

# Chapter 7

## Scaling up family planning service innovations in Brazil: the influence of politics and decentralization

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### Summary

The principles of strategic management suggest that a major step in ensuring effective scaling up is to understand the diverse environments in which health service innovations are expanded. When service innovations are expanded in the public sector, the political and administrative institutions, as well as the health sector setting constitute major environmental influences. This chapter analyses these factors in Brazil, using the experience of a project which sought to enhance equitable access and improve the quality of care in public sector family planning services. Nongovernmental organizations acted as the resource team that facilitated the testing of the original service innovations in one municipality and then assisted with their expansion to others. The chapter shows that scaling up is influenced by an ongoing process of decentralization and by the politics of family planning. Scaling up family planning innovations faces special challenges, which would not be encountered in other areas of reproductive health in Brazil.

### Introduction

The principles of strategic management suggest that a major step in ensuring effective scaling up is to understand the diverse environments in which health service innovations are expanded (1). These environments, or contexts, shape the opportunities and constraints that proponents of scaling up must navigate (see Chapter 1). When service innovations are expanded in the public sector, the political and administrative institutions, as well as the health sector setting constitute major environmental influences. This chapter analyses these factors

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in Brazil, using the experience of a project which sought to enhance equitable access and improve the quality of public sector family planning services. Nongovernmental organizations (NGOs) acted as the resource team that facilitated the testing of the original service innovations in one municipality and then assisted with their expansion to others. We show that scaling up is influenced by an ongoing process of decentralization and by the politics of family planning. Scaling up family planning innovations in Brazil faces special challenges that would not be encountered in other areas of reproductive health.

In Brazil, an estimated 75% of the population depend on the public sector for their health care (2), which at the primary level is provided through health posts, health centres or community-based family health outreach services (3). Clinic-based family planning services are provided by gynaecologists, assisted by auxiliary and technical nursing personnel, on contract with the public sector for a specified number of hours. These services are free of charge to the users. The community-based family health service is supposed to include contraceptive care, but lack of contraceptive supplies is a major barrier. The Sociedad Civil Bem-Estar Familiar, an NGO, has provided extensive support to the public sector family planning programme, maintaining agreements with 1001 municipalities predominantly in the north-east of the country for the provision of technical assistance, training and evaluation (4). Although public sector responsibilities have been established and some services are indeed available, overall access to family planning care is extremely constrained and the care that is provided tends to be of poor quality (5-7).

In 1995 a project in the municipality of Santa Barbara d'Oeste (referred to in this chapter as Santa Barbara) in the State of São Paulo in southern Brazil initiated a systematic process of dealing with these weaknesses in access and quality of care. Interventions in the pilot municipality focused on:

- upgrading all elements of quality of care through training;
- restructuring providers' roles and service delivery patterns so as to maximize the use of scarce medical personnel;
- improving the management process in order to ensure accountability and supportive supervision;
- creating a referral centre where regular availability of contraceptive care would be assured;
- establishing a participatory process including representation from the community (8);
- introducing outpatient vasectomy services (9);
- developing a programme for adolescents.

Comprehensive training played a major role in introducing these innovations. In 1997, evaluation results demonstrated that the public sector service system had improved availability, access, and the quality of family planning services within the resource constraints of the municipal health sector (10). Support from the NGO resource team of action researchers and trainers was an important factor in this success.

For most projects this would be the end of the story; but not so in this case. Activities in Santa Barbara were implemented as part of the Strategic Approach to Strengthening Reproductive Health Policies and Programmes sponsored by the World Health Organization (WHO) (11–13). One of the special characteristics of the Strategic Approach is its emphasis on scaling up (14). The positive evaluation results therefore raised the question whether the model implemented in the pilot, and the many lessons that were learned, could benefit other municipalities in Brazil. The resource team that had facilitated the development, implementation and evaluation of the project in Santa Barbara took on the challenge and, with funding from WHO, initiated and supported replication of the approach in three other municipalities between 1997 and 1999.

Because their needs were similar, the three new municipalities adopted many of the core service innovations from Santa Barbara. In 1999, after three years of replication in these localities, significant improvements in access to services and their quality had once again been achieved. In fact, the process had been easier and faster because of the learning that had occurred in the pilot project (15). Santa Barbara was used as a demonstration site where professionals from the new municipalities could see how the innovations functioned in actual practice. Moreover, the NGO resource team was now more skilled in supporting the introduction of service innovations because of its experience in the pilot site which resulted in greater sophistication in navigating health sector and local government institutions.

This scaling-up success, however, posed a dilemma as well as a new question. Brazil has over 5500 municipalities, but the project had worked in only four. That scaling up would not proceed spontaneously, but instead requires active support from a resource team, became apparent during the first phase of expansion. In a decentralized health system such as Brazil this implies that a large number of local governments, whose management capacity tends to be weak, depend on external assistance in the process of adopting service innovations (16–18). The need and actual interest among municipalities in joining the project was great. In fact, the demand for such support during the first phase of expansion was more than what the resource team could

offer. For example, in one of the new municipalities, health professionals expressed disappointment that the level of support received had been less than they would have liked. Thus the question was whether the relatively small, nongovernmental team of action researchers and trainers could facilitate the process of expansion beyond what had been accomplished during the first phase of scaling up.

In 1999, funding from the Bill and Melinda Gates Foundation made it possible to continue the process of scaling up, and provided the opportunity to develop a strategy for multiplying the capacity to support expansion of service innovations. This strategy, implemented through what was now referred to as the Reprolatina Project, had two key components.

- Development of training capacity that would enable newly trained municipal trainers to expand training to all health posts and centres within their municipality and beyond. Creating a municipal resource team rather than relying exclusively on external facilitators would make it possible for local trainers to introduce innovations within their own municipality and subsequently expand them to neighbouring ones.
- Active networking and the use of information technology to facilitate information exchange and ensure that municipal innovators would support each other rather than rely exclusively on the NGO resource team.

Over the past six years, training capacity has been created in nine municipalities which, in turn, have expanded activities to an additional 26 smaller ones. Periodic participatory seminars for leaders of the municipal implementation teams and the creation of web-based conferences and other forms of electronic communications have enabled ongoing opportunities for experience sharing and social learning. Simultaneously the project has further refined its strategy for adolescents and training for local leaders. A discussion of the Reprolatina training approach is provided in the next chapter.

Many lessons have been learned in the course of scaling up. The one initially most underestimated is the importance of understanding the political, administrative and health sector contexts.<sup>1</sup> Throughout the project, this lesson has emerged as more and more important. At the beginning, the external resource team members were confident that they knew a great deal about the sociocultural, institutional and political environment of public sector family planning services. Certainly,

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<sup>1</sup> For a systematic assessment of the influence of social organization and political culture on decentralized health care in Brazil see 19.

enough was known about the health system and the bureaucratic institutions in Brazil to proceed with appropriate intervention strategies. Several years after seeking to expand service innovations to new municipalities, however, it is clear that learning about the institutional setting and about political culture never stops. More important still, learning must be actively encouraged, both among members of the resource team and among municipal partners. The public health system always holds surprises, especially since it continues to evolve and is highly variable among municipalities. In Brazil, where decentralization has become a major component of political and health sector reform, efforts to improve family planning and related services benefit from strategies that adjust to such ongoing change and variability.

This chapter identifies both environmental opportunities and constraints that affect the wider use of successfully tested programme innovations. In the Brazilian context, as in many others, the constraints can be daunting, but recognizing them should not discourage initiatives. Rather, taking constraints into account allows the innovators to choose realistic strategies, anticipate the level of resources needed, and assess the type, pace and extent of scale that can be achieved.

The information contained in this chapter comes from six sources: 1) participant observation, covering more than 10 years during which members of the resource team implemented the WHO-sponsored Strategic Approach and the Reprolatina Project; 2) published papers and unpublished reports from these projects; 3) qualitative assessments conducted in participating municipalities as a central component of the health service renewal process; 4) meetings and interviews with Ministry of Health, state and municipal officials; 5) official reports, laws and guidelines of the Ministry of Health; and 6) literature on health sector reform and decentralization in Brazil.

### **Decentralization: opportunities and constraints in scaling up**

In Brazil, health reform began in the 1970s as part of a wider movement for the democratization of the country (20–23). The health reform movement advocated for the principles of universality and equality in health, seeking to combat the injustices of a bifurcated medical/health-care system. Services were available through insurance programmes to workers in the formal sector of the economy, leaving the rural and urban poor without access to health care. Insurance programmes for workers were administered by the Instituto Nacional de Assistência Médica da Previdência Social (INAMPS, National Institute of Medical Care of the Social Welfare System) under the authority of the Ministry

of Social Security;<sup>2</sup> other areas of health were the responsibility of the Ministry of Health. With return to democracy in 1984 many of the principles of the health reform movement were enshrined in article 196 of the Constitution (1988), which guarantees health as a universal right and commits the country to the provision of equal and universal access to services. Family planning is considered a basic right and the state is charged with the responsibility of providing educational and scientific resources to ensure access to care. Decentralization and the participation of civil society in policy development and implementation are mandated. The Constitution also declares that health services should be organized under a single, decentralized system, with a preventive focus and the participation of communities. With the formal creation of the Sistema Único de Saúde (SUS, Unified Health System), in 1990 (25), the dual authority over health was ended and the Ministry of Health assumed sole responsibility for public sector health care.

Decentralization in the health sector was formally initiated with the Basic Operating Rules of 1991, 1993 and 1996, by progressively shifting authority for decision-making to government at the state and municipal levels with major responsibility to the latter (21, 26). Such “municipalization” proceeds through transference of resources according to the capacity of the municipality to assume “full management of basic care”<sup>3</sup> or “full management of the municipal system”.<sup>4</sup> In 2005, 88.2% of the 5561 municipalities in Brazil were still in the first stage of decentralization (28, 29).

### **Decentralization dictates a focus on horizontal scaling up**

A distinction has been made in the literature between replication or expansion of innovations, and political, policy or legal scaling up (30, 31 and Chapter 1). The former is focused on geographical expan-

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<sup>2</sup> INAMPS was an autonomous institution associated with the Ministry of Social Security until 1990 when it became part of the Ministry of Health; it ceased to exist in 2002 (24).

<sup>3</sup> Municipalities with the “full management of basic care” receive a fixed per capita amount and, with these funds have to develop all primary health activities, including assistance and rehabilitation, prevention and health promotion. In addition, municipalities receive a variable amount for epidemiological surveillance, the environment, essential treatments, the family health programme and prevention of nutritional deficiencies.

<sup>4</sup> Municipalities with “full management of the municipal system” have more managerial autonomy and must provide primary, secondary and tertiary levels of care, including hospitalization. Where official agreements among municipalities have been made, they should also provide care to people referred from surrounding municipalities (27). These municipalities receive, besides the Piso de Atenção Básica (minimum level of services in primary care), resources for secondary and tertiary care, including some funds for specific programmes (26).

sion or horizontal scaling up, and the latter on institutionalization or vertical scaling up.

The process of decentralization in Brazil had major implications for the design of the pilot project in Santa Barbara and for subsequent scaling-up initiatives. It was clear from the outset that, given the municipalities' predominant role in programmatic decision-making, the focus would have to be on the municipality and that scaling up would have to proceed mainly as a process of geographical expansion. As we indicate below, this approach had advantages but also faced major constraints. Municipal autonomy facilitates the introduction of innovations, but sustainability and collaboration among municipalities in their expansion can be problematic.

### *Municipal autonomy facilitates the introduction of innovations*

Municipal autonomy implies that local health authorities are able to institute major programmatic innovations as long as they comply with national policies and guidelines. These fully endorse, and in fact mandate, the provision of reproductive health services, including family planning (32–34). There is no need to obtain authorization from the state or federal level, or to provide information about what changes are being made. Thus, where municipal authorities are supportive, major service renewal can be initiated. Moreover, given the considerable fiscal discretion associated with decentralization, it is often possible to identify necessary local resources to improve facilities, ensure supplies or recruit additional staff.

In the pilot site, municipal autonomy was a clear advantage at the beginning of the project. The municipal health secretary was highly motivated to improve family planning services, and had turned to the nongovernmental resource team to provide training and other technical support (10). Local resources were mobilized to recruit additional health-care providers, to remodel one of the facilities to create a reproductive health referral centre, and to introduce an adolescent programme and a vasectomy service. This pattern repeated itself in the other municipalities (15). Federal or state regulations have not been an obstacle in the effort to expand innovations.

### *Politicization of technical issues and leadership changes threaten sustainability*

Decentralization of authority to the municipal level has been associated with a change in the status of technical personnel which has had a negative effect on sustainability. Under the earlier centralized system, health professionals had more autonomy to make decisions because they were employed by the federal government rather than by the municipality (25). As part of a competitively recruited cadre of

federal appointees in permanent positions, they also had greater job security. Personnel hired at the municipal level, in contrast, often do not have secure jobs. Facing severe and regular financial constraints, local legislatures tend to be unwilling to authorize permanent positions that require competitive recruitment. As a consequence, most recruitment is for jobs on temporary contracts from which staff can be easily dismissed. This has made technical professionals subject to greater political accountability and has led to frequent changes among key personnel.

Such turnover generally occurs in the wake of elections, especially when the party in power changes, but it also takes place at other times. In the period between the last two local elections, project municipalities changed their secretary of health several times, with an average of three replacements between 2000 and 2004; one municipality had seven. Leadership change tends to be associated with replacement of other staff who are political appointees or personal friends. For example, the coordinators of the Women's Health Programme – who play a central role in implementing reproductive health service innovations – were always removed at the same time as the health secretary. Frequent personnel change has undermined the sustainability of health service innovations and has required extensive resource-team support to ensure continuity.

The impact of leadership change is exacerbated by the fact that new officials are rarely briefed about ongoing programmes and often come with specific instructions to abandon innovations in order to weaken the political image of the previous administration (35). Given the autonomy of elected municipal officials, innovations can be abolished by a new administration even though they are fully integrated into local service systems. Even when the party in power is confirmed by the election, a change of the mayor may require several months to reinstate activities with new authorities. As a result, the window of opportunity for building new initiatives lasts at best four years, and the sustainability of innovations, no matter how beneficial, is not easily ensured.

### ***Lack of collaboration between municipalities jeopardizes scaling up***

The federally mandated pattern of decentralization officially encourages collaboration among municipalities (36) which could increase access to needed technology for more people and could provide a mechanism for scaling up health service innovations. In reality, however, political and financial considerations discouraged such collaboration, thereby curtailing opportunities for scaling up. In the experience of the Reprolatina Project, collaboration was not easily realized for us-

ing newly trained reproductive health trainers to train neighbouring municipalities. Some health and local authorities saw collaboration as a beneficial strategy, arguing that improved capacity in neighbouring municipalities would reduce the number of patients who crossed municipal borders to seek care in their health facilities. Others, however, objected to such training as an unjustified use of municipal resources for neighbouring areas. Political rivalries among office-holders from different parties added to the difficulties of arriving at collaborative agreements.

As a result of these constraints, efforts to utilize newly created training capacity as a means of expanding innovations to neighbouring municipalities did not always succeed. A collaborative strategy for scaling up health service innovations among municipalities was thus not as powerful a tool as expected. Multiplying training capacity improved the ability of project municipalities to respond to training needs within the municipality but continued to require heavy reliance on the training role of the project's core resource team in the expansion to other municipalities.

### **Limited opportunities for vertical scaling up in a decentralized setting**

Scaling up should involve not only the expansion of innovations from site to site but also interventions at the political, policy and legal levels - which has been defined as vertical scaling up (30). Such interventions are essential for all levels of government but are particularly critical for higher echelons. Institutionalization at these levels facilitates and sustains the process of expansion. Effective decentralization - and by implication effective scaling up - requires a strong level of intergovernmental liaison and some oversight or incentives from the state and federal level (21).

Even though much decision-making authority passes to the municipality in the process of decentralization in Brazil, the federal and state government maintains critical functions which can and should be engaged in scaling up. Federal-level initiatives occur in regard to the provision of contraceptive supplies to municipalities and in priority setting through the creation of financial incentives for special programmes. The state level plays a role in the allocation of resources for training. If scaling-up advocates succeed in influencing decisions in these areas, the prospects for institutionalizing and expanding innovations are substantially enhanced. The Reprolatina Project attempted to work on the vertical scaling up, but the overall success in this area was limited. It is important to understand what factors explain this result.

The Ministry of Health participated in the nationwide assessment that demonstrated the need to improve access and quality of family planning services (5) and led to the innovations in the Santa Barbara municipality. The project thus followed the basic principle that future “users” of the innovations must be involved from the outset. As time progressed, however, it became more difficult to continue this pattern. In recent years the Ministry has assigned only 4–6 professionals to the national women’s health programme, giving them responsibility for obstetric care, gynaecology, adolescent health, early detection of gynaecological cancers and family planning. With this broad range of national responsibilities, the small group of professionals can devote only limited efforts to the improvement of family planning services; consequently it was difficult to maintain their ongoing involvement. Nonetheless, as described below the project sought to engage with state and federal authorities in the three central areas where their intervention could have major impact on scaling up: contraceptive supplies, training resources and financial incentives (25).

#### *Facilitating regular availability of contraceptive supplies*

The Brazilian Ministry of Health has declared its commitment to meeting a portion of the municipal need for contraceptive supplies. Municipalities do not have adequate financial resources to provide for their contraceptive needs and the federal government can negotiate better prices with the pharmaceutical industry than can individual municipalities.<sup>5</sup> The Ministry of Health is also in a better position to ensure quality control (7, 37). In previous years, when supplies were available from donors, the Ministry provided contraceptive methods to municipalities if the appropriate requests were made. However, such distribution rarely worked well because municipalities were often unaware of the complex bureaucratic mechanisms involved in submitting their requests.

After the progressive loss of donor contributions in the early 1990s, various efforts were made to distribute contraceptives to municipalities, none of which brought lasting solutions to the supply problem. When the federal government undertook procurement in the mid-1990s, the acquisition of oral contraceptives of unacceptable quality created delays in further action, and subsequently the expectation was that contraceptive procurement would be handled by the states. However, several states refused to include contraceptives in their list of basic medicines, in part because they were afraid quality control problems might be repeated (7). Thereafter, the government planned

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<sup>5</sup> The need for a continued role of central governments in the provision of contraceptive supplies in decentralized health systems has been noted for other countries as well (16).

to provide contraceptive kits to municipalities on a three-month basis, expecting to cover 30% of need in 2001, 60% in 2002, and 100% in 2003. However, the Ministry encountered difficulties with reliable distribution to the over 5000 municipalities and local storage of supplies. As a result, implementation of the scheme has been irregular (7). In 2004, no kits were distributed for a period of at least six months; subsequently some distribution was resumed.

The Reprolatina Project resource team observed the intricate and evolving variations in federal contraceptive distribution schemes, expecting to assist project municipalities in securing regular supplies once the system was clearly established. The forever changing and unpredictable nature of the process at the federal level, however, left little room for involvement from below. Some of the project municipalities have been able to persuade local authorities to purchase contraceptives. Nonetheless the fact that federal support remains sporadic hinders the process of scaling up family planning innovations.

#### *Mobilizing resources for training*

There are few public sector institutions in Brazil that provide in-service training for professionals in family planning and related aspects of reproductive health. The states address the need for human resource development by providing grants to a variety of institutions with relevant training capacity, many of them universities. Scaling up family planning innovations tested by the Reprolatina Project benefited in one region of the country from the availability of such state-level training resources. This became possible because the project was able to establish a close connection to the relevant state-level decision-maker who was convinced of the importance of family planning and has consistently supported logistics and related costs for training programmes organized by the project.

Similar success was not possible in other regions. Because such training funds are not specifically earmarked for family planning but are available for a range of health areas, there is no guarantee that the limited resources can be mobilized for family planning. Success depends on the specific circumstances in each state, especially on the interests of the key decision-maker. Given competing demands on these resources, strong advocacy is required in seeking these funds and many bureaucratic hurdles must be overcome before municipalities succeed.

#### *Lobbying for financial incentives*

Influencing financial incentives for family planning was a third area where the Reprolatina Project expected to affect higher-level decision-making in order to institutionalize service innovations

pioneered in municipalities. As discussed further in the next section, health sector financing leaves family planning in a position of disadvantage. The project municipalities and the Reprolatina Project resource team discussed the possibilities of influencing the existing pattern of financing with the purpose of ensuring a more favourable incentive structure for family planning.

The suggestion was to bring this issue onto the agenda of the powerful national Council of Municipal Secretaries of Health. However, project municipalities have not been able to accomplish this, in part because of the frequent turnover of health secretaries. More importantly, the project has not pursued this plan because conversations with federal officials indicated that, given the continuing political sensitivities surrounding family planning in Brazil, such proposals would be unlikely to succeed in the near future. The discussion in the next section clarifies these political liabilities.

Thus, overall, the Ministry of Health and the state-level secretariats have not played a strong role in scaling up family planning service innovations originally tested in Santa Barbara. This is so even though these innovations conform to the central agenda of the Brazilian policy framework as most recently articulated in the Family Planning Law (32). As a result, the success with vertical scaling up and institutionalization has been limited.

In theory, the Reprolatina Project resource team could have taken more vigorous advocacy steps with other stakeholders, for example parliamentarians, the National Commission for Population and Development and other national or state-level agencies. The lesson here is that the small NGO resource team had obvious limits in its capacity to advance vertical scaling up. Given the extensive demands for technical assistance and training required in expanding service innovations to new municipalities, a stronger advocacy role of the project at the national and state levels was not feasible.

### **Political obstacles to scaling up family planning innovations**

Considerable progress in the evolution of strong rights-based reproductive health policies has been made in Brazil over the last 15 years. Brazil has shaped the global reproductive health agenda and was itself strongly influenced by international forums such as the 1993 World Conference on Human Rights, Vienna; the 1994 International Conference on Population and Development, Cairo; and the 1995 Fourth World Conference on Women, Beijing. In the past decade, improvements were obtained in hospital-based obstetric services, expansion in prenatal care and cervical cancer screening. New regulations

were issued on how the SUS should respond to women who had suffered gender violence, and an increasing number of service sites are providing abortion on grounds permitted by law (38). In 1996 and 1997 the Family Planning Law (32) was enacted, reconfirming family planning as a right within the context of integrated attention to health and obliging the government to provide services respecting each individual's right to choice. A major contribution of this law has been to legalize sterilization, which had been considered semi-illegal, even though it was widely practised. The law also requires that all safe and scientifically proven contraceptive methods are made available.

Although the right of access to contraceptive services is anchored in the Brazilian Constitution, confirmed by the new law and declared important by the Ministry of Health, in practice family planning is not a high priority at either the federal, state or municipal level. No organized set of national or state activities or financial incentives directs the service system to the provision of family planning education and care. At the local level, family planning services are usually among the first to be reduced when municipalities encounter financial constraints or lack of personnel. This position of disadvantage is reflected in health sector financing and can be attributed to the continued religious sensitivities as well as to the overall lack of political appeal of these preventively focused services. As a consequence, efforts to expand family planning innovations are faced with special challenges which would not be encountered in scaling up other reproductive health programmes in Brazil. Understanding how these constraints operate is an essential step in setting realistic scaling-up goals and designing effective strategies.

### *Family planning's disadvantage in health sector financing*

Although health services are controlled at the municipal level, approximately 75% of public sector health-care financing comes from the federal government; the remainder is provided from state and municipal revenues. Federal health financing is provided in the form of per capita allocations, reimbursements for services and financial incentives for special programmes. At the present time, key special programmes supported by the federal government are the safe motherhood and community-based family health initiatives. These are implemented in municipalities that applied for these funds.

Under the SUS each municipality is allocated a fixed per capita amount of about US\$ 4 per year. Out of these funds, municipalities should cover primary care including vaccines, maternal health, child nutrition, family planning and tuberculosis treatment (27). In addition to this federal allocation, municipalities are legally committed to de-

vote to health a minimum of 15% annually out of their own budget. Over the past decade, the overall amount of funding for health from federal, state and municipal levels has grown. Because no allocations are designated for contraceptive services, however, family planning competes for funding with other health activities. It rarely does well in this competition, as municipalities are likely to allocate federal funds as well as funds from local revenues for other health priorities, especially curative care.<sup>6</sup> Municipalities often resist requests to purchase contraceptives or purchase them only sporadically, far below actual needs. Previously, when they could request reimbursement from the SUS for services provided, the situation was somewhat better. Although in practice a ceiling was imposed on reimbursements, the system provided an incentive for municipalities to invest in contraceptive services.

Municipalities which have implemented the family health programme can receive additional funds over the Piso de Atenção Básica (minimum level of services in primary care). Other programmes, such as humanized delivery, also receive special financial incentives. Although such special funds are assigned for primary health care, funds for special programmes cannot be used to purchase contraceptives. Discussion with Ministry representatives revealed that, given the political sensitivities, the prospects for changing the current incentive system in favour of family planning are extremely low.

### *Religious sensitivities and general lack of political appeal*

The political sensitivities surrounding contraception are an important explanation for the low priority accorded to family planning. Even though the Church does not officially oppose family planning, many politicians prefer to support other issues, fearing opposition from local priests who continue to be concerned that methods such as the intrauterine device (IUD) and emergency contraception are abortifacients. For example, in one of the project municipalities, a local law prohibited the use of IUDs, thereby creating a major restriction of contraceptive options available to women. Although this law was in clear violation of federal law, it was passed because of the powerful influence of a local Catholic priest who threatened to shut down the women's health centre if IUDs continued to be provided. After three years of persistent efforts from the women's health coordinator, this law was repealed. The use of IUDs still has not come back to previous levels, in part because the priest continues his campaign against the device.

More recently, religious-political tensions surrounding family planning have coalesced around the issue of emergency contrac-

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<sup>6</sup> The local expenditure choice for curative care has also been observed in other settings. See for example 39.

tion, which some local religious groups view as an abortifacient (7). This reaction is so intense that some municipalities are turning entirely against family planning, even though federal law clearly approves a broad range of methods including emergency contraception. Decentralization leaves municipalities at liberty to make such decisions because the national government is unable to monitor events at the local level and to enforce federal policies and regulations.

The impact of religious sensitivities is compounded by family planning's lack of political appeal more generally. Mayors seek to maximize their standing with the local electorate and tend to invest in highly visible projects, which demonstrate their contributions in tangible ways. They give priority to building new facilities, buying ambulances, dealing with an epidemic or focusing on child health and see little political advantage in supporting improvements in contraceptive and related reproductive health services. The benefits of family planning and prevention more generally are less obvious to politicians. With the continued high levels of contraceptive prevalence and the increasing availability of Misopristol for medical abortion through the private sector, the argument that family planning saves lives does not carry the same conviction that it did in the past. Equitable access, quality of care and reproductive rights in contraceptive care are not perceived as having the same political pay-offs as other primary health-care initiatives.

## Conclusions

Although Brazil's national policy framework is extremely favourable to reproductive health generally and family planning in particular, scaling up family planning service innovations faces extensive constraints. The combination of policy support at the national level and decentralized decision-making can facilitate scaling up, but it can also impede it. The autonomy vested in the municipal governments in the wake of decentralization makes change possible in the many municipalities where interest in these innovations is strong. Such autonomy allows for innovations to be adapted and modified according to local needs. This is a major benefit, because needs vary and particular interventions must be responsive to the local institutional and sociocultural contexts. Inequities arise, however, when there is no interest among municipalities to improve reproductive health services, or when such interest changes over time.<sup>7</sup>

In contrast, the authority to make change also implies that valuable innovations can be swept aside in the face of political change.

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<sup>7</sup> The fact that decentralization may lead to inequities has been widely discussed in the decentralization literature. See for example 39–41.

Sustainability at the local level cannot be taken for granted. Over and over again the Reprolatina Project had to shift emphasis from a focus on further expansion to putting energy into sustaining innovations in municipalities where changes in leadership and other personnel threatened continuity. In most cases sustainability could be ensured, but it required extensive support from the project's resource team.

Decentralization provides the context in which political, financial and other institutional factors are played out. In the decentralized, federal setting of Brazil, the Ministry of Health communicates its interest in priority health areas through the mechanism of financial incentives to municipalities. For the political reasons discussed above, contraceptive services have not received such special incentives and are not likely to benefit from them in the near future. Contraceptive services, as well as resources for training, must compete with other pressing primary health-care priorities. Given the continued political sensitivities of family planning and the fact that the benefits of preventive services are not considered as politically rewarding by local decision-makers as are the benefits of curative services, municipalities do not regularly purchase essential contraceptive supplies. The Ministry of Health in turn has sought to provide contraceptive supplies through various schemes but these have not yet succeeded in meeting the need. While federal funds are earmarked for training, they are not necessarily allocated to family planning.

Thus scaling up family planning innovations faces particularly heavy barriers in Brazil. Service innovations related to safe motherhood or the family health programme, for example, would be considerably easier because they benefit from greater priority on the local and national health policy agenda. An important conclusion from this analysis is that the success of scaling up is influenced not only by the intrinsic demands of the service innovations themselves but also by how they fit within the national and local priorities.

What advice can one give to others who seek to ensure successful scaling up in a decentralized setting where successfully tested service innovations do not benefit from high priority on the national and local policy agenda? We list seven key recommendations, which represent the most essential lessons.

1. *Analyse the environmental context of scaling up.* The most general lesson is that understanding the environmental context within which scaling up takes place is vital. Even though a deep understanding of the institutional context for scaling up may at times appear discouraging, it is only when one understands the system well that the opportunities for positive action become apparent.

Examination of the environmental context provides a solid foundation for setting realistic goals and for maximizing existing opportunities.

2. ***Focus on sustainability even though this slows down the pace and scope of expansion.*** In the long run, fewer but sustainable innovations stand a greater chance of serving as models that can inspire others and generate broader reform than larger expansion that does not survive.
3. ***Use national legal and policy frameworks as tools for reproductive health and rights-based training and social mobilization focused on government accountability.*** Communities as well as local health authorities and providers are often not well informed about policy and legal advances in reproductive health, nor are they familiar with the mechanisms by which decentralization creates opportunities for resource mobilization. Using such information in training generates demand from below and empowers communities, local authorities and providers to participate effectively in newly created decentralized decision-making forums and advances scaling up.
4. ***Use policy windows wisely.*** It is essential to keep an eye on policy windows that may open, especially those created by the electoral cycle, and to use the time of such openings wisely. For example, major innovations should not be started at the end of an electoral cycle but at the beginning, so as to maximize the time period in which sustainable innovations can be implemented.
5. ***Work with strong municipal teams.*** Select municipalities with several strong team members at the level of providers, authorities and the community. This can buffer the effects of frequent change in personnel and ensure sustainability.
6. ***Provide training that addresses the rights, gender and reproductive health agenda as well as technical, management and systems needs.*** In a decentralized setting where more responsibility for programme design and management falls upon local health teams than in a centralized setting, sustainable scaling up requires training that prepares health teams and communities for a broader range of competencies than was needed in the past. Training should generate a vision of what is possible within the constrained context, create commitment to achieving it, address the need for effective technical and managerial skills, and empower the team to move forward together.

7. ***Ensure the availability of an external resource team with long time horizons and the ability to support both vertical and horizontal scaling up.*** Continuity from an external resource team over a number of years ensures sustainability of the scaling-up process because longer time horizons make it possible to outlast short-term political change.

The analysis in this chapter reinforces the wisdom that scaling up should be based on an understanding of the context or environment within which it takes place. Such analysis should be ongoing because the institutional context does not stay frozen in time. This is particularly true as long as decentralization is still in the process of being shaped and finalized. Such change may provide new opportunities, but it may also imply that old solutions do not work any longer and new ones need to be discovered. In decentralized and constrained political settings, scaling up must begin with the willingness to engage in a learning process.

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