1994. p. 13-26.

HERA: Health, Empowerment, Rights & Accountability. Empoderamento das Mulheres. In: **Direitos sexuais e reprodutivos e saúde das mulheres. Idéias para ação**. New York, USA: Hera, s/d. p. 1.

HULL, V.J. **Improving quality of care in family planning: How far have we come?** Jakarta: South & East Asia. Regional Working Paper, nº 5, 1996.

IBGE. Dados históricos dos censos. Disponível em: http://www.ibge.gov.br/ibge/estatistica/populacao/censohistorico. Acesso em: 17 julho 2001.

INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT PROGRAM OF ACTION (ICPD). Cairo, Egito, 1994.

KLINMAHORM, S.; IRELAND K. NGO – government collaboration in Bangkok. In: EDWARDS, M. e HULMES, D. (Ed.). **Making a difference: NGOs and development in a changing world.** London: Earthscan Publications, 1992. p. 60-69.

LAURENTI, R.; BUCHALLE, C.M.; LOLIO, C.A.; SANTO, A.H.; JORGE, M.H.P.M. Mortalidade de mulheres em idade fértil no município de São Paulo (Brasil), 1986. I metodologia e resultados gerais. **Revista de Saúde Pública**, São Paulo, v. 24, p. 128-133, 1990.

LOURO, G.L. **Gênero, sexualidade e educação – uma perspectiva pós-estruturalista**. 2ª Edição. Petrópolis, RJ: Vozes, 1998. 179p.

MAGUIRE, P. **Doing participatory research: a feminist approach.** Amherst, Massachusetts, USA: The Center for International Education. School of Education. University of Massachusetts, 1987. 253p.

MARIN, A.J. Educação continuada: introdução a uma análise de termos e concepções. In: CADERNOS CEDES 36. **Educação Continuada.** 1ª edição. Campinas, SP: Papirus, 1995. p.13-20.

MINELLA, L. S. A produção científica sobre esterilização feminina no Brasil nos anos 80 e no início dos 90: um debate aberto. **Revista Brasileira de Estudos Populacionais de Brasília,** v. 15, n. 1, p. 3-22, 1998.

NOGUEIRA, A. (org.). **Estendendo fronteiras: a extensão e a pesquisa na formação do educador**. Taubaté: Cabral Editora Universitária, 2001. 79p.

NOVAK, J.D. **Uma teoria de educação.** Biblioteca Pioneira de Ciências Sociais. São Paulo, SP: Pioneira, 1981. 252 p.

ORGANIZAÇÃO DAS NAÇÕES UNIDAS. **IV Conferência mundial sobre a mulher**. Beijing, China – 4 a 15 de setembro de 1995. Rio de Janeiro: FIOCRUZ, 1996. 352p.

OSIS; M.J. PAISM: um marco na abordagem da saúde reprodutiva no Brasil. **Cadernos de Saúde Pública,** v. 14, n. 1, p. 25-32, 1998.

PARIANI, S. **Continued use of contraceptives among clients is East Java, Indonesia.** 1989. Ph.D. Dissertation. Department of Sociology, University of Southern California. Los Angeles.

PATTON, M.Q. Developmental Evaluation. **Evaluation Practice,** v. 15, n. 3, p. 311-319, 1994.

PEDRO, A.O. **Causas básicas de óbito em homens e mulheres de 40 anos ou mais no complexo hospitalar da Unicamp.** 1995. 84 f. Dissertação (Mestrado em Ciências Médicas) – Curso de Pós Graduação em Ciências Médicas, Universidade Estadual de Campinas, São Paulo.

PILETTI, N. **História da educação no Brasil**. São Paulo, SP: Ática, 1990. 183 p.

PRESTES, N.H. A razão, a teoria crítica e a educação. In: PUCCI, B. (org). **Teoria crítica e educação: a questão da formação cultural na Escola de Frankfurt**. 2ª Edição. Petrópolis, RJ: Vozes; São Carlos, SP: EDUFISCAR, 1995. p. 85-101.

PROGRAM FOR APPROPRIATE TECHNOLOGY IN HEALTH. **Production and use of media and materials curriculum.** Washington – DC: PATH, 1992. 208 p.

PUCCI, B. Teoria crítica e educação. In: Pucci B. (org.). **Teoria crítica e educação: a questão da formação cultural na Escola de Frankfurt**. 2ª Edição. Petrópolis, RJ: Vozes; São Carlos, SP: EDUFISCAR, 1995. p. 11-58.

SERRÃO, M.; BALLEIRO, M.C. **Aprendendo a ser e a conviver**. São Paulo: FTD, 1999. 382p.

SIMMONS, R.; HALL, P.; DÍAZ, J.; DÍAZ, M.; FAJANS, P.; SATIA, J. The strategic approach to contraceptive introduction. **Studies in Family Planning,** v. 28, n. 2, p. 79-93, 1997.

SIMMONS, R.; FAJANS, P. Contraceptive Introduction Reconsidered: A new methodology for policy and program development. **Journal of Women's Health,** v. 8, n. 2, p.163-173, 1999.

SIMMONS, R.; BROWN, J.W.; DIAZ, M. Facilitating large scale transitions to quality of care in family planning programs: an idea whose time has come. **Studies in Family Planning.** (Aceito para publicação).

SONI, V. The development and current organization of the family planning programme. In: DYSON T., COOK N. (Ed.). **India's demography: Essays on the contemporary population.** New Delhi: South Asian Publishers Pvt Ltd. 1984.

SPICEHANDLER, J.; SIMMONS, R. Expanding family planning options. Research on the introduction and transfer of technologies for fertility regulation. **Contraceptive introduction reconsidered: A review and conceptual framework.** Geneva: WHO, 1994. 34p.

THE ALAN GUTTMACHER INSTITUTE. **Aborto clandestino: uma realidade latino-americana.** Nova Iorque: The Alan Guttmacher Institute. 1994. 32p.

VIEIRA, E.M. A esterilização de mulheres de baixa renda em região metropolitana do sudeste do Brasil e fatores ligados à sua prevalência. **Revista de Saúde Pública,** v. 28, n. 6, p. 440-448, 1994.

WESTHOFF, C.F.; MORENO, L.; GOLDMAN, N. The demographic impact of changes in contraceptive practice in Third World populations. **Population and Development Review,** v. 15, n. 1, p. 91-106, 1989.

WORLD HEALTH ORGANIZATION. **Contraceptive Method Mix. Guidelines for policy and service delivery.** Geneva: WHO, 1994a. 143p.

_____. An assessment of the need for contraceptive introduction in Brazil. **Expanding Family Planning Options.** Geneva: WHO, 1994b. 60p.

_____. **Improving access to quality care in family planning. Medical eligibility criteria for contraceptive use.** 2nd Edition. Geneva: WHO, 2000. 118p.

_____. Expanding options in reproductive health. **Making decisions about contraceptive introduction: a guide for conducting assessments to broaden contraceptive choice and improve quality of care.** Geneva: WHO, 2001. 82p.

ZEIDENSTEIN, G. The user perspective: an evolutionary step in contraceptive service programs. **Studies in Family Planning,** v. 11, n. 1, p. 24-29, 1980.

Anexo 1

Boletim Informativo nº 3: "Uma Estratégia Participativa para Melhorar a Qualidade de Atenção para Adolescentes em Saúde Sexual e Reprodutiva"

Boletim Informativo

Projeto: MELHORIA DA QUALIDADE DE ATENÇÃO EM SAÚDE REPRODUTIVA EM SANTA BÁRBARA D'OESTE - SP

Boletim Informativo N° 3

Uma Estratégia Participativa para Melhorar a Qualidade de Atenção a Adolescentes na Área de Saúde Sexual e Reprodutiva

Introdução

A análise do diagnóstico dos serviços de saúde reprodutiva em Santa Bárbara d'Oeste, São Paulo, mostrou uma alta incidência de gravidez na adolescência. As estatísticas dos serviços indicaram que aproximadamente 20% das mulheres que se consultavam nos ambulatórios de pré-natal tinham menos de 20 anos. Esse dado tem causado profunda preocupação porque, além do aumento do número de adolescentes grávidas, a gestação está acontecendo em idade cada vez mais precoce.

O diagnóstico também indicou que não havia, no município de Santa Bárbara d'Oeste, serviços de saúde especificamente destinados aos adolescentes, especialmente na área de saúde sexual e reprodutiva; conseqüentemente, os jovens não contavam com locais a que recorrer para resolver seus problemas nessa área. Outro dado importante é que eles não se sentiam à vontade para freqüentar os serviços para adultos, porque muitos profissionais de saúde agiam como censores quando eles solicitavam atendimento, especialmente na área de anticoncepção. Além disso, o diagnóstico mostrou que, apesar da atividade sexual se iniciar cada vez mais precocemente, tanto a família quanto o sistema educacional não eram eficientes para oferecer informações e/ou orientação adequada aos jovens. Conseqüentemente, a grande maioria dos adolescentes sexualmente ativos não usavam nenhuma proteção contra a gravidez não planejada ou doenças sexualmente transmissíveis, incluindo o HIV-AIDS. Não é demais salientar que a gravidez não planejada, quando ocorre na adolescência, além dos riscos maternos e perinatais decorrentes da carência de cuidados durante o período pré-natal e o parto, e dos riscos do aborto clandestino, traz sérias conseqüências sociais, inclusive o abandono da escola para assumir os cuidados com o filho, casamento precoce, trabalho mal remunerado etc.

O programa de atendimento aos adolescentes, organizado em Santa Bárbara d'Oeste, procura satisfazer suas necessidades com a formação de um grupo de adolescentes que atuam como agentes de saúde e da implantação de um serviço destinado a atender especificamente suas necessidades em saúde sexual e reprodutiva. A originalidade do projeto está no fato de que esse grupo de adolescentes, captados nas escolas, cria um vínculo entre a comunidade, o sistema de saúde e o sistema educacional, buscando envolver o maior número de adolescentes possível, para uma atenção integral na área da saúde sexual e reprodutiva.

Envolvimento dos/das adolescentes no processo participativo de planejamento

Os primeiros contatos com os adolescentes mostraram que eles estavam cansados de receber informações ou normas de conduta de maneira autoritária e acadêmica, sem nunca terem a oportunidade de discutir francamente, nem participar das decisões sobre seus problemas de saúde sexual e reprodutiva. A queixa concreta era que os adultos (pais, professores etc.) não os escutavam.

Cientes dessa queixa, os coordenadores do programa utilizaram, desde o início das atividades, técnicas participativas, para permitir que eles se incorporassem ao processo de diagnóstico de suas principais necessidades e ao planejamento das possíveis soluções.

A principal característica do processo participativo é a atuação do coordenador, que age não como um professor que sabe todas as respostas, mas como um facilitador que promove a discussão, possibilitando não apenas a construção do conhecimento a partir das contribuições dos membros do grupo como também que ele se estabeleça como uma referência de acompanhamento contínuo. O trabalho se estrutura a partir dos conhecimentos, crenças, sentimentos e dúvidas dos próprios adolescentes.

Esse processo participativo permitiu conhecer os principais problemas e definir uma estratégia conjunta de ação para resolvê-los.

Criação do grupo de agentes de saúde – IRSSA

O processo participativo permitiu detectar que os adolescentes se entendem melhor e se identificam mais facilmente com outros adolescentes. A partir dessa realidade, decidiu-se capacitar um grupo de adolescentes que se ofereceram para atuar voluntariamente como agentes de saúde e se autodenominaram IRSSA (instrutores de referência à saúde sexual do adolescente). Algumas de suas funções são: oferecer informações sobre saúde sexual e reprodutiva aos seus pares, distribuir preservativos com orientação para os adolescentes da comunidade e agir como “ponte” entre os adolescentes e os serviços de saúde reprodutiva.

A capacitação dos IRSSA foi realizada em 14 sessões semanais de três horas cada uma, em que se trabalhou sempre com técnicas participativas. Após sua conclusão, os agentes, sob supervisão, começaram a desenvolver suas ações nas escolas, na comunidade e no centro de referência.

Implantação de um centro de referência em saúde sexual e reprodutiva para adolescentes

O esforço dos agentes de saúde não apresentaria resultados positivos se não houvesse um serviço apropriado capaz de atender à demanda que seria gerada pelas suas ações. Por essa razão, foi solicitado pelos coordenadores do projeto a criação de um centro de referência para atender às necessidades específicas dos adolescentes na área de saúde sexual e reprodutiva.

O comitê executivo do projeto aprovou a solicitação, e o centro foi implantado no mesmo local em que funciona o centro de referência para adultos, mas funcionando em horários diferenciados (veja *Boletim Informativo* n.º 4). O centro conta com médico, psicólogo, pessoal de enfermagem e tem obtido excelente receptividade entre os jovens.

Resultados

- A atividade do grupo de agentes de saúde (IRSSA) tem possibilitado o acesso efetivo dos adolescentes das escolas à informação sobre saúde sexual e reprodutiva. Isso tem se refletido num aumento importante das consultas no Centro de Referência, não só para o controle pré-natal, mas também para atividades educacionais, preventivas e de anticoncepção.

- O grupo IRSSA tem criado oportunidades para que outros adolescentes participem de suas atividades e inclusive se incorporem a ele como membros ativos.

- Escolas e outras instituições comunitárias, de que fazem parte os adolescentes têm solicitado de maneira crescente a participação e colaboração do grupo de agentes (IRSSA) em atividades educativas, o que vem facilitar a discussão de temas de saúde sexual e reprodutiva, principalmente gravidez, anticoncepção, DST e HIV-AIDS.

- Desde a implantação do Centro de Referência para Adolescentes, o número de jovens que se consulta nos serviços de saúde tem aumentado significativamente. Antes da implantação do centro, praticamente todas as consultas de menores de 20 anos eram feitas por motivo de gravidez. Atualmente, no mês, uma média de 60 adolescentes se consultam para atendimento pré-natal e uma média de 136 adolescentes consultam por problemas ginecológicos, incluindo a anticoncepção.

- O grupo de agentes de saúde (IRSSA) tem realizado uma intensa atividade de ligação com o Centro de Referência e um trabalho de disseminação de informação muito importante e frutífera. Mediante um trabalho supervisionado, alguns membros do grupo têm promovido bate-papos informativos e participado de outras atividades educacionais com jovens, nas escolas e na comunidade. Nesse sentido, um dos trabalhos mais importantes foi a manutenção, durante oito semanas, de um programa de rádio semanal de uma hora. Uma grande proporção dos adolescentes que se consultam no Centro tem sido referido pelos agentes.

Dificuldades

- Apesar da grande motivação demonstrada pelos adolescentes do grupo, sua permanência fica comprometida porque muitos deles precisam começar a trabalhar.

- A área de educação ainda não está homogeneamente motivada. Falta sensibilização e capacitação dos educadores, para que a orientação/educação sexual possa ser incorporada no cotidiano escolar.

- A disponibilidade de serviços no Centro de Referência está sendo insuficiente, apesar da ampliação dos períodos de atendimento. Se a demanda continuar a crescer no mesmo ritmo, podem surgir importantes problemas de oferta e disponibilidade.

Recomendações

- Deveriam ser selecionados adolescentes de no máximo de 16 anos para participar do grupo. Isso permitiria que tivessem um período de pelo menos dois anos de atividades após a capacitação.

- Sem desvirtuar a característica de atividade voluntária, os adolescentes agentes de saúde deveriam receber alguma ajuda financeira, pelo menos para transporte e refeições.

- As atividades do grupo deveriam ser institucionalizadas no Município para garantir os recursos necessários, de modo a favorecer a sustentação do programa a médio e longo prazos.

Este projeto foi realizado pela Secretaria Municipal de Saúde de Santa Bárbara d'Oeste, SP, em parceria com o CEMICAMP, e com o apoio técnico da OMS, Population Council e da Universidade de Michigan.

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Anexo 2

Boletim Informativo nº 7: “Grupo de Apoio para Adolescentes Grávidas”

Boletim Informativo

Projeto: MELHORIA DA QUALIDADE DE ATENÇÃO EM SAÚDE REPRODUTIVA EM SANTA BÁRBARA D'OESTE - SP

Boletim Informativo nº 7 **Setembro/98**

Grupos de Apoio a Adolescentes Grávidas

Introdução

A análise do diagnóstico dos serviços na área de saúde sexual e reprodutiva em Santa Bárbara d'Oeste, SP, mostrou uma taxa elevada de incidência de gravidez entre adolescentes, assim como um baixo uso dos serviços de atendimento pré-natal. As estatísticas dos serviços mostraram que aproximadamente 20% das mulheres que se consultavam nos postos de saúde para acompanhamento pré-natal tinham menos de 20 anos, sendo que muitas delas haviam feito menos de 4 consultas, número considerado deficiente segundo as normas do Ministério da Saúde. Muitas dessas adolescentes desconheciam a importância do acompanhamento pré-natal e nunca tinham ido a um ginecologista antes de engravidar, sendo a consulta pré-natal sua primeira experiência nesse particular. O diagnóstico também mostrou que no município não havia serviços especializados para atender às necessidades das adolescentes grávidas e que elas não se sentiam à vontade para ir aos postos de saúde e ao ginecologista.

De modo geral as/os adolescentes dispunham de pouca informação sobre seu corpo, as mudanças que acontecem durante a gravidez, o trabalho de parto, o parto e o puerpério, mostrando ansiedade em relação a essa etapa da vida: a gravidez, a relação com o bebê, ao o futuro, a relação com o parceiro e a família. Pais e professores não estavam preparados para oferecer o apoio que elas/eles precisavam em relação a informação, orientação e apoio.

Foi criado um serviço de atendimento para adolescentes “grávidas”, como parte do Programa de Assistência Integral ao Adolescente (*Boletim Informativo* # 3). O objetivo desse serviço é prover atendimento multidisciplinar especializado durante o período pré-natal, coadjuvado pelo trabalho de grupos de apoio às adolescentes grávidas, oferecendo também um espaço para que os parceiros e as famílias trabalhem suas ansiedades e dúvidas. O atendimento médico durante o período pré-natal é realizado por um ginecologista/obstetra especializado em adolescentes. Nos grupos de apoio, coordenados por uma psicóloga, as adolescentes recebem informação e orientação sobre gravidez, trabalho de parto, parto e puerpério, desenvolvendo ainda trabalho corporal e de reflexão sobre projeto de vida.

Criação do espaço

Para atender a grávida adolescente, seu parceiro e família, foi criado um serviço específico no Centro de Referência, aproveitando instalações já existentes, como sala de espera, sala de pré-consulta e um consultório de ginecologia/obstetrícia. Foi adaptado um espaço para as reuniões dos grupos de apoio com as/os adolescentes e famílias. Portanto, dispensou-se a aplicação de recursos financeiros adicionais na preparação desse espaço; organizou-se “uma campanha” entre os funcionários do próprio centro e a comunidade, com o intuito de conseguir os materiais necessários para equipar o local. Foram doados colchonetes, almofadas, um carpete, uma boneca “bebê”, uma banheirinha, fraldas, roupinha de bebê etc, além material educativo. Essas doações ajudaram a tornar o espaço mais aconchegante e apropriado para o trabalho com os grupos.

Equipe

Uma vez detectada a necessidade de oferecer atendimento especializado e multiprofissional às adolescentes “grávidas”, formou-se uma equipe multidisciplinar constituída por uma ginecologista, uma psicóloga, uma enfermeira e uma auxiliar de enfermagem. Todos profissionais com experiência em serviços de saúde municipal. O principal critério para a escolha dos componentes da equipe foi: motivação para trabalhar com as adolescentes e disposição para participar de uma capacitação destinada a preparar os interessados para assumir essa tarefa.

Capacitação

A capacitação dos profissionais foi feita no decorrer de 5 oficinas, cada uma com de 4 horas de duração, cuja proposta consistiu no seguinte:

- Reciclar as informações básicas sobre as mudanças corporais na gravidez, trabalho de parto, parto e puerpério, bem como refletir sobre as vivências ocorridas nesse período.
- Refletir e revisar as informações básicas sobre a relação mãe-filho, as necessidades de um bebê e o aleitamento natural.
- Refletir sobre as vivências e as necessidades das mães adolescentes no dia-a-dia com o bebê; o significado da gravidez e da maternidade na adolescência.
- Introduzir os participantes nas técnicas de trabalho corporal para gestantes, bem como na prática de exercícios respiratórios destinados a facilitar o trabalho de

o trabalho de parto e o próprio parto.

óprio parto.

da equipe de saúde no programa de atenção integral às adolescentes grávidas, eus parceiros e famílias.

e famílias.

e famílias.

s reuniões de supervisão contínua, com o objetivo de dar apoio técnico, aprofundar os ctos teóricos trabalhados nas oficinas e propor novas leituras, a fim de aprimorar a formação ão da equipe.

da equipe.

se durante os primeiros 6 meses de funcionamento do grupo. Nos três meses seguintes assaram a ser quinzenais e depois mensais, até completar o ano.

letar o ano.

etar o ano.

upos de apoio

os de apoio

o agendadas a consulta médica e a participação no grupo de apoio. Habitualmente a consulta a pré-natal é realizada mensalmente, e na medida do possível tenta-se agendar o mesmo grupo para o mês seguinte, a fim de permitir que as adolescentes recebam ambos os imentos em um só dia.

em um só dia.

um só dia.

mesmo dia da consulta, têm freqüência mensal e duração de uma hora e meia, e os grupos são abertos.

são abertos.

entados para:

tados para:

ecimento mais amplo do corpo e técnicas de relaxamento, com prática de de exercícios respiratórios e de relaxamento.

relaxamento.

em ao grupo.

eto de vida.

dolescentes.

As adolescentes são orientadas a participar dos grupos semanalmente, se quiserem, e não necessariamente só do grupo vinculado ao seu dia de consulta pré-natal.

Os grupos funcionam com um coordenador e um co-coordenador, porque a própria dinâmica de grupo aberto estabelece um número variável de participantes, e por serem dois facilitadores, há a possibilidade de se dar atenção tanto à dinâmica do grupo quanto às necessidades individuais de cada integrante.

Principais resultados

Observou-se um aumento constante de consultas para exame pré-natal, assim como o número de consultas de acompanhamento pré-natal de cada adolescente grávida foi aumentando à medida que o programa foi se consolidando. Também se observou uma evolução constante no número de adolescentes que participavam dos grupos de apoio e uma aproximação entre o número de adolescentes que faziam parte dos grupos de apoio e o número de consultas.

O número de parceiros e de pais de adolescentes grávidas que procuravam orientação no grupo de apoio foi aumentando mês a mês; no início, um ou dois requeriam orientação. Depois dos primeiros 6 meses de funcionamento foi aberto um espaço, depois de cada reunião do grupo de apoio, para atendimento às famílias.

Durante o primeiro ano de funcionamento (fevereiro 1997/fevereiro 1998) participaram do programa 143 adolescentes grávidas. Todas receberam atendimento médico pré-natal, e 142 delas participaram do grupo de apoio, enquanto 45% participaram de 3 a 5 reuniões de grupo e 20% de mais de 5 reuniões. Atualmente, uma média de 60 adolescentes fazem consulta pré-natal.

Na avaliação realizada com a ginecologista que faz atendimento pré-natal de adolescentes, destaca-se maior adesão às consultas e às orientações médicas por parte das adolescentes que participam dos grupos de apoio. Na avaliação realizada com os profissionais de saúde, 4 médicos e 2 parteiras da maternidade onde a maioria das adolescentes do programa são atendidas para o parto, destaca-se que todos os profissionais entrevistados observaram diferenças entre as atitudes das adolescentes que participam do grupo de apoio e aquelas que não participam. Todos fazem referência ao fato de que essas adolescentes se mostram mais tranqüilas durante o trabalho de parto, apresentam menos ansiedade e medo, são mais participativas e seguem melhor as indicações da equipe de saúde.

Dificuldades

➲A maternidade não faz parte da rede municipal de saúde, por isso o programa não pode se completar com uma capacitação para os profissionais daquela instituição para atingir o atendimento integral.

➲Deficiência no sistema de referência dos postos de saúde para o encaminhamento das adolescentes grávidas ao Centro de Referência para participar do programa rotatividade dos profissionais de saúde na rede pública, representando um desafio quanto a manter constante capacitação dentro do serviço, realizada pelos primeiros profissionais capacitados, a fim de garantir a continuidade desse tipo de atendimento.

➲Alta rotatividade dos profissionais de saúde na rede pública, representando um desafio quanto a manter constante capacitação dentro do serviço, realizada pelos primeiros profissionais capacitados, a fim de garantir a continuidade desse tipo de atendimento.

Este projeto foi realizado pela Secretaria Municipal de Saúde de Santa Bárbara d'Oeste, SP, em parceria com o CEMICAMP, e com o apoio técnico da OMS, Population Council e da Universidade de Michigan.

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Anexo 3

Registro de Atendimento Ambulatorial – PAISM

PREFEITURA MUNICIPAL DE SANTA BÁRBARA D'OESTE / SECRETARIA DA SAÚDE

REGISTRO DE ATENDIMENTO AMBULTORIAL/PAISM

UNIDADE | Nº REGISTRO | DIA MÊS ANO

NOME | SOBRENOME | R.G.

IDADE anos

MUNICÍPIO 1. Santa Bárbara d'Oeste - SP

6. Outro:_____UF:_____

1. Consulta:
- 10. Consulta 1ª vez no posto para o PAISM
- 12. Já consultou no posto para o PAISM

2. Tipo de consulta:
- 20. Pré-natal
- 22. GINECOLOGIA
- 24. Coleta C.O.
- 26. Planej. familiar
- 28. Resultado do C.O.
- 30. Rev. pos parto/ cirurgia
- 32. Outros

INFORMAÇÕES SOBRE O USO DE ANTICONCEPCIONAIS

3. Assinale com X conforme o método utilizado antes e depois da consulta:

MAC	ATÉ A CONSULTA	DEPOIS DA CONSULTA
1. Nenhum	11	13
2. Tabela	15	17
3. Pílula	19	21
4. Condom	23	25
5. Injetável	27	29
6. D.I.U.	31	33
7. Diafragma	35	37
8. Ligadura	39	41
9. Outros (especificar)	43	45

4. Código da consulta:
- 101. Consulta médica
- 103. Consulta médica com adm. medicamentos
- 105. Consulta de enfermagem

5. Assinale com um X os outros procedimentos realizados nessa consulta: (Deixe em branco se não houver nenhum desses procedimentos)
- 107. Biópsia colo uterino
- 109. Biópsia endométrico
- 111. Inserção DIU
- 113. Medição diafragma
- 115. Retirada DIU simples
- 117. Retirada DIU instrumental
- 119. Vulvoscopia
- 121. Secreção vaginal a fresco
- 123. Crio eletro cauteriz. de colo
- 125. Aminioscopia
- 127. Colposcopia
- 129. Curativos/pontos

C.I.D.

MÉDICO C.R.M. _____ ASSINATURA

ENFERMEIRO: COREN _____ ASSINATURA

100x100x1 - 05/95 - MAZIERO

Anexo 4

Instrumentos para Diagnóstico:

- Inventário
- Roteiro de Observação dos Serviços de Saúde
- Fluxo de Usuárias/os na Unidade
- Tempo na Consulta
- Competência Técnica
- Entrevista
- Roteiro para Entrevista Informal com Usuárias/os
- Roteiro para Diálogo Comunitário
- Roteiro para Grupo Focal com Provedores
- Roteiro para Entrevista com Autoridades
- Consentimentos Informados

REPROLATINA

PROJETO REPROLATINA

FORMULÁRIO PARA DIAGNÓSTICO E AVALIAÇÃO DOS SERVIÇOS DE SAÚDE SEXUAL E REPRODUTIVA

INVENTÁRIO

I – IDENTIFICAÇÃO DA UNIDADE DE SAÚDE (US)

1. Unidade de Saúde: _____ **Nº:** | | | | | | |

2. Endereço: _____

3. Distrito/Bairro: _____ **4. Município:** _____ **5. Estado:** | | |

6. Data: | | | | | | |

7. Tipo:

	1. Unidade Básica		2. Centro de Especialidades
	3. Hospital		4. Outro. Qual? _____

8. População total da área atendida: _____

9. Qual é o horário de atendimento?

	Início	Final
1. Manhã		
2. Tarde		
3. Noite		

10. Horário de chegada do(a) primeiro(a) usuário(a): | | : | | | Horas

11. Horário do primeiro atendimento no período da manhã | | : | | | Horas

12. Horário do primeiro atendimento no período da tarde | | : | | | Horas

13. Horário do primeiro atendimento no período da noite | | : | | | Horas

14. A US permanece aberta nos finais de semana e feriados?

1. Sim | | 2. Não | |

15. Turnos por semana em que os serviços de saúde sexual e reprodutiva são oferecidos (marque com um "X" no quadro correspondente)

	Segunda			Terça			Quarta			Quinta			Sexta		
Serviços Oferecidos:	**M**	**T**	**N**	**M**	**T**	**N**	**M**	**T**	**N**	**M**	**T**	**N**	**M**	**T**	**N**
1. Ginecologia geral															
2. Planejamento familiar															
3. Detecção Ca colo uterino															
4. Controle pré-natal															
5. Consulta pós-parto															
6. Esterilidade															
7. DST/HIV-AIDS															
8. Adolescentes															
9. Sexualidade															
10. Prevenção Ca Mama															
11. Menopausa															

16. Marque com um "X" no quadro correspondente que profissional realiza os atendimentos listados abaixo. Pode marcar mais de uma alternativa.

	Médico	**Enfermeira**	**Técnico de Enfermagem**	**Auxiliar de Enfermagem**
Ginecologia Geral				
Planejamento Familiar:				
• Primeira consulta				
• Abastecimento MAC				
Coleta citologia oncótica				
Colposcopia				
Exame de mama				
Controle pré-natal				
Consulta pós-parto				
Esterilidade				
DST/HIV-AIDS				
Adolescentes				
Sexualidade				
Menopausa				

II - PESSOAL

17. Anote o número de pessoas trabalhando em saúde sexual e reprodutiva neste serviço:

☐	1. Médico(a) - (total)	☐	7. Assistente social
☐	2. Ginecologistas/obstetras	☐	8. Técnicas(os) de enfermagem
☐	3. Generalistas	☐	9. Auxiliares de enfermagem
☐	4. Pediatras	☐	10. Atendentes de enfermagem
☐	5. Enfermeira(o)	☐	11. Agentes de saúde
☐	6. Psicólogo(a)	☐	12. Outros: _____

18. A Unidade promove reuniões administrativas com os seus funcionários?

☐ 1.Sim, regularmente. ☐ 2. Sim, esporadicamente. ☐ 3. Não.

19. A Unidade promove reuniões técnicas/científicas com os seus profissionais?

☐ 1. Sim, regularmente. ☐ 2. Sim, esporadicamente. ☐ 3. Não.

20. A Unidade oferece capacitação em saúde sexual e reprodutiva para os seus funcionários?

☐ 1. Sim, regularmente. ☐ 2. Sim, esporadicamente. ☐ 3. Não.

III – INFORMAÇÃO, EDUCAÇÃO E COMUNICAÇÃO (IEC)

21. Número de cartazes atuais afixados no local: ☐☐☐

Se existem, sobre que assuntos: _____

_____

22. Existe sinalização para as(os) usuárias(os) da Unidade?

☐ 1. Sim. ☐ 2. Não. ☐ 3. Em alguns lugares.

23. Que materiais de IEC em saúde sexual e reprodutiva estão disponíveis? (Marque com um "X" no quadro correspondente).

Assunto	Álbum Seriado	Manual de Normas	Folhetos ou Cartilhas	Outros
1. DST/HIV-AIDS				
2. Planejamento familiar				
3. Detecção de Ca ginecológico				
4. Atenção pré-natal				
5. Assistência ao parto				
6. Cuidados ginecológicos				
7. Seguimentos pós-parto				
8. Esterilidade				
9. Adolescência				
10. Sexualidade				
11. Menopausa				
12. Outros:				

24. Quais equipamentos audiovisuais existem na Unidade e com que freqüência eles são usados? (Marque com um "X" no quadro correspondente).

Equipamento	Não tem	Sim, é usado freqüentemente	Sim, é usado às vezes	Não é usado
Televisão				
Vídeo cassete				
Fitas de vídeo				
Projetor de slides				
Retroprojetor				
Outro:				

25. Quais ações educativas que a Unidade realiza?

Assuntos	Não realiza	Diariamente	Uma vez por semana	Uma vez por mês
1. Cuidados ginecológicos				
2. Planejamento familiar				
3. Detecção Ca colo uterino				
4. Auto-exame de mamas				
5. Grupo de gestantes				
6. Amamentação				
7. Cuidados do recém-nascido				
8. DST/HIV-AIDS				
9. Esterilidade				
10. Sexualidade				
11. Grupo de adolescentes				
12. Grupo de gestantes adolescentes				
13. Menopausa				
14. Outros:				

IV - INSTALAÇÕES

26. Quais e quantas destas instalações estão em funcionamento? (Marque o número no quadrado correspondente).

	Em funcionamento	Não funciona	Não dispõe
Consultório GO			
Consultório pediatria			
Consultório clínica geral			
Consultórios (total)			
Sala de vacinação			
Sala de esterilização			
Sala de preparo do material			
Farmácia			
Almoxarifado			
Cozinha			
Lavanderia			
Expurgo			
Sala administrativa			
SAME			
Sala de espera			
Banheiros			
Sala de ação educativa			
Outros:			
Número total de cômodos			

27. A sala de espera oferece proteção contra sol/chuva?

☐ 1. Sim. ☐ 2. Não.

28. Há assentos suficientes para todos(as) os(as) usuários(as)?

☐ 1. Sempre. ☐ 2. Às vezes. ☐ 3. Não.

29. É aproveitado o tempo de espera para atividades informativas/educativas?

☐ 1. Sim, sempre. ☐ 2. Sim, às vezes. ☐ 3. Não.

30. Há banheiros disponíveis para a clientela?

☐ 1. Sim. ☐ 2. Não.

31. Condições de limpeza da Unidade.

☐ 1. Boas ☐ 2. Regulares ☐ 3. Más (ruins) ☐ 4. Péssimas

32. Utilizam lençóis e toalhas descartáveis para o(a) usuário(a)?

☐ 1. Sim, sempre. ☐ 2. Sim, às vezes. ☐ 3. Não.

33. Existe pia com água corrente disponível nas salas de consultas/exames?

☐ 1. Sim, em todas. ☐ 2. Sim, em algumas. ☐ 3. Não.

34. Há falta de água na Unidade?

☐ 1. Freqüentemente. ☐ 2. Às vezes. ☐ 3. Nunca.

35. Há falta de energia elétrica na Unidade?

☐ 1. Freqüentemente ☐ 2. Às vezes. ☐ 3. Nunca.

36. É dada prioridade na distribuição de suprimentos e medicamentos para aqueles com menor prazo de validade?

☐ 1. Sim. ☐ 2. Não.

37. Os locais para armazenamento dos insumos são protegidos do sol/chuva e insetos?

☐ 1. Sim ☐ 2. Não

38. Com que freqüência é feito o balanço dos estoques?

☐ 1. Mensal. ☐ 3. Semestral. ☐ 5. Outra: _____

☐ 2. Trimestral. ☐ 4. Anual. ☐ 6. Não é feito.

39. Com que freqüência a Unidade solicita suprimentos?

☐ 1. Mensal. ☐ 3. Semestral. ☐ 5. Outra: _____

☐ 2. Trimestral. ☐ 4. Anual. ☐ 6. Não é feita.

40. Assinale com um "X" na coluna correspondente, se os seguintes insumos de saúde sexual e reprodutiva estão disponíveis atualmente, se são suficientes e qual é a fonte de obtenção.

Obs.: Considere suficiente quanto o estoque atende a clientela por, no mínimo, 15 dias.

			Fontes de Obtenção			
Insumos	**Disponível**	**Suficiente**	**Ministério da Saúde**	**Secretaria Municipal de Saúde**	**Secretaria Estadual de Saúde**	**Outros**
- Pílula combinada						
- Minipílula						
- Anticoncepção de emergência						
- Camisinha masculina						
- Camisinha feminina						
- Diafragma						
- Espermicida						
- DIU:						
• T de cobre 380						
• Multiload						
- Injetável mensal						
- Injetável trimestral						
- Sulfato ferroso						
- Ácido fólico						
- Antiácidos						
- Dupla adulto						
- Antieméticos						
- Antibióticos						
(marca:)						
(marca:)						
(marca:)						
(marca:)						
- Antifúngicos						
- Lugol						
- Ácido acético						
- Álcool absoluto						
- Carbovax						
- Ácido tricloroacético a 90%						
- Solução de podofilina alcoólica a 25%						
- Albocresil						
- Estrogênios conjugados 0.625						
- Acetato de medroxiprogesterona 5 ou 10 mg						
- Gaze						
- Algodão						
- Compressas						

41. A unidade realiza coleta e/ou recepção de material para análise laboratorial de: (marque com um "X" no quadro os exames realizados).

- ☐ Sangue
- ☐ Urina
- ☐ Fezes
- ☐ Citologia oncótica colo
- ☐ Citologia oncótica mama
- ☐ Conteúdo vaginal
- ☐ Secreção cervical
- ☐ Tecidos orgânicos (colo, endométrio, etc)
- ☐ Outros: _____

42. Os(as) usuários(as) são referidos(as) para especialidades ou para unidades de maior complexidade?

☐ 1. Sim ☐ 2. Não

43. Se sim, especifique as principais unidades de referência:

1. _____
2. _____
3. _____

VI – REGISTROS E RELATÓRIOS

44. Em que condições encontra-se o arquivo de registro de usuários(as)? (marque com um "X" no quadro correspondente).

- ☐ 1. Bem organizado.
- ☐ 2. Parcialmente organizado. Utilizável.
- ☐ 3. Desorganizado, sem condições de uso.
- ☐ 4. Não existe.

45. Existe algum registro diário de atividades de saúde reprodutiva?

☐ 1. Mapa de registro diário ☐ 2. Formulário individual ☐ 3. Não existe

VII – ADMINISTRAÇÃO E SUPERVISÃO

46. Existe um quadro que mostre a descrição do organograma de cargos e funções na Unidade?

☐ 1. Sim ☐ 2. Não

47. Quais dados estão disponíveis na Unidade? (Marque com um "X" no quadro correspondente)

- ☐ 1. População do município/área de cobertura
- ☐ 2. População feminina em idade fértil
- ☐ 3. População infantil
- ☐ 4. Mapa/descrição da área de cobertura da Unidade
- ☐ 5. Outros:_____

VII – ADMINISTRAÇÃO E SUPERVISÃO

48. Existem normas e padronizações por escrito para os seguintes atendimentos em saúde? Caso afirmativo, marque com um "X" no quadro correspondente.

☐ Ginecologia geral	☐ Seguimento pós-parto	☐ Adolescentes
☐ Planejamento familiar	☐ Menopausa	☐ Sexualidade
☐ Detecção Ca colo uterino	☐ DST/HIV-AIDS	☐ Aleitamento materno
☐ Controle de Ca de mama	☐ Esterilidade conjugal	☐ Vacinação
☐ Controle pré-natal		

49. Qual é o sistema de agendamento?

☐ Marcação de consulta na Unidade ☐ Marcação de consulta por telefone ☐ Agenda aberta

50. Qual é o sistema de ordenação do atendimento?

☐ Formação de fila ☐ Atendimento com hora marcada

☐ Distribuição de senha ☐ Outros: _____

51. Esta Unidade é visitada por um supervisor?

☐ Sim, esporadicamente. ☐ Sim, regularmente. ☐ Não.

52. Se sim, o que ele faz durante a visita?

☐ Observa as ações e os atendimentos de saúde	☐ Elogia o trabalho bem desempenhado
☐ Pergunta sobre os problemas da Unidade	☐ Dá assistência técnica
☐ Faz sugestões para melhorias	☐ Fiscaliza os funcionários
☐ Examina os registros	☐ Outros

53. Quantas vezes nos últimos TRÊS meses um supervisor visitou a Unidade?

Número de vezes: _____

54. Anote o número de materiais/equipamentos atualmente em uso para atendimento em saúde sexual e reprodutiva.

Obs.: Marque insuficiente quando o número em funcionamento ou as condições de conservação comprometem a qualidade do atendimento.

Equipamento	Total	Nº Funcionando	Suficiente	Insuficiente
1. Esfigmomanômetro adulto				
2. Estetoscópio biauricular				
3. Balança de adulto				
4. Balança infantil				
5. Termômetros				
6. Régua pediátrica				
7. Lanterna				
8. Oto-oftalmoscópio				
9. Agulhas e seringas descartáveis				

Equipamento	Total	Nº Funcionando	Suficiente	Insuficiente
10. Luvas (pares) estéreis				
11. Luvas de procedimento				
12. Cubas				
13. Mesas ginecológicas				
14. Focos de Luz				
15. Espéculos				
16. Lâminas para coleta de CO				
17. Espátulas de Ayre				
18. Escovinhas				
19. Pinças de Cheron				
20. Pinças de PozzI				
21. Histerômetro				
22. Tesouras				
23. Agulhas de crochê				
24. Colposcópio				
25. Eletrocautério				
26. Criocautério				
27. Fita métrica				
28. Estetoscópio de Pinard				
29. Doppler fetal				
30. Microscópios				
31. Ultrassom				
32. Estufas/autoclaves				
33. Panela de pressão				
34. Ambulância/transporte				

55. Para limpeza e preparo dos insumos e materiais, marque com um "X" quais dos seguintes procedimentos são feitos na Unidade.

- [ ] Realiza imersão em solução de cloro a 0.5% por 10 minutos.
- [ ] Utiliza luvas de borracha ou vinil para lavagem do material.
- [ ] Realiza limpeza de superfícies (como mesa de exame) antes de voltar a utilizar ou pelo menos uma vez ao dia.
- [ ] Limpa os instrumentos em água e sabão com auxílio de uma escova.
- [ ] Realiza enxágüe do material com água fria abundante.
- [ ] Seca os instrumentos ao ar ou com toalha.
- [ ] Embrulha e empacota os instrumentos.
- [ ] Os desinfetantes químicos são armazenados em local fresco e escuro.

56. Para esterilização do material, marque com um "X" quais os procedimentos que são feitos na Unidade?

- ☐ Realiza desinfecção por fervura durante 20 minutos em um recipiente com uma tampa.
- ☐ Esteriliza em estufa por 1 hora depois de alcançar 170º C.
- ☐ Esteriliza em autoclave por 20 ou 30 minutos (para pacotes) a 121º C.
- ☐ Realiza esterilização química, deixando os instrumentos imersos em glutaraldeido por 8-10 horas, ou fomaldeido a 8% durante pelo menos 24 horas.
- ☐ Enviam o material para esterilização externa.

57. Marque com um "X" os procedimentos feitos na Unidade para o cuidado com a limpeza e preparo de roupas:

- ☐ Deixa roupas contaminadas em imersão por 10 minutos em solução de cloro a 0.5%.
- ☐ Lava as roupas com detergente e água em abundância.
- ☐ Deixa as roupas secar ao ar ou na secadora.
- ☐ Enviam roupas para limpeza externa.

58. Marque com um "X" os procedimentos adotados pela Unidade para o armazenamento e recolhimento do lixo:

- ☐ O lixo não contaminado é transportado para a área de eliminação em recipientes cobertos.
- ☐ Utiliza luva para manipulação do lixo.
- ☐ Usa recipientes laváveis e não corrosivos com tampa para o lixo contaminado.
- ☐ Lava os recipientes com solução desinfetante cada vez que são esvaziados.
- ☐ Coloca o lixo contaminado em saco plástico resistente.
- ☐ Coloca o lixo contaminado em um ambiente isolado até ser recolhido.

59. Marque com um "X" os procedimentos adotados pela Unidade, no cuidado com objetos pérfuro-cortantes:

- ☐ Usa luvas grossas para a manipulação desses objetos.
- ☐ Dispõe de recipientes de papelão grosso apropriados para o armazenamento.
- ☐ Fecha e elimina os recipientes quando estão ¾ cheios.
- ☐ Realiza desinfecção, limpeza e esterilização de objetos não descartáveis.

60. Observações: _____

_____

_____

_____

_____

Nome: _____

Cargo/função na Unidade: _____

PROJETO REPROLATINA

TRABALHO DE CAMPO: ROTEIRO DE OBSERVAÇÃO DOS SERVIÇOS DE SAÚDE SEXUAL E REPRODUTIVA

1. **Acesso:** transporte, área de atenção, distância, custo, sinalização.

2. **Recepção:** atenção, esquema de marcação de consultas, primeira vez e seguimento, usuárias novas e antigas.

3. **Registro de informações/arquivos:** ficha de registro para planejamento familiar, envio dos registros (como, cada quanto tempo, para quem), uso dos registros, sistema de arquivo.

4. **Local:** espaço da sala da espera, cadeiras, limpeza dentro e fora da unidade, sinalização, banheiros (número e limpeza), lixeiras (se tem), estado das lixeiras, eliminação do lixo, eliminação de material pérfuro-cortante.

5. **Consultórios:** condições, materiais, pia com água corrente, limpeza, privacidade, sinalização.

6. **Condições de saneamento básico:** água, esgoto, energia elétrica, etc.

7. **IEC:** cartazes, folhetos, sala de ação educativa, materiais educativos, equipamentos (TV, vídeo, retro-projetor, etc).

8. **Farmácia:** disponibilidade dos MAC, estoque de métodos, horário de entrega de métodos, o que é necessário para que o usuário receba o método.

9. **Sistema de logística de MAC**

10. **Sistema de informática:** quantidade de: computador, impressora, acesso à Internet, telefones.

11. **Telefones:** tem telefone? Quantos? Funcionam ou não? Como?

Nota: Anote todas as informações obtidas no seu caderno de campo.

REPROLATINA

PROJETO REPROLATINA

FORMULÁRIO PARA DIAGNÓSTICO E AVALIAÇÃO DOS SERVIÇOS DE SAÚDE SEXUAL E REPRODUTIVA

FLUXO DE USUÁRIAS/OS NA UNIDADE

	Usuária/o nº	
1. Unidade de Saúde: _____	**Data:**	
2. Município: _____	**Estado:**	

INSTRUÇÕES:

1. ***Esta ficha deve ser preenchida por todos os(as) profissionais que têm algum contato com a(o) usuária(o).***
2. ***Esta ficha deve permanecer com a(o) usuária(o) durante sua permanência na unidade.***
3. ***O(a) primeiro(a) profissional que der o atendimento deverá perguntar o horário que a(o) usuária(o) chegou à unidade e marcar no item correspondente.***
4. ***Cada profissional que atender a(o) usuária(o) deve marcar o tipo de atendimento (por exemplo: recepção, verificação de PA, consulta, entrega de medicação, etc), o horário de início do atendimento, o horário final do atendimento e devolver a ficha para a(o) usuária(o), que a entregará no atendimento seguinte.***
5. ***Todos os(as) profissionais envolvidos(as) deverão estar informados(as) sobre o preenchimento desta ficha e deverão ter seus relógios ajustados no mesmo horário.***

EXEMPLO:

TIPO DE ATENDIMENTO	*INÍCIO*	*TÉRMINO*
1º Atendimento Recepção	07 : 00	07 : 03

Horário de chegada na Unidade: ☐☐ : ☐☐

TIPO DE ATENDIMENTO	**INÍCIO**	**TÉRMINO**
1º Atendimento _____	☐☐ : ☐☐	☐☐ : ☐☐
2º Atendimento _____	☐☐ : ☐☐	☐☐ : ☐☐
3º Atendimento _____	☐☐ : ☐☐	☐☐ : ☐☐
4º Atendimento _____	☐☐ : ☐☐	☐☐ : ☐☐
5º Atendimento _____	☐☐ : ☐☐	☐☐ : ☐☐
6º Atendimento _____	☐☐ : ☐☐	☐☐ : ☐☐
7º Atendimento _____	☐☐ : ☐☐	☐☐ : ☐☐

Horário de saída da Unidade: ☐☐ : ☐☐

Tempo de permanência na Unidade: ☐☐ **Horas e** ☐☐ **Minutos**

REPROLATINA

PROJETO REPROLATINA

FORMULÁRIO PARA DIAGNÓSTICO E AVALIAÇÃO DOS SERVIÇOS DE SAÚDE SEXUAL E REPRODUTIVA

TEMPO NA CONSULTA

GUIA DE OBSERVAÇÃO

1. Unidade de Saúde: _____ **Data:** | | | | | | |

2. Município: _____ **Estado:** | | | |

Instruções: ***1. Esta ficha deve ser preenchida fora do consultório.***
2. Marque na coluna correspondente, o início e o término de cada consulta.
3. Utilize uma ficha para cada tipo de profissional.

Tipo de Profissional:		**1. Médico(a)**		**3. Técnico(a) de enfermagem**
		2. Enfermeiro(a)		**4. Auxiliar de enfermagem**

Tipo de Consulta: _____

	Tempo de Consulta				**Tempo Total**
	Início		**Término**		**(minutos)**
1.		:		:	
2.		:		:	
3.		:		:	
4.		:		:	
5.		:		:	
6.		:		:	
7.		:		:	
8.		:		:	
9.		:		:	
10.		:		:	
11.		:		:	
12.		:		:	
13.		:		:	
14.		:		:	
15.		:		:	
16.		:		:	

Tempo total observado: | | | |

Número de Observações: | | | |

Média de Tempo na Consulta: | | | | **minutos**

Para calcular a média de tempo na consulta, divida o tempo total observado pelo número de observações.

REPROLATINA

PROJETO REPROLATINA

FORMULÁRIO PARA DIAGNÓSTICO E AVALIAÇÃO DOS SERVIÇOS DE SAÚDE SEXUAL E REPRODUTIVA

COMPETÊNCIA TÉCNICA NA CONSULTA

Observação nº ____

1. Unidade de Saúde: _____ **Data:** ____/____/____

2. Município: _____ **Estado:** ____

3. Pessoa Observada:

- ☐ 1. Médico(a)
- ☐ 2. Enfermeiro(a)
- ☐ 3. Auxiliar de enfermagem
- ☐ 4. Técnico(a) de enfermagem
- ☐ 5. Recepcionista
- ☐ 6. Outro(a) _____

Hora de início: _____ **Hora de término:** _____

INSTRUÇÕES:

1. ***Esta ficha deve ser preenchida dentro do consultório. Utilize uma ficha para cada consulta observada.***
2. ***Marque na coluna correspondente, as ações realizadas pelo profissional observado durante a consulta.***
3. ***Diga ao profissional observado, que a/o apresente.***

	Sim	Em parte	Não	Não aplica
1. ESTABELECE UMA RELAÇÃO CORDIAL				
Cumprimenta				
Apresenta-se				
Pergunta o nome/chama pelo nome				
Utiliza apelidos/diminutivos (bem, querida, benzinho)				
Estabelece um clima de confiança				
2. IDENTIFICA AS NECESSIDADES DAS(0S) USUÁRIAS(OS)				
Pergunta o motivo da consulta				
Aprofunda informações				
Escuta com atenção				
3. RESPONDE ÀS NECESSIDADES NA CONSULTA				
Exame Físico Geral				
Verifica peso, altura, PA				
Examina conjuntivas/pele/membros				
Realiza ausculta cardíaca/pulmonar				
Examina abdômen				
Usa corretamente materiais/instrumentos				
Maneja corretamente as técnicas				
Exame Ginecológico				
Examina mamas				
Examina vulva/períneo				
Realiza exame especular				
Colhe CO/verifica CO				
Realiza toque vaginal				
Usa corretamente materiais/instrumentos				
Maneja corretamente as técnicas				
Exame Obstétrico				
Examina mamas				
Realiza palpação abdominal				
Realiza medida da altura uterina				
Verifica batimentos cardíacos fetais				
Usa corretamente materiais/instrumentos				
Maneja corretamente as técnicas				
Educação e Informação				
Explica diagnóstico				
Explica exames				

Responde perguntas adequadamente				
	Sim	**Em parte**	**Não**	**Não aplica**
Dá informações necessárias (MAC, CO, medicação, etc)				
Dá informações corretas				
4. VERIFICA A COMPREENSÃO DAS(OS) USUÁRIAS(OS)				
Pergunta se entendeu/verifica satisfação				
Pede para repetir instruções				
5. MANTÉM O AMBIENTE DE CORDIALIDADE				
Coloca-se à disposição				
Solicita/agenda retorno				
Refere a outros serviços/profissionais				

Observações: _____

REPROLATINA

PROJETO REPROLATINA

FORMULÁRIO PARA DIAGNÓSTICO E AVALIAÇÃO DOS SERVIÇOS DE SAÚDE SEXUAL E REPRODUTIVA

O SERVIÇO DE SAÚDE NA PERSPECTIVA DAS(OS) USUÁRIAS(OS)

ENTREVISTA

Entrevista nº ☐☐☐☐

Unidade de Saúde: _____ **Data** ☐☐/☐☐/☐☐

Município: _____ **Estado** ☐☐

Instruções:

1. ***Apresente-se, explique que você irá fazer algumas perguntas sobre a Unidade de Saúde.***
2. ***Explique que não haverá a identificação de quem respondeu, e que ela pode concordar ou não em responder, sem que isto prejudique seu atendimento na Unidade.***
3. ***Para o preenchimento, faça as perguntas em negrito e marque a resposta no quadro correspondente.***
4. ***Não leia as alternativas de respostas.***
5. ***A entrevista deve ser realizada, de preferência, depois da consulta.***

1. Qual a sua idade? ☐☐ anos

2. Quantas vezes você engravidou? ☐☐ ☐ **Filhos vivos** ☐ **Filhos mortos** ☐ **Abortos**

AGORA EU VOU FAZER ALGUMAS PERGUNTAS SOBRE ESTE POSTO DE SAÚDE

3. Como você soube deste posto?

☐ 1. Vizinha/Amiga
☐ 2. Parente
☐ 3. TV/Rádio
☐ 4. Referida prof./serviço
☐ 5. Já sabia/já conhecia
☐ 6. Outros. _____

4. Por que você vem a este posto?

☐ 1. Fica perto de casa
☐ 2. Gosta do atendimento
☐ 3. Aqui tem médico
☐ 4. Consulta toda a família
☐ 5. Fica perto do trabalho
☐ 6. Gosta do horário
☐ 7. É de fácil acesso
☐ 8. Outra(s): _____

5. Você acha o atendimento deste posto ótimo, bom, regular ou ruim?

☐ 1. Ótimo ☐ 2. Bom ☐ 3. Regular ☐ 4. Ruim

6. Por que? (Marque com um "X" no quadro correspondente)

☐ A recepcionista atende bem	☐ Demora para ser atendida(o)
☐ A enfermeira atende bem	☐ A consulta é muito rápida
☐ O médico atende bem	☐ Não tem médico em todos os horários
☐ Têm medicamentos	☐ Não têm medicamentos
☐ Não espera muito para ser atendida(o)	☐ Não tem lugar para esperar a consulta
☐ Consegue consultar no mesmo dia	☐ A recepcionista atende mal
☐ Têm vários tipos de atendimento	☐ A enfermeira atende mal
☐ Demora para marcar consulta	☐ O médico atende mal
☐ O atendimento é gratuito	☐ Outra(s): _____

7. Você acha o horário de atendimento deste posto ótimo, bom, regular ou ruim?

☐ 1. Ótimo ☐ 2. Bom ☐ 3. Regular ☐ 4. Ruim

8. Por que? (Marque com um "X" no quadro correspondente)

☐ Não tem problema de horário
☐ Tem consulta de manhã e à tarde
☐ Tem atendimento fora do meu horário de trabalho
☐ Não tem opções de horários para consulta
☐ Tem que chegar muito cedo para consultar
☐ Perde hora de trabalho para consultar
☐ Os médicos demoram para atender
☐ Outra(s): _____

9. Em geral é: **1. fácil** ☐ **2. ou difícil ser atendida aqui?** ☐

10. Por que? (Marque com um "X" no quadro correspondente)

☐ Atende no mesmo dia
☐ O tempo entre a marcação e a consulta é menor que 15 dias
☐ O tempo entre a marcação e a consulta é maior que 15 dias
☐ Outra(s): _____

11. Como você faz para marcar consulta aqui?

☐ Agenda aberta
☐ Telefone
☐ Fila
☐ Outra:_____

12. Você recomendaria este posto para outras pessoas, ou não?

☐ 1. Sim ☐ 2. Não

13. Qual o motivo de você procurar o posto hoje?

☐ 1. Ginecologia geral
☐ 2. Planejamento familiar
☐ 3. Prevenção de Ca colo uterino
☐ 4. Prevenção de Ca de mama
☐ 5. Controle pré-natal
☐ 6. Consulta pós-parto
☐ 7. Esterilidade
☐ 8. DST/HIV-AIDS
☐ 9. Adolescente
☐ 10. Sexualidade
☐ 11. Clínica geral
☐ 12. Outro(s): _____

14. Você já recebeu, ou não, este atendimento hoje? (Já foi consultada(o)?)

☐ 1. Sim ☐ 2. Não **(PASSE PARA A PERGUNTA 19)**

AGORA EU VOU FAZER ALGUMAS PERGUNTAS SOBRE SUA CONSULTA

15. Você acha que recebeu o atendimento que estava precisando/querendo na consulta de hoje?

☐ 1. Sim ☐ 2. Em parte ☐ 3. Não

16. Por que?

☐ Foi examinada
☐ O problema de saúde foi resolvido
☐ Tirou as dúvidas
☐ Recebeu os medicamentos
☐ Não deu tempo de explicar tudo para o médico
☐ O médico não explicou o problema
☐ Precisava da avaliação de um especialista
☐ Precisa fazer vários exames
☐ Outro(s):_____

17. Você acha que a consulta durou muito, mais ou menos, ou pouco tempo?

☐ 1. Muito tempo ☐ 2. Mais ou menos ☐ 3. Pouco tempo

18. Você ficou satisfeita, mais ou menos satisfeita, ou insatisfeita com a consulta?

☐ 1. Satisfeita ☐ 2. Mais ou menos satisfeita ☐ 3. Insatisfeita com a consulta

19. Aqui no posto, eles atendem em planejamento familiar, como evitar filhos?

☐ 1. Sim ☐ 2. Não ☐ 3. Não sabe

20. Você está usando algum método para evitar filhos?

☐ 1. Sim **(PASSE PARA A PERGUNTA 22)** ☐ 2. Não

21. Por que você não está usando método?

☐ 1. Não necessita
☐ 2. Não consegue atendimento
☐ 3. Não tem o método que escolheu
☐ 4. Não tem dinheiro
☐ 5. Não sabe onde procurar atendimento
☐ 6. Motivos religiosos
☐ 7. Companheiro não aceita
☐ 8. Outro(s): _____

(PASSE PARA A PERGUNTA 26)

22. Qual método anticoncepcional você está usando?

☐ Tabelinha
☐ Muco cervical (Billings)
☐ LAM
☐ Diafragma
☐ Camisinha
☐ Pílula
☐ Injeção
☐ DIU
☐ Ligadura
☐ Vasectomia
☐ Outro: _____

23. Quem escolheu o método?

☐ Eu
☐ Eu e meu parceiro
☐ Médico
☐ Outro: _____

24. O método que você usa, o posto oferece sempre, às vezes ou nunca?

☐ 1. Sempre ☐ 2. Às vezes ☐ 3. Nunca

25. No caso de alguma dúvida, ou problema com o método, você consegue consulta fora da data marcada?

☐ 1. Sim ☐ 2. Não ☐ 3. Não sabe

26. Você consegue marcar consulta de planejamento familiar por telefone?

☐ 1. Sim ☐ 2. Não ☐ 3. Não sabe

27. Há quanto tempo você freqüenta este posto?

☐☐ Anos ☐☐ Meses

28. Agora eu vou perguntar para você sobre alguns aspectos gerais do posto. Para cada um deles, responda se você acha:

1. Ótimo 2. Bom 3. Regular 4. Ruim 5. Não sabe

☐ 1. Área física/local
☐ 2. Acesso
☐ 3. Condições de limpeza
☐ 4. Banheiro
☐ 5. Sala de espera
☐ 6. Sinalização
☐ 7. Marcação de consulta
☐ 8. Encaminhamento
☐ 9. Exames
☐ 10. Entrega de medicamentos
☐ 11. Entrega de MACs

29. Sobre que assuntos de saúde da mulher você tem recebido informações nesta unidade? (Se a/o usuária/o não entender, dê um exemplo)

- ☐ Informações sobre MAC
- ☐ Informações sobre DST/HIV-AIDS
- ☐ Informações sobre sexualidade
- ☐ Informações sobre adolescência
- ☐ Informações sobre gravidez
- ☐ Outros: _____

30. Você pagou algo pelo atendimento ou para a obtenção do método anticoncepcional, ou não?

☐ Sim ☐ Não **(PASSE PARA A PERGUNTA 32)**

31. Quanto você pagou pelo método anticoncepcional que você recebeu aqui no Posto?

R$ _____

32. Você gostaria de dizer mais alguma coisa, ou dar alguma sugestão?

_____

_____

_____

_____

_____

_____

_____

_____

Observações:

_____

_____

_____

_____

_____

_____

_____

_____

Nome do entrevistador: _____

PROJETO REPROLATINA

PERCEPÇÃO DAS USUÁRIAS EM RELAÇÃO AOS SERVIÇOS DE SAÚDE SEXUAL E REPRODUTIVA

Roteiro para Entrevista Informal com usuárias/os

INSTRUÇÕES:

De preferência, realize a entrevista informal com mulheres/ homens da comunidade no domicílio, ou outros locais da comunidade (praças, feiras, centro comunitário, etc).

A entrevista informal também pode ser realizada na unidade de saúde com mulheres/homens que esperam atendimento para outras ações que não sejam de Saúde Sexual e Reprodutiva (Ex. pediatria, clínica geral etc).

Apresente-se e diga que gostaria de conversar algumas coisas sobre as unidades de saúde e sobre a atenção na área do Planejamento Familiar, porque a opinião dela/dele é muito importante e será de grande ajuda para o programa que está sendo implementado, que tem como objetivo melhorar a qualidade da atenção.

PRINCIPAIS PERGUNTAS A SEREM INCLUÍDAS:

1.- Qual o seu nome?
2.- Quantos anos você tem?
3.- Você tem filhos? Se tem, quantos?
4.- Você conhece a unidade de saúde do seu bairro?
5.- Você consulta na sua unidade?
Se sim, para que? Se não, porque não?
6.- É fácil ou difícil conseguir consulta na sua unidade?
7.- Como se consegue consulta na unidade?
8.- Você conhece os métodos para evitar filhos?
Se sim, quais?
9.- Você usa algum método anticoncepcional?
Se sim, qual? Onde consegue o método?Se não, porque não?
10.-Peça algumas idéias ou sugestões que ajudem a melhorar a unidade de saúde.

Nota: Anote todas as informações obtidas no seu caderno de campo.
Agradeça a participação.

PROJETO REPROLATINA

PERCEPÇÃO DAS MULHERES EM RELAÇÃO AOS SERVIÇOS DE SAÚDE SEXUAL E REPRODUTIVA

DIÁLOGO COMUNITÁRIO COM MULHERES / AVALIAÇÃO

1. Quais são os problemas de saúde que a mulher pode ter?
2. Quando a mulher tem esses problemas de saúde, o que elas fazem?
3. No bairro em que vocês moram, tem posto de saúde que atenda as mulheres com esses problemas, ou não?
4. (Se existe posto no bairro). As mulheres consultam nestes postos, ou não?
5. O que vocês acham do atendimento para os problemas de saúde da mulher, nos postos de saúde que vocês freqüentam?
6. É fácil ou difícil conseguir consultas nesses postos de saúde? Por que?
7. Qual é o horário de atendimento desses postos? Esses horários são adequados ou não para vocês?
8. Na sua opinião, qual seria o melhor horário para vocês consultarem?
9. O que as mulheres gostam nesses postos de saúde?
10. O que elas não gostam nos postos de saúde?
11. O que as mulheres fazem para evitar filhos?
12. Que métodos para evitar filhos vocês conhecem?
13. Vocês acham que os métodos para evitar filhos podem causar algum problema de saúde para a mulher, ou não?
14. E os homens, o que eles acham desses métodos para evitar filhos?
15. De quem é a responsabilidade de evitar filhos? Da mulher, do homem, ou dos dois?
16. E onde as mulheres conseguem, ou podem conseguir os métodos anticoncepcionais (para evitar filhos)?
17. Aqui nessa cidade, existe algum lugar que dá informações sobre estes métodos?
18. E aqui nessa cidade, existe algum lugar em que se pode fazer o planejamento familiar?

19. Se uma amiga de vocês, ou uma parenta,quisesse evitar filhos. Para onde vocês encaminhariam ela?

20. Pensando nos serviços de saúde que vocês falaram. O que vocês acham que falta nesses serviços?

21. Na opinião de vocês, qual é o papel das pessoas da comunidade no programa de saúde? O que vocês poderiam fazer para participar do cuidado da saúde?

22. Tem mais alguma coisa que vocês gostariam de falar ou perguntar?

Obrigada!!!

PROJETO REPROLATINA

PERCEPÇÃO DOS PROVEDORES EM RELAÇÃO AOS SERVIÇOS

ROTEIRO PARA GRUPO FOCAL

Bom dia/boa tarde. Estamos aqui para conversarmos sobre o Programa de Saúde da Mulher, ou como se chama agora, o Programa de Saúde Sexual e Reprodutiva.

A nossa reunião vai durar em torno de 1 hora a 1 hora e 30', e tudo o que for dito aqui é confidencial e vai ser utilizado somente para a elaboração do Programa e, se vocês permitirem, nós gostaríamos de gravar, já que tudo o que vocês disserem é importante e é muito difícil escrever tão rápido.

1. Vocês tinham ouvido falar, ou não, de Saúde Sexual e Reprodutiva? E em Programa de Saúde da Mulher?

2. Aqui na sua cidade:....., tem Programa de Saúde da Mulher? Se sim, quais são os atendimentos que esse programa inclui?

3. Que tipos de atendimento esta unidade oferece? (Focalizar a Saúde Sexual e Reprodutiva). Vocês acham que dão conta da demanda? Como e quem estabelece as prioridades?

4. (Se não mencionam PF) Nas Unidades de Saúde vocês atendem Planejamento Familiar? Quem atende? Se não, onde se atende em PF?

5. Que métodos anticoncepcionais vocês têm na unidade?

6. Esses métodos anticoncepcionais estão regularmente disponíveis, ou faltam?

7. Vocês acham que esses métodos anticoncepcionais são suficientes para atender a população, ou seriam necessários outros métodos anticoncepcionais? Quais?

8. O que vocês acham desses métodos?

9. Que tipos de pessoas procuram o planejamento familiar? (homens, mulheres, adolescentes). Como são essas pessoas, trabalham ou não, o que fazem, etc?

10. As/os adolescentes procuram métodos anticoncepcionais? (Se sim) Procuram antes da gravidez, ou depois? (Se não) Por que não?

11. É fácil ou difícil conseguir uma consulta em PF nas Unidades? (Por exemplo: se uma mulher vem hoje solicitar um MAC, quando ela consegue consulta?)

12. Qual é o horário mais procurado pela população?

13. A unidade oferece, ou não ações educativas em saúde sexual e reprodutiva para as mulheres/casais? Se sim, quais os assuntos tratados? Quem faz? Onde são feitas? Se não, por que não?

14. A unidade tem, ou não, materiais educativos para utilizar com as mulheres/casais? Se sim, quais? É distribuído ou mostrado? Se não, por que não?

15. Vocês receberam alguma capacitação específica em planejamento familiar? Se sim, quando? Quem ofereceu? Qual a carga horária?

16. Vocês se sentem preparadas(os) para atender em planejamento familiar, ou vocês necessitam (mais) capacitação?

17. O que vocês gostam no trabalho que vocês realizam?

18. O que vocês não gostam?

19. Quais as dificuldades que vocês encontram para realizar seu trabalho?

20. Vocês realizam atividades diretamente na comunidade que atendem, ou não? Se sim, quais? Se não, por que não?

21. Vocês têm algum sistema de referência nesta unidade ou não? Se sim, qual? Se não, o que as pessoas fazem quando não tem o atendimento que necessitam na unidade?

22. Na opinião de vocês, para dar uma atenção de qualidade às mulheres nesta unidade, o que poderia ser feito/melhorado?

23. Vocês gostariam de dizer mais alguma coisa?

Obrigada!

PROJETO REPROLATINA

PERCEPÇÃO DAS AUTORIDADES EM RELAÇÃO AOS SERVIÇOS DE SAÚDE SEXUAL E REPRODUTIVA

ROTEIRO PARA AUTORIDADES

Bom dia/boa tarde. Estamos aqui para conversarmos sobre o Programa de Saúde da Mulher, ou como se chama agora, o Programa de Saúde Sexual e Reprodutiva.

A nossa reunião vai durar em torno de 1 hora a 1 hora e 30', e tudo o que for dito aqui é confidencial e vai ser utilizado para a elaboração do Programa e, se você permitir, nós gostaríamos de gravar, já que tudo o que você disser é importante e é muito difícil escrever tão rápido.

1. Quais são os principais problemas de saúde de Campo Largo? Quais são as prioridades nessa área?

2. A saúde da mulher, ou mais especificamente, o planejamento familiar é prioritário para o seu município? Por que?

3. No Programa de Governo da gestão atual estão incluídas ações de planejamento familiar e outros aspectos da saúde sexual e reprodutiva? (Prevenção de Ca, DST/AIDS, etc).

4. (Se tem programa) Quem participou da elaboração? Ele foi aprovado pelo Conselho Municipal de Saúde? Se não, há interesse em implementar um programa de Saúde Sexual e Reprodutiva?

5. Do total do orçamento do Município, qual é a porcentagem para a saúde? Essa quantia permite atender as necessidades da população?

6. Qual é a colaboração do Estado e do Governo Federal para os programas de saúde, em especial da saúde da mulher?

7. Qual é a estrutura da Secretaria de Saúde? Como estão organizados os programas? E como eles se relacionam?

8. Existe algum programa específico para atender adolescentes em saúde sexual e reprodutiva no Município? Se sim, onde? Está sob a coordenação da Secretaria de Saúde ou não?

9. O que você esperaria da colaboração com a Reprolatina?

10. Você gostaria de falar mais alguma coisa?

Obrigada!!

PROJETO REPROLATINA

Fone: (55-19) 3289-1735

CONSENTIMENTO INFORMADO
ENTREVISTAS COM USUÁRIAS/OS

Eu, _____, fui informada(o) que um projeto será implantado neste município para melhorar os serviços de saúde para mulheres, por isso uma pesquisa está sendo realizada para se saber as necessidades, perspectivas e preocupações que as mulheres têm sobre sua saúde.

Eu fui convidada(o) a participar de uma entrevista para responder perguntas sobre o serviço de saúde que utilizei, sobre minha saúde e sobre as maneiras de evitar filhos.

Fui informada(o) que minha participação nesta pesquisa não vai me trazer nenhum benefício pessoal, que não seja a satisfação de poder contribuir com este estudo.

Fui também informada(o) que todas as informações pessoais que der serão mantidas em segredo. Como parte deste estudo, meu nome ou qualquer outra forma de identificação pessoal não aparecerá em nenhum lugar (a não ser nesta folha).

,

Disseram-me que a entrevista será feita em um local privado nesta unidade de saúde e que irá durar entre 10 a 15 minutos. Somente a equipe de pesquisa terá acesso às entrevistas, que serão mantidas em confidencialidade na Reprolatina por um período de cinco anos. Após este período elas serão destruídas.

Fui informada(o) que minha participação é voluntária, ou seja, eu só participarei se quiser, e que tenho o direito de não responder qualquer pergunta que queira. Eu também posso interromper a entrevista quando quiser. Garantiram-me que isto não irá interferir no atendimento que receberei neste centro de saúde agora ou no futuro.

Li ou leram para mim as informações acima e tive a chance de esclarecer dúvidas e fazer perguntas sobre esta pesquisa, que me foram respondidas satisfatoriamente.

Data de hoje: ____ de _____ de 200_.

Assinatura da(o) participante _____

Assinatura da testemunha _____

Eu certifico que todas informações acima foram dadas à(ao) participante.
Assinatura da pessoa que obteve o consentimento informado _____

Assinatura do(a) investigador principal_____

PROJETO REPROLATINA

Fone: (55-19) 3289-1735

CONSENTIMENTO INFORMADO
GRUPOS FOCAIS/DIÁLOGOS COMUNITÁRIOS COM MULHERES DA COMUNIDADE

Eu, _____, fui informada(o) que um projeto será implantado neste município para melhorar os serviços de saúde, por isso uma pesquisa está sendo realizada para se saber as necessidades, perspectivas e preocupações que as mulheres têm sobre sua saúde.

Eu fui convidada(o) a participar de uma discussão em grupo com outras mulheres da comunidade para discutir sobre minha saúde, as formas de evitar filhos, os serviços de saúde e as necessidades da comunidade em relação à saúde.

Fui informada(o) que minha participação nesta pesquisa não vai me trazer nenhum benefício pessoal, que não seja a satisfação de poder contribuir com este estudo.

Fui também informada(o) que todas as informações pessoais que eu der serão mantidas em segredo. Como parte deste estudo, meu nome ou qualquer outra forma de identificação pessoal não aparecerá em nenhum lugar (a não ser nesta folha). Entendo que eu devo manter em sigilo o que eu escutar sobre outras participantes. Eu também entendo que devo manter confidenciais todas as discussões aqui realizadas hoje e também irei manter confidenciais tudo que for discutido pelo grupo.

Disseram-me que a discussão em grupo será feita em um local privado e que irá durar entre uma hora e uma hora e meia. Esta discussão será gravada. Somente a equipe de pesquisa terá acesso às fitas e às discussões transcritas, que serão mantidas em confidencialidade na Reprolatina por um período de cinco anos. Após este período, ambas serão destruídas. Eu também fui informada que esta discussão será conduzida por um pesquisador e que uma segunda pessoa irá tomar notas da discussão.

Fui informada(o) que minha participação é voluntária, ou seja, eu só participarei se quiser, e que tenho o direito de não responder qualquer pergunta que queira. Eu também posso me retirar do grupo quando quiser.

Li ou leram para mim as informações acima e tive a chance de esclarecer dúvidas e fazer perguntas sobre esta pesquisa, que me foram respondidas satisfatoriamente. Além disso, autorizo que a gravação seja feita.

Data de hoje: ____ de _____ de 200_.

Assinatura da(o) participante _____

Assinatura da testemunha _____

Eu certifico que todas informações acima foram dadas à(ao) participante.
Assinatura da pessoa que obteve o consentimento informado _____

Assinatura do(a) investigador principal_____

PROJETO REPROLATINA

Fone: (55-19) 3289-1735

CONSENTIMENTO INFORMADO
GRUPOS FOCAIS COM PROVEDORES

Eu, _____, fui informada(o) que um projeto será implantado neste município para melhorar os serviços de saúde, por isso uma pesquisa está sendo realizada para se saber as necessidades, perspectivas e preocupações que as mulheres têm sobre sua saúde.

Eu fui convidada(o) a participar de uma discussão em grupo com outros provedores para discutir sobre o serviço de saúde e sobre as necessidades da comunidade.

Fui informada(o) que minha participação nesta pesquisa não vai me trazer nenhum benefício pessoal, que não seja a satisfação de poder contribuir com este estudo.

Fui também informada(o) que todas as informações pessoais que eu der serão mantidas em segredo. Como parte deste estudo, meu nome ou qualquer outra forma de identificação pessoal não aparecerá em nenhum lugar (a não ser nesta folha). Eu também entendo que devo manter confidenciais todas as discussões aqui realizadas hoje e também irei manter confidencial tudo que for discutido pelo grupo.

Disseram-me que a discussão em grupo será feita em um local privado e que irá durar entre uma hora e uma hora e meia. Esta discussão será gravada. Somente a equipe de pesquisa terá acesso às fitas e às discussões transcritas, que serão mantidas em confidencialidade na Reprolatina por um período de cinco anos. Após este período, ambas serão destruídas. Eu também fui informada que esta discussão será conduzida por um pesquisador e que uma segunda pessoa irá tomar notas da discussão.

Fui informada(o) que minha participação é voluntária, ou seja, eu só participarei se quiser, e que tenho o direito de não responder qualquer pergunta que queira. Eu também posso me retirar do grupo quando quiser.

Li ou leram para mim as informações acima e tive a chance de esclarecer dúvidas e fazer perguntas sobre esta pesquisa, que me foram respondidas satisfatoriamente. Além disso, autorizo que a gravação seja feita.

Data de hoje: ____ de _____ de 200_.

Assinatura da(o) participante _____

Assinatura da testemunha _____

Eu certifico que todas informações acima foram dadas à(ao) participante.
Assinatura da pessoa que obteve o consentimento informado _____

Assinatura do(a) investigador principal_____

PROJETO REPROLATINA

Fone: (55-19) 3289-1735

CONSENTIMENTO INFORMADO
ENTREVISTA COM AUTORIDADES

Eu, _____, fui informada(o) que um projeto será implantado neste município para melhorar os serviços de saúde para mulheres, por isso uma pesquisa está sendo realizada para se saber as necessidades, perspectivas e preocupações que as mulheres têm sobre sua saúde.

Eu fui convidada(o) a participar de uma entrevista para responder perguntas sobre o serviço de saúde e sobre as necessidades da comunidade nesta área.

Fui informada(o) que minha participação nesta pesquisa não vai me trazer nenhum benefício pessoal, que não seja a satisfação de poder contribuir com este estudo.

Fui também informada(o) que todas as informações pessoais que der serão mantidas em segredo. Como parte deste estudo, meu nome ou qualquer outra forma de identificação pessoal não aparecerá em nenhum lugar (a não ser nesta folha).

Disseram-me que a entrevista será feita em um local privado e que irá durar entre 30 a 45 minutos. Esta entrevista será gravada. Somente a equipe de pesquisa terá acesso às entrevistas, que serão mantidas em confidencialidade na Reprolatina por um período de cinco anos. Após este período elas serão destruídas.

Fui informada(o) que minha participação é voluntária, ou seja, eu só participarei se quiser, e que tenho o direito de não responder qualquer pergunta que queira. Eu também posso interromper a entrevista quando quiser.

Li as informações acima e tive a chance de esclarecer dúvidas e fazer perguntas sobre esta pesquisa, que me foram respondidas satisfatoriamente. Além disso, autorizo que a gravação seja feita.

Data de hoje: ____ de _____ de 200_.

Assinatura da(o) participante _____

Assinatura da testemunha _____

Eu certifico que todas informações acima foram dadas à(ao) participante.
Assinatura da pessoa que obteve o consentimento informado _____

Assinatura do(a) investigador principal_____