Chapter 8

An innovative educational approach to capacity building and scaling up reproductive health services in Latin America

Margarita Díaz, Francisco Cabral[a]

Summary

As governments seek to meet the global health agendas of the past decade, new approaches to the training of health professionals are needed. Training must move away from an exclusive focus on technical skills and begin to incorporate educational strategies that empower providers, programme managers and community leaders to become agents of change. This chapter describes a methodology for in-service training that builds on Paulo Freire's educational philosophy and explains how the capacity to provide innovative training was scaled up in public sector reproductive health services in Brazil, Bolivia and Chile. Statistics on the training sessions demonstrate the reach of this training initiative, and testimonials show its profound impact on newly trained trainers.

Introduction

The 1994 International Conference on Population and Development (ICPD), held in Cairo, as well as several subsequent international summits, challenged governments to implement far-reaching goals in reproductive and primary health care, gender and women's empowerment, and the eradication of poverty and major diseases (*1–3*). At the same time, many national governments have been striving to enact changes in their health systems in the wake of decentralization and health sector reform. Realizing the vision of these global and national agendas requires a process of social transformation that includes changes in the attitudes of health authorities, managers, providers and the community. In this chapter we argue that working to-

[a] Margarita Díaz is President and Francisco Cabral is Vice-president of Reprolatina; they designed and implemented the training methodology described in this paper.

wards such changes has major implications for training, because training is one of the main tools by which new attitudes and skills can be developed.

Given the magnitude of change implied in the necessary transformation, training itself has to change. It must move away from an exclusive focus on technical skills and from biological notions of reproductive health that give little consideration to social, cultural and political dimensions. Training must incorporate educational strategies that will allow providers, programme managers and community leaders to become agents of change. Without such empowerment, the massive reform implied in global visions cannot be achieved. The challenge is to develop innovative approaches and to build the capacity for widespread utilization and scaling up of new and empowering training methodologies in public sector service systems.

We had the opportunity to develop such a new approach and to demonstrate how the capacity to provide innovative in-service training could be expanded within the public sector. This chapter describes the key elements of the training methodology and shows how it was developed in one municipality in Brazil and was subsequently scaled up to several others and extended to Bolivia and Chile. This chapter identifies how a small nongovernmental team can initiate change and build public sector training capacity that orients managers, providers and community leaders to new visions of reproductive health.

The information presented here is based on four sources of data: our own experience as sexual and reproductive health trainers; focus groups with newly trained trainers, which we conducted in July–November 2005 with six groups in Brazil and one each in Bolivia and Chile; in-depth interviews we conducted with municipal health and local government authorities in July–November 2005 (11 in Brazil, 2 in Bolivia, and 9 in Chile); and project statistics on the number of training programmes conducted.

Evolution of Reprolatina's training approach

The opportunity to develop innovative training presented itself first in connection with the implementation of the Strategic Approach to Strengthening Reproductive Health Policies and Programmes sponsored by the World Health Organization (WHO) (*4, 5*) and subsequently with the Reprolatina Project, an initiative funded by the Bill and Melinda Gates Foundation. Strategic assessments, undertaken first in Brazil (1993) and subsequently in Bolivia (1995) and Chile (1996), revealed glaring shortcomings in the provision of public sector reproductive health services (*6, 7*). Although there were differences among

the findings in the three countries, the assessments identified similar weaknesses. Access to reproductive health care and to quality family planning services was extremely constrained, and health-care providers' technical knowledge was outdated. Interpersonal relations reflected the power, class and ethnic differentials between providers and local people and were not conducive to interactions that educate or empower the participants. The sexual and reproductive health and rights vision articulated in Cairo was not present in day-to-day health-care delivery, and providers and managers were not prepared to incorporate its multiple challenges into their work.

In 1995 the Center for Mother and Child Research of Campinas (CEMICAMP) initiated an action research project to test appropriate responses to the assessment findings in a low-income municipality. The Population Council and the University of Michigan collaborated with this project and financial support was provided by WHO (*8, 9*). Focus on a municipality was dictated by the fact that in the decentralized setting of Brazil programmatic decisions about service delivery are made at the municipal level (see Chapter 7). The Santa Barbara Project – named after the municipality in which it was implemented – used a participatory organization development approach, in which municipal providers, health authorities, community representatives and researchers worked in close collaboration.[1] They began with a diagnostic assessment to establish specific needs; followed by designing and implementing interventions, and ongoing evaluation. The main interventions focused on:

- upgrading all elements of quality of care (*11*);
- 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 contraceptive services would be available on a regular basis;
- establishing a participatory process of project decision-making with representation from the community (*12*);
- introducing outpatient vasectomy services (*13*);

[1] Organization development is 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 technology of applied behavioural science, including action research" (*10*, p. 28).

- developing a programme for adolescents.

As described later, these interventions were supported with training programmes for all members of the municipal health team.

Evaluation results in 1997 indicated that these interventions substantially improved both quality and access to family planning and related reproductive health care in the municipality (*8*). At this stage the project began to turn its attention to scaling up, asking whether expansion of the successful interventions to other municipalities in Brazil would be feasible. Initial scaling up was undertaken in three municipalities with support from WHO and proved successful (*14*). This led to further expansion within Brazil and the initiation of activities in Bolivia and Chile between 1999 and 2006 through the Reprolatina Project, which created training capacity in nine municipalities in Brazil, eight in Bolivia and three in Chile (for the sake of simplicity we use the term "municipality" for Bolivia and Chile, though other terms are used locally).

Training was provided by a resource team consisting of ourselves and colleagues, first from CEMICAMP and subsequently from Reprolatina, a small Brazilian nongovernmental organization (NGO) created in 1999. This training was instrumental in producing the project's success and, as we describe below, was a key component of the scaling-up strategy. One of us (M.D.) had had many years of experience in training family planning providers in Brazil and other countries of Latin America and had already begun to recognize that training on technical aspects of contraceptive care needed to be complemented with a focus on interpersonal relations, gender and sexuality. In the course of implementing the training first in Santa Barbara and in the subsequent scaling up in Brazil, Bolivia and Chile, this perspective evolved further.

Such evolution occurred along two dimensions. First, it quickly became apparent that training topics needed to be broadened to take account of the multiple needs and problems faced by the municipal health teams. For example, teams were not used to identifying their own problems and finding solutions within their resource constraints. Training thus had to be holistic, seeking to build and sustain capacity through a comprehensive educational approach that enables local teams to analyse their own reality and empowers them to change it, and to provide good sexual and reproductive health care. Second, it was clear that Reprolatina trainers had to develop the capacity of the municipal team to assume training tasks – so that they could train others within the municipality and expand training to neighbouring municipalities. With this recognition, the strategy of the resource team

shifted from training of providers to training of trainers in a broad, empowerment-focused educational approach.[2]

Reprolatina's educational philosophy

Reprolatina's educational philosophy builds on Paulo Freire's understanding that thinking critically about current and past practices allows us to improve the world in which we live (*15–17*). Freire argued that people can act as oppressors or as liberators of their own situation, and emphasized that the purpose of education is to create autonomous persons who engage with a project of emancipation. The objective of such an educational process is to transform current social structures (*18*).

Reprolatina considers education and health to be closely interrelated. The philosophy emphasizes that individuals have unique personal histories and live within a social, political, economic and cultural environment that influences them but that they also shape. Each person has unique knowledge, including those who never attended school. All people have the right and capacity to think, take part in dialogue, have opinions and make choices.

Typically, however, the education and health sectors do not give people the opportunity to participate in decisions about their lives. Education systems are built on power imbalances and passive approaches to learning. This model is repeated in the health profession, which typically treats people as patients or objects of programmes rather than as agents of transformation who participate in their own health care. To put the Cairo agenda into practice, the educational process in the health and the education sectors must change – promoting social and gender equality and encouraging the development of citizens with rights and responsibilities.

Reprolatina begins work in a new municipality by introducing an innovative educational process which, in turn, generates new ways of managing and providing services in reproductive health and facilitates scaling up. At the outset, the Reprolatina team takes the lead in the educational process, acting both as teacher and learner. Working in a participatory way, the team at times transfers new ideas; on other occasions, the team receives new ideas from the participants.

---

[2] Key dimensions of empowerment as used in Reprolatina's training programme include the ability to take decisions about one's life, effective expression of one's human rights as well as physical and emotional needs, capability to reflect collectively about one's experiences, and the ability to organize and articulate one's demands at local, national and international levels vis-à-vis governments and other institutions.

Reprolatina's educational strategy has four interrelated goals. The first, which is the essential precondition for the other three, focuses on ***personal and professional empowerment***. In order to be empowered, health providers must go through a process of reflection and self-evaluation to be able to identify why they should change. Before health professionals can provide a new standard of care they must discover their own ability to introduce changes that will improve the quality of care they provide. Training aims to enable individuals to be active participants in the learning process and to become dedicated agents of change. It takes into account the life experience, knowledge, expectations and self-esteem of learners and addresses cognitive, cultural and affective aspects including the feelings that emerge during the training process. Participants are expected to develop a greater sense of self-awareness and autonomy as well as a common sense of solidarity.

The second dimension addresses ***knowledge and technical skills***. Training provides accurate technical information that is offered at a level appropriate to the knowledge of different participants. Areas covered include knowledge and awareness of the human body, sexuality, power, and sexual and gender roles, as well as practical training on contraception and related aspects of reproductive health care. Training also develops counselling and communication skills to help participants improve communications within the health team and to interact supportively with service users.

A third dimension of training deals with the need to create the capacity for ***organization development*** so that trainees will be able to promote changes in the health system. Trainees are sensitized to the importance of understanding the characteristics of the health system that create and sustain current problems in quality of care and of the social and economic characteristics of the community they serve. Participants acquire the ability to diagnose problems, to identify opportunities for intervention and to test their proposed solutions and evaluate them. Simultaneously, they develop negotiation skills and learn how to work more effectively as a team and to undertake self-evaluation. Participants learn about and acquire the needed skills to conduct supervision and empowerment-focused evaluation (*19*).

The fourth goal of training is developing the capacity to act as facilitator for **s*ocial and cultural transformation***. Participants develop critical understanding of the social, economic and cultural dynamics that shape current health policies and practices, and the power relations that govern these dynamics, including tensions between the public and private health sectors. They gain a clearer understanding of the meaning and role that gender and power play in their health system

and in people's lives. Participants are trained to become trainers and facilitators of a process of change.

The process of capacity building

Building capacity to improve health service systems is a complex undertaking. It requires appropriate training programmes as well as efforts to create an enabling environment where training can succeed. These are not short-term interventions but initiatives requiring considerable investment of time and energy.

Types of training programmes

Reprolatina has assembled a range of training courses for health providers, educators, adolescents and community leaders.

Reprolatina's most important curriculum is for the training of trainers, which is provided by a midwife (M.D.) and a psychologist (F.C.) with the support of a physician from the Population Council, Brazil, who provides training on the technical aspects of contraceptive methods. Reprolatina begins by carefully selecting a group of up to 20 participants from among the team of municipal health providers (physicians, nurses, midwives, psychologists and social workers). Selection is based on the candidates' potential and previous experience as trainers, their past work in family planning and reproductive health, their commitment to complete the 80-hour course, and their ability to devote enough time to conduct at least one training course every other month. These conditions often limit the number of providers who qualify, but this selection process helps to ensure that the most appropriate providers receive the training.

The training-of-trainers curriculum is taught in two stages, each consisting of a 40-hour course. The first course begins with basic principles, concepts and values such as sexual and reproductive health and rights, gender, quality of care, informed choice and the user perspective. Subsequently the course moves to the development of skills and competencies focused on client-centred interpersonal relations, communication, counselling and provision of contraceptive methods. Skills development also covers participatory approaches, organization development and health systems analysis. In addition, the course includes attention to special topics such as adolescent sexual and reproductive health, sexuality, and HIV/AIDS. Trainees also learn about the experience of the Santa Barbara Project and the objective of scaling up pilot interventions more broadly in the country.

Between the first and second course is a break of approximately two months so that trainees can read the literature they are given upon completion of the first training. This literature includes publications

on the Strategic Approach, the Santa Barbara Project, scaling up, organization development, informed choice, reproductive rights, gender and Freire's educational philosophy. During this break, trainees also conduct a baseline diagnosis in their municipalities to assess community perspectives and needs in sexual and reproductive health as well as service access and quality at the primary care level in the public sector. Reprolatina provides training in how to conduct such a baseline diagnosis as well as instruments for interviewing members of the local community and local clinic staff, and for conducting observations of service provision and facilities. This diagnosis provides the basis for action planning subsequent to the completion of the training-of-trainers programme.

The second course prepares trainees for their role as trainers and leaders who will improve quality and access to sexual and reproductive health services in their municipality. It treats the issues covered in the basic training in greater depth, analysing in detail Reprolatina's philosophy and conceptual frameworks and providing specific training in educational methods, learning processes and group management. With this training behind them, the newly trained trainers are ready to replicate the basic training course (the same they received in the first 40-hour course) using the manual prepared for this purpose.[3]

In family planning, newly trained trainers offer either a 40-hour course or a shorter 24-hour course covering the same topics but in less detail. It is preferred that every member of the municipal health team receives the longer training, but the shorter course is given when either the trainer or the trainees do not have sufficient time for the longer one.

A team approach is used in training so that doctors, nurses, receptionists, social workers and psychologists are trained together. Such team training is essential to create an egalitarian environment where everyone's role receives respect and teamwork is practised. The first course conducted by new trainers is supervised by a member of the Reprolatina team who facilitated their training. Most of the trainers are able to continue on their own after this first observed training. They have a goal to train at least 80% of the providers in their municipality. Funding for such training is provided by the municipality, while Reprolatina provides the training materials.

In addition to the training-of-trainers curriculum, Reprolatina has developed several other courses related to its adolescent programme,

[3] The manual includes detailed instructions on how to manage each module, the time allocated for each activity and the summary points. An annex contains guidelines for participatory techniques, a bibliography, and a CD-ROM with all the slides to be used during training.

community participation, sexually transmitted infections (STIs) and HIV/AIDS, sexuality, breastfeeding, and screening for breast and cervical cancer. Reprolatina also organizes shorter seminars for physicians and other professionals who are not able to attend regular-length training courses. These 8-hour seminars cover the philosophy of rights, gender and quality of care – though obviously more briefly than the other training programmes – and update provider knowledge of contraceptive technology and prevention and treatment of STIs. In some cases Reprolatina also provides additional practical training on insertion of intrauterine devices (IUDs), Pap smear collection, how to fit diaphragms, and how to do non-scalpel vasectomy.

All of Reprolatina's training curricula are available to trainers who wish to use them in their municipality. For some of the courses, Reprolatina is able to provide additional training, for others it provides materials and slides that update providers on subjects with which they are already familiar.

In addition to their role as trainers, participants who have completed both courses are expected to act as a leadership team that will work with other providers to improve services in their municipality. During the training they had opportunity to learn from the innovations that succeeded in Santa Barbara and other municipalities in Brazil. The results from the diagnostic assessment they conducted between the two training courses provide the basis for determining which of the pilot innovations should be scaled up in their municipality and what other interventions should be undertaken.

The first activity the trainers are supposed to implement is establishing a training centre. They identify a place to meet at least once a month and to keep their computing equipment and other materials. Such a meeting place is essential because trainers work in different health centres within the municipality and they need a meeting place where they can plan training as well as other initiatives. Thereafter they begin the process of conducting training courses for providers as well as implementing necessary changes in service delivery identified during the baseline diagnosis undertaken in their municipality.

Creating an enabling environment for training

Training programmes often fail to have lasting impact. Recognizing from the outset that capacity building is not a short or easy process, Reprolatina seeks to create an enabling environment in each new municipality which ensures that the training-of-trainers programme and other innovations can be successfully introduced, sustained and expanded. Three measures are essential in this process: political commitment and participation of the municipal government and local health

authorities; empowerment-focused supervision; and an electronic information system to facilitate communication among participating municipalities and Reprolatina.

Political commitment and participation. Reprolatina signs an agreement with the state and/or municipal health authorities in the regions in the three countries where activities are being implemented. In these agreements the government endorses the creation of training capacity in the municipality, authorizes the participation of providers in the training programme and its subsequent replication and promises necessary support. Such formalized agreements between Reprolatina and each municipality have been instrumental in sustaining activities when local governments changed in the wake of elections.

Political commitment has been instrumental in maintaining activities when resources are scarce. On several occasions, municipal authorities have provided extra resources for new staff, information, education and communication (IEC) materials, contraceptive methods and other unforeseen needs. Nonetheless, regular municipal financing for these activities is not guaranteed.

Empowerment-focused evaluation and coaching. Capacity building requires performance evaluation that reinforces newly trained trainers in their role as innovators. In providing such support, Reprolatina staff work with the principles of empowerment evaluation, which is "designed to help people help themselves and improve their programmes using a form of self-evaluation and reflection" (*20*, p. 3). Trainers are taught to evaluate their activities and use results to plan new ones. These constitute entirely new approaches for most trainees, who are used to a narrow approach to supervision which is focused on administrative compliance. Similarly, when Reprolatina staff observe service delivery, they act as coaches rather than as conventional supervisors. The emphasis is not on criticism but on encouragement of self-evaluation, sharing of experience and reflection.

Electronic communication. When the volume of communication between Reprolatina and municipalities and among municipalities increased rapidly early in the project, an appropriate system was needed to manage it. A communication network was built, using WebBoard™ and three web sites, with technical support from the School of Information at the University of Michigan. This has proven to be efficient. All the trained personnel having an e-mail address were invited to participate in this electronic network and they all received information, bulletins and IEC materials through the network. To date, 71% of trained personnel have access to a computer. The three web sites provide updated technical information and project information to project partners and the community at large. One of the sites de-

scribes the philosophy, history and activities of the Reprolatina Project (http://www.reprolatina.net); the second, entitled Living Adolescence, provides correct and up-to-date information for adolescents on diverse subjects of sexual and reproductive health and rights (http://www.adolescencia.org.br); and the third, Contraception Online, is an extensive online resource for sexual and reproductive health information related to technical aspects of contraception (http://www.anticoncepcao.org.br).

Results

Scaling up training capacity

The first training of trainers was performed in 2000 in Brazil, in 2001 in Bolivia and in 2002 in Chile. Table 8.1 shows the number of training centres created and the number of trainers and providers trained per country, including providers attending 8-hour seminars for updating knowledge on family planning and STIs. An important indicator of training capacity is the fact that providers were trained by the newly trained trainers. The table, however, hides the variability of the results. Although the capacity-building process was implemented similarly in all sites, some centres were able to begin replication of the activities soon after training and needed only short-term supervisory support, while other centres were not able to expand the process.

Figure 8.1 shows the multiplicative scaling-up process in Brazil, in which Reprolatina-trained trainers are scaling up the process to other municipalities. The Ministry of Health and state governments have also been participants in this process, mainly by giving political support and financial resources in some cases.

	Number of training centres/ teams	Number of trainers trained	Number of providers trained	Number of providers attending 8-hour seminars
Brazil (2000–2005)	9	98	1921	1219
Bolivia (2001–2005)	8	34	741	758
Chile (2002–2005)	3	21	395	47
Total	**20**	**153**	**3057**	**2024**

Table 8.1 Training outputs

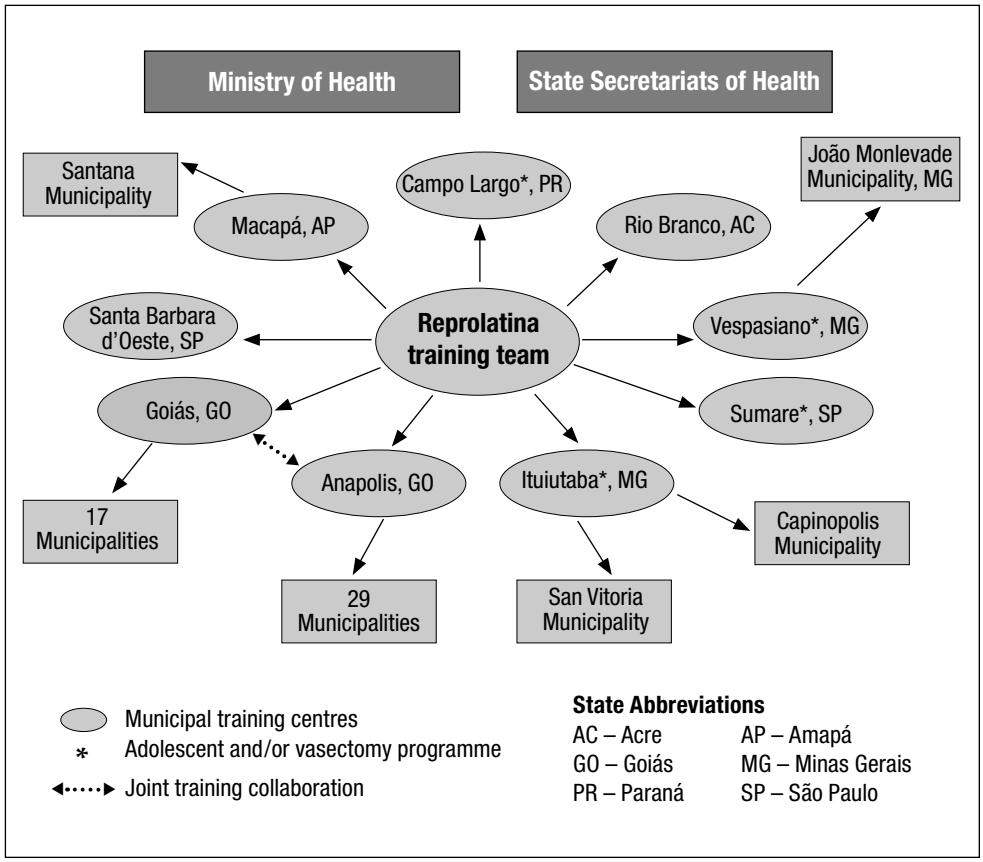

Figure 8.1 Scaling up training capacity in Brazilian municipalities

Building training capacity has progressed at different speeds in different places, because of political and administrative issues that either interfered with or facilitated the process (see Chapter 7). In some places, additional resources were mobilized. For example, in the State of Goiás the project was expanded to 38 municipalities with partial financing from the state level; another municipality in the State of Minas Gerais started scaling up with financial support from a private national foundation, Fundação Belgo. In Bolivia it was possible to expand the training capacity to four additional teams with the support of the United Nations Population Fund (UNFPA).

Most municipalities focused on scaling up innovations that improved existing reproductive health services. In some communities, however, scaling up also added new services for men or adolescents which previously had not been available, but had been tested in Santa Barbara. This required additional training, especially for the adolescent programme.

Trainers' testimonials

Perception of training impact and methodology. The Reprolatina training programme left a deep impression on participants.[4] It challenged them to reflect on their professional work and their personal goals. Concepts such as sexual and reproductive health, informed choice and reproductive rights are not just new technical terms for them but ideas that have transformed the way they look at their work and relate to others. Trainees feel connected – some of them for the first time – to the basic values of their profession, and talk about the new perspectives with which they look at service users, community members and also their colleagues. Extracts from some of their comments are given below, with the municipality and country of the respondent indicated in parentheses.

> *It's as if you light a candle in a person so that she knows she has a mission and is not alone; she has someone who stands behind all of this and gives support so that she is in a position to change.* (Macapá, Brazil)
>
> *I had never seen anything like this. I can say with complete certainty that this totally changed my way of looking at health, of looking at the world.* (Campo Largo, Brazil)
>
> *If I could put it in one word, this word would be "transformation", because… you enter in the process as one person and then it seems that this person flourishes, as pop-corn that explodes in knowledge and willingness of doing and modifying things, and begin having a different vision, not that technical but a very humanized vision … a stimulus so great that you feel willing and excited and wanting to work.* (Anápolis, Brazil)
>
> *The approach you gave on how to treat the users, the integrated care, this I liked very much, really it motivated me. One was used to talking about contraceptive methods and wanting to impose them. In Reprolatina the exercise of the right, that the person looks what is more convenient and one only orients her to what she can or cannot use, using the eligibility criteria ... That was the most important: the approach and our change of the attitude.* (Santa Cruz, Bolivia)

---

[4] The evidence presented in this section is based on focus group discussions (using standard focus group methodology) and in-depth interviews conducted with trained trainers in 2005 in Brazil, Bolivia and Chile, as part of the participatory and formative evaluation component of Reprolatina's training programme. Given that the interviewers were also the trainers there is likely to be a courtesy bias in these comments. Nonetheless, it is revealing to hear the words of the trainees describing how the training affected them.

> *No other training has this empowerment so that people come out from here with a sense of responsibility, knowing what they can do, that they can transform; that it is a process of transformation which is complicated and difficult and lengthy, … that's what I learned from you. … Much needs to be changed here, but you opened this space for people.* (Macapá, Brazil)

> *I had at times difficulty to relate to my place of work and to the people … I was stubborn and not tolerant … I saw that I changed … I now consider myself a better professional, I am better prepared, more attentive, not only in terms of knowledge but as a person, as a human being, and I can see that I can contribute more as a colleague.* (Ituiutaba, Brazil)

> *One of the things that affected me most was the part on sexuality, which led me to reflect; this is a part that has a different perspective. The other thing that also affected me … was the gender focus ... .And for sure, the case of Paulo Freire – this methodology affected me.* (Temuco, Chile)

> *I will always be grateful to you for the flipchart. I take it wherever I go … Once when there were 35 women gathered together … to hear about contraceptive methods, a woman said to me she had never heard an explanation about methods like this. And I felt fulfilled because I never had imagined that I would be able to communicate in this way.* (Campo Largo, Brazil)

> *In no other workshops I attended did it happen that at the end of the 40 hours I had the same enthusiasm as when I was in the workshop. The different approach on how to treat the users, how to treat ourselves, to discover that we were closed, blind … for me it was like awaking to another world and another vision regarding choice, consent.* (Santa Cruz, Bolivia)

The profoundly challenging and provocative nature of the training was expressed in the statement that sometimes the training was so intense and covered so many important issues that at times it made people

> *think too much … and at times robbed them of their sleep. In some moments I did not like some of the discussions but today I see that these were necessary.* (Ituiutaba, Brazil)

The training methodology used by the Reprolatina team was different from that which most participants had experienced in previous training courses, and was viewed as effective and inspiring. For example, the leader of a woman's health centre commented that seeing democratic leadership during the training affirmed her own leadership

style. She realized that her own style was not wrong, and that it was good to be flexible, open and friendly with team members (Ituiutaba, Brazil). Others had similar views:

> *What I noted in the second training was the manner in which you sold the fish (that is) the methodology which you used. There was no way we could get out of there without incorporating Reprolatina's style, and beyond the knowledge, of course, the manner in which you approached the subject. Sometimes you were in the skin of the patient, then you acted as the professional, this was very interesting.* (Campo Largo, Brazil)

> *I liked the participation, the exchange of information, each speaking from his or her own experience, the opportunity we had to speak, to discuss. This really was very different from all the courses I had previously.* (Macapá, Brazil)

> *I found the methodology interesting ... people absorb it, assimilate it. And this was incorporated in what people do. It's not a separate thing that is imposed by you, but one assimilates it in a natural way and there is a natural incorporation into one's work.* (Rio Branco, Brazil)

Replicating the training. Training municipal providers, using Reprolatina's methodology, was initially not easy for most newly trained trainers. They were nervous, uncertain whether they would succeed, and in some cases encountered initial resistance from the participants of the course they organized. However, most found that their initial anxiety disappeared and that they were capable of overcoming difficulties and succeeded in providing a good course. All agreed that in addition to the methodology, the training manual, the slides and all the materials were crucial for the success of replication.

> *The first day I was ready to die, you don't know how the group will be, you don't know whether there will be people who will ask many questions, you don't know whether they will all keep their mouths shut, and what you will do so that they will talk – this is the dilemma until you get to know the group … The second or third day is much easier, ... when you reach the fourth day you wish it would continue and when you reach the last day you realize that everything has been accomplished, that you succeeded and that is very good.* (Campo Largo, Brazil)

> *I was extremely stressed before my first training. I studied a lot; it seemed as if I was going take an exam … But when the time arrived it was a delight. It was so good, everything was fluent … I did not feel afraid at that moment. In the beginning I was insecure, with much fear,*

> *also because of my own lack of study, because one needs to prepare a lot in order to be in front of people. Even then, people saw the results … the unity of the group, the commitment of the group … it was very good.* (Ituiutaba, Brazil)

Success with improving service delivery and sexual and reproductive rights. The Reprolatina resource team observed important changes after the training that improved sexual and reproductive rights and health services in project municipalities. These included obtaining a new building for a health centre, persuading municipal authorities to purchase contraceptives, improving patient flow and the way the service staff related to clients, maintaining patient registers, increasing the volume of contraceptive services, expanding the type of methods used, implementing the informed choice process, and providing participatory educational activities and counselling sessions. Trainees also commented on these changes:

> *I have helped disseminate sexual rights and not only in the area of health but also in other instances in the community. Moreover, the whole team has done this as well.* (Temuco, Chile)

> *In terms of physical infrastructure people battled and requested Dr X ... to make a visit so that he could see the reality of our women's centre, how precarious it was. It was a victory – we succeeded in changing the building, and there … the access was more central, more accessible also in terms of information. (*Ituiutaba, Brazil)

> *We worked more fulfilled knowing that the user had gone satisfied from the service, feeling important and that that person had taken a decision about his/her life and health. So, that was remarkable as much professionally as in my personal life.* (Campo Largo, Brazil)

> *I don't know if it's the most important one, as you said, but I know about the change of attitude of professionals involved, all the professionals who were involved, even those that hadn't been trained were contaminated and realized the model and tried to change something too. I think that the new attitude of professionals was the most evident result of the project.* (Campo Largo, Brazil)

> *All the time that we start a follow-up meeting and we asked what changed, everybody said that now they attended the users in a most positive way, the user is really a subject, a person that has rights.* (Vespasiano, Brazil)

Improvements in service delivery and training also faced major difficulties, among which leadership change or inadequacies in leadership stand out as important barriers. As long as the team of municipal trainers and innovators had good leadership, many of the bureaucratic and even financial constraints could be overcome and remarkable successes were achieved. When leaders and key staff changed, however – in the wake of elections or for other reasons – or when the key coordinators were simply not working effectively with the team, progress was slower and more limited. Also, issues requiring repeated action, such as ensuring regular purchases of contraceptive supplies, were difficult to sustain. A detailed discussion of the larger institutional, bureaucratic and political issues that have stood in the way of implementing change is provided in Chapter 7.

Lessons and conclusions

The experience of implementing training programmes in Brazil, Bolivia and Chile for over six years validates the importance of the three central components of Reprolatina's approach:

- anchoring a participatory and comprehensive educational process in the philosophy of Paulo Freire and the vision of the ICPD;
- combining training with the creation of an enabling environment;
- building training capacity as a central element of scaling up.

Although not a magic bullet, Reprolatina's educational process generated essential actions in participating municipalities that began to transform the way reproductive health services are conceptualized and delivered. Participants reacted with a sense of fulfilment to the training and its methodology, indicating that this type of approach is what motivates them to work to implement the ICPD agenda. Public sector health systems in Latin America lack stability as a result of political changes and health reforms that are not well understood at the local level. Reprolatina's educational process was instrumental in increasing the morale and motivation of the health team, helping it to mobilize the community and to strengthen sexual and reproductive health services.

More than six years of experience and focus group results also confirmed the value of combining formal training with a range of other interventions that enable trainers to function in their new roles and implement change. Clear understandings and agreements with local authorities about the training-led change process could not al-

ways guarantee long-term support, but it was an essential ingredient for success. Continued and empowerment-focused supervision from the Reprolatina team provided much needed support with problem solving and inspiration. The electronic communications network in turn facilitated supervision and the exchange of information with the Reprolatina team and other municipal partners.

A key component of Reprolatina's scaling-up strategy – developing local training capacity – was also validated. In most of the municipalities, local trainers succeeded in training other municipal providers and in meeting the training needs resulting from staff turnover. Some newly trained trainers were able to take on responsibility for training providers in other municipalities. The capability to train new staff ensured sustainability; whereas training of other providers in the same or another municipality brought the benefits of Reprolatina's approach to new people and new areas.

Perhaps the greatest insight to be gained from engaging in the form of participatory education as advocated by Paulo Freire and practised by Reprolatina is the realization that change is possible: the way things are is not the way they have to be. A second key lesson from Reprolatina's experience is that transformative training and associated interventions are not short-term, one-time events; they are intensive endeavours requiring long time horizons because the quantum of change implied in these innovations is very large (see Chapter 2).

It took the sustained attention of a small nongovernmental training institution six years, as well as considerable financial resources, to achieve the results reported here. Moreover, given that the amount of change implied in the training and the related innovations is large, there are inherent limitations in the number of municipalities in which Reprolatina could work. This then, is a basic lesson of the experience: the far-reaching, transformational changes called for cannot happen quickly and cannot be scaled up dramatically if the resource team is a small, nongovernmental training institution.

Reprolatina's strategy of building training capacity made a major contribution in helping to sustain and expand the innovations. Nonetheless, the impact of this newly created training capacity on scaling up is also limited. Trainers have not been able to put into practice all the planned activities because they have to divide their time between multiple tasks: training and provision of services in reproductive health and other areas of primary health care. Moreover, political-administrative relationships among municipalities in a decentralized health system do not always encourage use of trainers from one municipality to conduct training in another (see Chapter 7).

The reproductive and other health-care challenges facing developing countries require that service provision be strengthened. The approach to training and scaling up described in this paper provides a methodology for getting such a strengthening process under way. Large-scale success, however, requires more than the work of a single, small NGO. The challenge thus remains to discover how such a powerful training methodology can be transferred more widely to the public sector and incorporated into the curricula of universities and other health professional training programmes.

Acknowledgements

Very special appreciation goes to Ruth Simmons for her ongoing assistance with the conceptualization and writing of this paper. We would also like to thank the many other people who reviewed the paper and provided input: Juan Díaz, Peter Fajans, Laura Ghiron, Max Heirich, Nancy Newton, Alexis Ntabona, Jeremy Shiffman, and Maxine Whittaker. We are extremely grateful for financial support from the Bill and Melinda Gates Foundation. Finally, we could not have implemented the training programmes described in this paper without the confidence and trust the trainees and the municipalities placed in us. We are deeply grateful for their support.

References

1. *Beijing Declaration*. Fourth World Conference on Women, Beijing, September 1995 (http://www.un.org/womenwatch/daw/beijing/platform/declar.htm, accessed 21 February 2006).

2. *Programme of Action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994*. New York, United Nations Population Fund, 1996.

3. *United Nations Millennium Declaration*. New York, United Nations, 2000 (United Nations General Assembly Resolution A/55/2, 18 September 2000; http://www.un.org/millennium/declaration/ares552e.pdf, accessed 1 March 2006).

4. Simmons R, Hall P, Díaz J et al. The strategic approach to contraceptive introduction. *Studies in Family Planning*, 1997, 28:79–94.

5. *The strategic approach to improving reproductive health policies and programmes: a summary of experiences*. Geneva, World Health Organization, 2002 (Department of Reproductive Health and Research, WHO/RHR/02.12).

6. Formiga JN, Diniz SG, Simmons R et al. *An assessment of the need for contraceptive introduction in Brazil*. Geneva, World Health Organization, 1994 (Special Programme of Research, Development and Research Training in Human Reproduction, WHO/HRP/ITT/94.2).

7. Camacho HV, de la Galvez A, Paz M et al. *Diagnóstico cualitativo de la atención en salud reproductiva en Bolivia [Qualitative assessment of reproductive health services in Bolivia]*. Geneva, World Health Organization, 1996 (Special Programme of Research, Development and Research Training in Human Reproduction, WHO/HRP/ITT/96.1).

8. Díaz M, Simmons R, Díaz J et al. Expanding contraceptive choice: findings from Brazil. *Studies in Family Planning*, 1999, 30:1–16.

9. Díaz M, Simmons R, Díaz J et al. Action research to enhance reproductive choice in a Brazilian municipality: the Santa Barbara Project. In: Haberland N, Measham D, eds. *Responding to Cairo: case-studies of changing practice in reproductive health and family* planning. New York, The Population Council, 2001:355–375.

10. French WL, Bell CH. *Organization development: behavioral science interventions for organization improvement*, International 6th ed. Englewood Cliffs, NJ, Prentice-Hall, 1995.

11. Bruce J. Fundamental elements of the quality of care: a simple framework. *Studies in Family Planning*, 1990, 21:61–91.

12. Díaz M, Simmons R. When is research participatory? Reflections on a reproductive health project in Brazil. *Journal of Women's Health*, 1999, 8:175–184.

13. Penteado LG, Cabral F, Díaz M et al. Organizing a public-sector vasectomy program in Brazil. *Studies in Family Planning*, 2001, 32:315–328.

14. *Evaluating World Health Organization 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. Final technical report*. São Paulo, Centro de Pesquisas Materno-Infantis de Campinas (CEMICAMP) [Centre for Mother and Child Research of Campinas], 2000 (unpublished).

15. Barretto V. *Paulo Freire para educadores [Paulo Freire for educators]*, 3rd ed. São Paulo, Arte e Ciência, 1998.

16. Freire P. *Pedagogia do oprimido [Pedagogy of the oppressed]*, 29th ed. São Paulo, Paz e Terra, 2000.

17. Freire P. *Pedagogia da autonomia: saberes necessários à prática educativa. [Pedagogy of autonomy: necessary knowledge for educational practice]*, 17th ed. São Paulo, Paz e Terra, 2001.

18. Pucci B. Teoria crítica e educação [Critical theory and education]. In: Pucci B, ed. *Teoria crítica e educação: a questão da formação cultural na escola de Frankfurt [Critical theory and education: the question of cultural development in the Frankfurt School]*, 2nd ed. São Paolo, Vozes; São Carlos, EDUFISCAR, 1995:11–58.

19. Patton MQ. Developmental evaluation. *Evaluation Practice*, 1994, 15:311–319.

20. Fetterman DM. *Foundations of empowerment evaluation*. Thousand Oaks, CA, Sage Publications, 2001.