⑥　調査団収集資料

FACTS AND FIGURES ON CEARA

Area- 146 817 Km

Municipes- 184

Ceara Population (1000 inhabitants)- 1991
Total- 6 362 [illegible]
Urban- 4 158 1
Rural- 2 204 6

Rate of Urbanization- 65.4%

Population in main municipes

Municipes	1981	1991	Growth rate per year %	State %
1) Metropolitan area of Fortaleza	1 580 066	2 303 645	3.4	36.2
Fortaleza	1 307 611	1 765 794	2.8	27.8
Caucaia	94 108	165 015	5.2	2.6
Maracanaú	37 894	157 029	13.8	2.5
Maranguape	53 232	71 628	2.7	1.1
Other municipes	87 221	144 179	4.7	2.3
2) Populous municipes	534 278	616 333	1.3	9.7
Juazeiro do Norte	135 616	173 320	2.3	2.7
Sobral	106 467	127 459	1.6	2.0
Crato	80 677	90 413	1.0	1.4
Itapipoca	72 650	77 225	0.6	1.2
Iguatu	68 169	75 619	0.9	1.2
Quixadá	70 787	72 297	0.2	1.1
STATE	5 288 253	6 362 620	1.7	100.0

Rate of Population growth -1980/1991- 1.7

Economically active population (1000 inhabitants)- 1990
Total- 2 552 5
Men- 1 668 8
Women- 883 7

Workers per type of activity (1000 inhabitants)- 1990
Total - 2 486 7
Agriculture- 828 8
Industry- 482 4
Services- 1 175 5

Gross income per capita composition(%) 1992
Agriculture- 14.7
Industry- 26.8
Services - 58.5

Gross income per capita(US$) 1992(1) 1327(2)
Total gross income(millions US$) 1992(1) 8 557(2)

EMPLOYMENT AND INCOME (FORTALEZA) (1992)
Employees- 259 825
Unemployment rate- 11.72%
Gini coefficient(1990)- 0.6258

HABITATION

Private domicile- 1 622 024
Urban - 1 063 786
Rural - 558 236

WATER AND SANITATION- (1992)

% of urban population with access piped water from public network- 75.5
% of urban population with access to public sewage network 14

EDUCATION -

1990- Overall Literacy rate (7 or more years old) 59.1%
Maternal literacy
Metropolitan area of Fortaleza - 84.5%
Rural- 63.7%
State- 71.5%

1992- Inscribed at private and public schools - 1 970 205
Pre-school - 566 496
Primary school - 1 180 822
High school - 117 867
Education for adults - 70 254
Special education - 78 333

Schools - 18 045
Classrooms- 38 798
Teachers - 78 333

HEALTH -

Life expectancy (1988)- 54 years

DATA FROM EPIDEMIOLOGICAL RESEARCH ON MATERNAL AND CHILD HEALTH IN CEARA 1990

Study population

Children under 3 years of age
Metropolitan - 762
Rural - 2099
Total - 2861

Women at reproductive age
Metropolitan - 3201
Rural - 5360
Total - 8561

% of women who delivered within the year prior to the research
Metropolitan - 8.1
Rural - 13.1
State - 11.0

% of women who received no pre-natal care in the last pregnancy
Metropolitan 12% Rural 43%

Tetanus (immunization)
No dosis during the last pregnancy
Metropolitan 24.7% Rural 39.6% State 53.5%
Never immunized against tetanus
Metropolitan 11.6% Rural 25.8% State 22.0%

Birth place(%)	**Metropolitan**	**Rural**	**State**
Hospital	92.9	66.7	73.8
Birth Center	3.5	4.4	4.1
Household	3.1	28.3	21.6
Other	0.4	0.6	0.5

Nutritional status of women 15 to 49 years old

Arm circunference % of women under percentile 5	Metropolitan	Rural	State
	13.9	17.3	17.1

Family Planning

% women who were pregnant in the day of the interview	Metropolitan	Rural	State
	3.7	7.4	6.0
% of women who were willing to have a baby	4.7	5.4	5.1

Family planning method

	Metropolitan	Rural	State
Not sexually active	37.7	34.9	35.9
No method	21.6	26.3	24.5
Tube ligation	16.8	14.3	15.3
Pill	15.1	14.1	14.3
"Natural methods"	3.5	5.3	4.7
Condom	1.5	0.9	1.1
Injections	1.5	0.3	0.8
IUD	0.3	-0.1	0.1
Vasectomy	0.3	-0.1	0.1

Infant mortality
42% of infant deaths occur during the first month of life
83% of these deaths occur in rural areas

Causes of death of children under 3 years of age
- Perinatal causes - 26%
- Diarrhoea - 32%
- Respiratory infections - 9%
- Other causes - 21%
- Unknown causes - 13

Infant feeding

% of infants according to feeding mode

Never breastfed- 20%

In the first month of life: Exclusively breastfed - 1%
Receiving other milk - 69%
% of breastfed babies until four months - 8%
Mean breastfeeding duration < 4months

Diarrhoea point prevalence

	Metropolitan	Rural	State
Diarrhoea on the day of the interview	8.9	8.4	19.6
Diarrhoea within the last 2 weeks	10.6	12.9	12.3
Total	19.6	21.3	20.9

Nutritional status of children under 3 years of age

Nutritional Status — %

Gomez	Metropolitan	Rural	State
Normal	73.8	63.9	66.5
DI	22.3	30.2	28.1
DII	3.0	5.4	4.7
DIII	0.9	0.6	0.7
Percentile			
up to 10	83.9	74.2	76.8
3- 9.9	8.5	14.0	12.5
< 3	7.6	11.8	10.7
Standard Deviation			
= or > -1	76.5	66.0	68.8
-1 to -1.9	16.3	23.6	21.7
-2 to -2.9	5.8	8.8	8.0
-3 or more	1.3	1.7	1.6
Height/Age (in standard deviation)			
= or > - 1	61.3	47.0	50.8
-1 to -1.9	23.7	29.6	28.1
-2 to -2.9	10.2	14.6	13.4
-3 or more	4.8	8.8	7.7
Weight/Height (in standard deviation)			
= or > - 1	89.5	89.6	89.6
-1 to -1.9	8.1	8.7	8.5
-2 to -2.9	1.5	1.3	1.4
-3 or more	1.0	0.4	0.5

1992 - Hospitals- 277
Beds- 18 108
Health Units- 1069
Health Centers- 345

Source IBGE/IPLANCE/COELCE/SUDENE AND PESMIC II

Ceara is the poorest state within the impoverished Northeast region of Brazil with a legacy of unequal income distribution, recurring drouhgt and a health system that has historically neglected the most needy population.

Political will and good planning and government brought rapid changes to the health conditions in the state within the last few years. Before 1987 one in ten babies died before reaching its first birthday, most of them from preventable illnesses such as dehydration from severe diarrhoea and infectious diseases. Only 25% of children in Ceara were vaccinated against measles and polio. Today over 90% are vaccinated and most families know how to prevent dehydration. Ceara's infant mortality rate is nearly 35% lower than it was just five years ago.

MATERNAL AND CHILD HEALTH PROGRAMMES IN CEARA

PROGRAMA VIVA CRIANCA (LONG LIVE THE CHILD PROGRAMME)

Main objective: To reduce infant morbidity and mortality by implementing primary health care for children.

Target population: children 0-5 years old (950 000 children in Ceara)

Programme goal: to cover 70% of all children under five years of age (666 400).

Methodology: Systematic training of health professionals (doctors, nurses, nutritionists) and community health workers.

Activities: Perinatal care; Breastfeeding promotion; Growth monitoring; Immunizations; Diarrhoeal diseases control including prevention (ORT) and management; Acute respiratory infections control.

Achievments: The programme has been implemented in 145(78.8%) out of 185 municipes.

PROGRAMA AGENTES DE SAUDE (THE HEALTH AGENTS PROGRAMME)

The **Programa Agentes de Saude** was established by the state decree n° 19 945 on 2nd January 1989 to promote health for the poor people and to strenghten the link betwenn the community and health services in Ceara. It involves 7 333 Health Agents trained and supervised by health professionals. The Health Agents are Community Health Workers, local people who undergo training in preventive basic health care. Each one assists 100 families in rural area and 250 families in urban area. Each family is visited at least once per month.

Coordination - Health Secretariat of State.
Coverage :
183 out of 184 municipes (only Fortaleza is not covered)
879 960 families
3 959 820 people

Main activities: Early identification of pregnant women. Growth Monitoring. Breastfeeding promotion. Oral rehydration therapy, immunization. Monitoring infant mortality.

The programme has a built-in information system which allows its continuous monitoring and evaluation.

PROGRAMA VIVA MULHER (LONG LIVE THE WOMAN PROGRAMME)

The Programa VIVA MULHER corresponds to the implementation of the technical guidelines of the National Women Programme of the Ministry of Health in all the health units of Ceara State.
Its launching was in August 1992 in a seminar with more than 1000 participants.

Developed and coordinated by the Health Secretariat of State VIVA MULHER has been designed, planned and implemented in collaboration with several national and international Institutions to change for the better the maternal health profile in Ceará.

The envisaged technical and financial support from the United Nations Population Fund speeded up the programme development and implementation. It stimulated both the National Programme for Women and the mayor of several municipalities of Ceará

to immediately carry out the planning activities and to define the logistics for the programme activities.

The four years collaborative project between the State government and the United Nations Population Fund is being implemented to cover all 184 municipes with activities such as outpatients gynecologic clinic, family planning, cancer prevention and pre-natal care. In collaboration with PAHO, the programme will be working specifically on gender issues. Also collaborative agreements are well advanced with ODA, USAID and UNICEF for the implementation of priority activities as identified by the Health Secretariat of State.

BACKGROUND INFORMATION ON THE PLACES TO BE VISITED

NAME: HEALTH CENTRE RODOLFO TEOFILO (WEDNESDAY- 11 AM)
INSTITUTION: HEALTH SECRETARIAT OF FORTALEZA

ASSISTANCE:
Mothers: Pre-natal care; Cancer prevention; Outpatients clinics.

Children: Outpatients clinics; Growth monitoring; Breastfeeding promotion; Oral rehydration therapy; Immunizations; Suplementary feeding to pregnat and nursing mothers and children. Nutrition rehabilitation.

Routinely and specialized exames. Dentistry.

TEACHING: Pediatrics, Orthopedics, Hematology, Nursery to medical, nursery and pharmacy students.

Routinely and specialized exames. Dentistry

* * *

NAME: SCHOOL OF PUBLIC HEALTH DR. PAULO MARCELO M. RODRIGUES(WEDNESDAY - 2 PM)
INSTITUTION: HEALTH SECRETARIAT OF STATE

The School of Public Health of Ceara was created by the state law n° 12 140 in 22nd July 1993.

TEACHING: Posgraduate and refreshing courses for health professionals who work in the State Integrated Health System.

COLABORATIVE WORK WITH:

National School of Public Health - Rio de Janeiro
Faculty of Public Health of the University of São Paulo
School of Public Health of Minas Gerais
Instituto Superiore de Sanitá- Rome
London School of Hygiene and Tropical Medicine

CURRENT COURSES OF STUDIES: Auxiliary nurses; Cytotechnitians; Technician in Pathology; Technicians in Dental Hygiene; Atualization in Epidemiological Surveillance; Atualization in Community Medicine; Specialization in Hospitalar Administration; Atualization in Community Nursing; Atualization in Personnel Administration; English for begginers; Training in basic health care for health professionals from Health Centers; Advanced course in Epidemiology; Informatics in Epidemiology.

* * *

NAME: MATERNIDADE ESCOLA ASSIS CHATEAUBRIAND (WEDNESDAY 3:30 PM)
(MATERNITY SCHOOL ASSIS CHATEAUBRIAND)
NAME: DEPARTAMENTO DE PEDIATRIA (DEPARTMENT OF PEDIATRICS)
INSTITUTION: SCHOOL OF MEDICINE/ FEDERAL UNIVERSITY OF CEARA

The Maternidade Escola Assis Chateaubriand has a 25 years tradition in assisting mothers and children. It is the main reference birth centre for Ceara. The Department of Pediatrics is located at the same building and works in close collaboration with the Maternity School. It is a well equiped training centre for both brazilian and foreign students.

Its interdisciplinary staff includes doctors, nurses, social workers, psychologists.

TEACHING : Gynecology, Obstetrics, Neonatology and Pediatrics at undergraduate and postgraduate level (MSc course and residence) for medical students.

ASSISTANCE:
Mothers: Pre-natal care, deliveries (40 per day), out patients clinics, cancer prevention. Dentistry.

Children: Room-in, out patients clinics, breastfeeding promotion, growth monitoring, immunizations, oral rehydration therapy, nutrition rehabilitation. Supplementary feeding to children, pregnant and nursing women. Intensive care unit for newborn babies. Emergency. Pediatric surgery. Human milk bank. Dentistry.

Routinely and specialized laboratorial exames for mothers and children.

RESEARCH CENTRE ON MATERNAL AND CHILD HEALTH and LIBRARY

ON GOING RESEARCH:
-Sexually transmitted illnesses in children and adolescents
- Early puberty: anthropometry and ultrasonography
- Blood pressure pattern in adolescent pregnant
- Use of low dosis of aspirin to prevent eclampsia in adolescents
- Use of Zoladex® in the treatment of early puberty
- Determination of amino-oxidase level in patients with cancer
- Genetic repercussions of the use of theratogenic drugs during pregnancy.
- Neonatology
- Growth and development
- Diarrhoeal Diseases

* * *

NAME: HOSPITAL GERAL E MATERNIDADE DR. CESAR CALS (THURSDAY 8 AM)
(DR. CESAR CALS GENERAL HOSPITAL AND MATERNITY)
INSTITUTION: HEALTH SECRETARIAT OF STATE

ASSISTANCE:
Mothers: Pre-natal care; Deliveries; Cancer prevention; Internal Medicine. Oupatients and in-patients clinics.

Children: Room-in; Neonatal intensive care unit; Breastfeeding promotion; Growth monitoring; Immunization.

Laboratory for routinely and specialized exames.

TEACHING: Internal Medicine, Surgery, Obstetrics, Pediatrics for undergraduate and postgraduate students (residence).

* * *

NAME: INSTITUTO DE PREVENCAO DO CANCER DO CEARA (THURSDAY 9:30 AM)
(CANCER PREVENTION INSTITUTE)
INSTITUTION: HEALTH SECRETARIAT OF STATE

ASSISTANCE: Cancer prevention.

TEACHING: Colposcopy and Cytopathology to Doctors, nurses and technicians.

* * *

NAME: CENTRO DE SAUDE MEIRELES (THURSDAY 10:30 AM)
(MEIRELES HEALTH CENTER) and HEADQUARTERS of PROGRAMME VIVA MULHER
INSTITUTION: HEALTH SECRETARIAT OF STATE

ASSISTANCE:
Mothers: Pre-natal care; Cancer prevention; Outpatient clinics; Family planning.
Children: Outpatients clinics; Growth monitoring; Oral rehydration; Immunizations. Dentistry. Routinely exames

* * *

NAME: HOSPITAL GERAL DE FORTALEZA (THURSDAY 2 PM)
(FORTALEZA GENERAL HOSPITAL)
INSTITUTION: HEALTH SECRETARIAT OF STATE

ASSISTANCE:
Mothers: Pre-natal care; Birth assistance; Cancer prevention; Outpatients clinic;Family planning; Surgery; Dentistry.

Children: Room-in; Outpatients clinic; Growth monitoring; Breastfeeding promotion; Oral Rehydration; Immunizations; Supplementary feeding to children, pregnant and nursing mothers; Nutrition rehabilitation; Surgery; Dentistry.

Laboratory for routinely and specialized exames.

TEACHING: Residence for Doctors, nurses and physiotherapists.

RESEARCH: Medicine.

* * *

NAME: HOSPITAL INFANTIL ALBERT SABIN (THURSDAY 3:30 PM)
(ALBERT SABIN HOSPITAL)
and HEADQUARTERS OF PROGRAMA VIVA CRIANCA
INSTITUTION: HEALTH SECRETARIAT OF STATE

The Hospital Infantil Albert Sabin, in which 1500 children are assisted daily, is the main reference hospital for children attendance at Ceara.
The activities are defined and implemented as programmes concerning mother and child with close mothers' participation in all the activities carried out within the hospital.

ASSISTANCE:
Mothers: Pre-natal care, out patients clinics, cancer prevention. Odontological care.

Children: Out patients clinics; Breastfeeding promotion;Growth monitoring, immunizations, oral rehydration therapy, nutrition rehabilitation. Supplementary feeding for children. Emergency. Pediatric surgery.

Routinely laboratorial exames for mothers and children.
X Ray and Ultrasonography services.

Reference services: Neurology; Brain surgery; Cardiology; Orthopedics; Respiratory illnesses; Child cancer; Hematology; Intensive care unit; Plastic surgery; AIDS treatment.

TEACHING : Albert Sabin Hospital is the main training center for health professionals working in the health services at both state and municipality levels. Postgraduate training (residence) in Pediatrics (clinical and surgery), Orthopedics and Hemathology.

SALZBURG SEMINAR

HEALTH PROGRAMS AT THE COMMUNITY LEVEL

PROAIS: A PRIMARY HEALTH CARE PROGRAM

THE CASE OF CEARA- NORTHEAST BRAZIL

APRIL, 1994

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This document was prepared for presentation at the SALZBURG SEMINAR, "Health programs at the community level", M 4 tr 1. 1994, by F.M. Andrade (Director of Health Services, Ceará State Department of Health) and M Kisil (W.K.Kellogg Foundation. gra Director for Latin America and Caribbean) with the collaboration of the following members of PROAIS:

- Dr. Jay Francis McAuliffe (Program Director of Project HOPE-Brazil)
- Dr. Luciano Lima Correia (Lecturer, Department of Social Medicine, Federal University of Ceará) - Dr. José Malbio de eira Rolim (Ex Coordinator of PROAIS and President of ISDS - Institute for Health and Social Development).
- Dr. Dirlene Mafalda Idelfonso da Silveira (Viva Women Program Coordinator, Ceará State Department of Health).
- Dr. Marilyn Nations (Tropical Institute of Applied Social Medicine)

A PRIMARY HEALTH CARE PROGRAM
THE CASE OF CEARÁ - NORTHEAST BRAZIL

1. INTRODUCTION

PROAIS is a Primary Health Care Program which was developed in Ceará, in the Northeast of Brazil, beginning in 1975. In recent years the State of Ceará has made significant achievements in the health field and has served as a model for many health initiatives within Brazil. What follows is a description of the two experiences and an analysis of the influence that PROAIS has had, as a pilot program in community health, on the institutionalized changes in the health area that have led to the major advances seen in Ceará.

2. BACKGROUND - BRAZIL, THE NORTHEAST AND CEARÁ

2.1. DEMOGRAPHIC, GEOGRAPHIC AND POLITICAL CHARACTERISTICS

Brazil is a federal country composed of 26 states divided between five megaregions: the North (including Amazonas), Northeast, Central-West (Brasilia), Southeast (Rio de Janeiro and São Paulo), and South (Porto Alegre). The states are further divided into municipalities, totalling nearly 4,500, each one with its own locally elected government.

The 153 million Brazilians who inhabit this immense tropical country of some 8.512.000 km^2, live the sharp contrast between the well developed South and the poverty-stricken, poorly developed North and Northeast. Like much of the developing world, there is a major urban migration taking place.

The Northeast Region needs to be considered separately due to its magnitude and distinctly different conditions compared to the rest of Brazil. If we were to consider the Northeast as a country, distinct from the remaining regions of Brazil, and compare it with the other countries of South America, it would be second in population, and third in land size (behind the rest of Brazil and Argentina). However, based on data from 1984, the Northeast of Brazil would have the second lowest GNP/capita, trailing only Bolivia. Compared to a value of $2337 for the "other" Brazil, the GNP/capita for the Northeast was $759. As such, the Northeast would be the largest pocket of poverty in the Americas. (McAuliffe, 1993)

Droughts periodically afflict the Interior of the Northeast. These droughts have devastated the region in the period 1978-82 and have recurred in 1987 and 1993. For the rural population which lives off agriculture, their domestic food needs and minimal source of income are lost, often precipitating migrations to urban centers with the

accompanying destabilization that such events produce on the individual and society.

This discussion will focus specifically on the State of Ceará, traditionally one of the poorest of the Northeast, where 6.500.000 people live, one third in Metropolitan Fortaleza, and two-thirds in the semi-arid Interior.

TABLE 1

DEMOGRAPHIC/GEOGRAPHIC AND POLITICAL CHARACTERISTICS - 1991		
CHARACTERISTICS	BRAZIL	CEARÁ
TOTAL POPULATION	153.000.000	6.500.000
AREA (Km^2)	8.512.000	146.817
GEO-POLITICAL DIVISION	26 STATES 4.486 MUNICIPALITIES	184 MUNICIPALITIES

2.2. SOCIAL AND ECONOMIC CONDITIONS

"With a gross domestic product of $350 billion and annual exports of $ 34 billion, Brazil has emerged in recent years as the largest economy in Latin America. This, together with vast natural resources - rich agricultural lands, forests and abundant deposits of petroleum, gems, gold and other minerals - makes Brazil a giant, but a huge, sleeping giant which has yet to reach its inherent potential". (Nations, 1993)

"Alongside the industrialized Brazil lives another, desperately poor country". Despite an average per capita income five times that of South Asia or Sub-Saharan Africa, nearly one-fifth of Brazilians live in absolute poverty (1/5 = 30.000.000). While 31% of employed people earn one minimal salary (US$ 60,00) or less in the South, the percentage rises to 54% in the Northeast. And the majority of low paid Southern workers are immigrants from the Northeast. Seventy per cent of total salary income in the Northeast is earned by only 10% of the population. (Nations, 1993)

"In the World Championship of Poverty, Brazil wins the embarrassing and lamentable third place for countries with the worst distribution of income, the bronze medal of poverty" (Nations, 1993). The Gini Index, which describes the distribution of income between the wealthiest and the poorest segments of the population, is 0.57 for Brazil, reflecting the third worst distribution in the world, trailing only Sierra Leone and Honduras.

TABLE 2 - SOCIAL INDICATORS OF BRAZIL, NORTHEAST AND CEARÁ, 1970/90

INDICATORS	BRAZIL		NORTHEAST		CEARÁ	
	1970	1990	1970	1990	1970	1990
INFANT MORTALITY RATE	116.9	58.0	151.2	---	156.5	65.0
LITERACY RATE (3)	66.0	81.7	45.3	63.6	45.0	61.0
LIFE EXPECTANCY (YEARS)	52.7	64.9(4)	44.4	58.8(4)	43.1	54.0(4)
PHYSICIANS/1000 POP	0.5	1.4(4)	0.3	1.0(4)	0.2	0.7(4)
HOUSEHOLDS WITH WATER PROVISION	29.3	66.7	9.7	41.2	5.3	31.4
HOUSEHOLDS WITH ELECTRIC ENERGY	47.5	87.8	23.3	70.3	20.2	62.4
GNP PER CAPITA	1253	2542	488	1157	383	1005

SOURCE: IBGE/IPEA/FGV/WOULD BANK/UNICEF
(3) AGE 15 YEARS OR MORE
(4) 1988

In Brazil piped water is available to about 82.7% of urban population and only to 37.9% of rural families. Sewage connections are available to about 53% of the urban population and 4% in rural area.

In relation to the population's literacy, for the country as a whole, almost 20% of the people are illiterate. In the northeast region the situation is much worse, with 40% enable to read and write.

Thousands of children under the age of five die each year of infection and malnutrition, and the infant mortality rate for the country is estimated to be 58/1000; though there are some states in the South that have 20/1.000 and others in the Northeast with 100/1.000. In many of the States diarrhoeal diseases are the leading causes of death, with respiratory infections and perinatal causes also being prominent.

"Life expectancy in the lower socioeconomic groups is only 40 years, a situation which UNICEF has described as shameful". (Nations, 1993)

The socio-economic conditions of Ceará reflect the harsh reality of the Northeast. Fortaleza, the capital city, is the only area that has some incipient industrial activity such as fishing, cashew nuts, clothes and handcrafts. The rest of the State has an underdeveloped agricultural economy.

The structure of land tenure is unfair: "latifundios" (large unproductive farms) are common, such that only 7% of the population

owns more than 65% of Ceará's land (SPCA, 1985). On the other hand, thousands of illiterate small farmers make their living out of subsistence agriculture. In some areas irrigation has drastically increased the productivity of crops but, in general, those people do not have financial and/or educational background to allow the access to such technology.

Roughly 60% of Ceará work force receives less than US$60.00 per month and in rural areas, nearly 80% earn less than this minimal wage. As a result, nearly half of Ceará entire population lacks sufficient income to meet basic food needs. (Freedheim, 1993)

The state of Ceará can be seen as reflecting the poor socio-economic conditions that characterize the limited level of development in contrast to the regions of Brazil to the south.

2.3. THE HEALTH DELIVERY SYSTEM

"Until several years ago, the Brazilian health care delivery system could be labelled as a non-system", represented by a lack of coordination among multiple public and private institutions and by overlapping duplication of services for some population groups or geographic areas, and a scarcity of services for others. (Kisil, 1993)

Prior to health reform, there were at least 3 parallel systems operating health facilities. The National Social Security Institute (INAMPS) was responsible for curative care. With its facilities mostly located in large urban centers, it operated its own hospitals and health centers (PAMs) as well as contracting services from private sector hospitals, clinics and laboratories. With its budget arising from salary-based contributions, it was the wealthiest of the public health institutions.

The Ministry of Health was primarily responsible for preventive care, with its more limited funds coming from the federal budget. Most of its activities were carried out by its counterpart institution at the state level, the State Secretariat of Health. This entity had its own network of hospitals, mostly in the large cities, and health centers and posts distributed throughout the state.

Finally, some municipalities had their own small network of health facilities.

The patients were to receive free health care. Presumably this responsibility was to be shared by all these levels, but in fact, none really met the population's needs.

The provision of health services by the public sector in Brazil had also been plagued by a number of other problems which have seriously limited their effectiveness. Political interference

exists at all levels. Authorities of opposing political parties may feud in ways that paralyze necessary cooperation between different health institutions, or between the state and municipal levels. At the local level, especially in the North and Northeast regions, public services still use to be often exploited for personal political advantage, especially during election campaign periods.

Another problem has been the emphasis on a medicalized health care model, emphasizing curative, rather than preventive care.

Many factors lead to a low motivation of the physician community to meet the health needs of the population. The salaries offered by many public institutions are often extremely low (US$ 500 monthly). This may be, especially in the North and Northeast, accompanied by late payments and a poorly functioning work environment. The physicians, who are predominantly from the capital, have little interest in living in the Interior where the population/physician ratio is the highest. In addition, the medical curriculum that they have studied has not emphasized the training of a general physician, but instead has offered specialists as their role models.

The geographic distribution of health care units is not adequate, and the level of functioning of many units is extremely limited. Mid-level personnel, who often work alone in rural health posts, normally are not delegated functions which they would be capable of executing, and receive minimal supervision from public health nurses or physicians. Few efforts have been made to integrate traditional health providers with the health system. Even in the absence of adequate obstetric services, for example, traditional birth attendants are not trained to provide their services within the formal health system.

This was the context in which PROAIS was to arise.

In the mid-1980's, in response to the inequity and inefficiency of this health structure, a health reform movement began to build in Brazil, culminating with the VIII National Health Conference held in Brazil in 1986. The concept of health as a right of all citizens', the demand for decentralization and an unified health system; better definition of the relations between the public and private sectors and between the Federal, State and local levels; the society's participation in the health decision-making process; these constitute some of the fundamental principles of the Brazilian health reform movement. (Kisil, 1993)

Many of the recommendations of this historic conference were incorporated into the new Federal Constitution of 1988, establishing legal bases for the reorganization of the health system.

The basic guidelines that were formulated for restructuring the health sector were: (Kisil, 1993)

- Decentralization and compliance with the principle of federalization. The federal unit (State) becomes the basis for the national health system's organization, and simultaneously the role of the municipalities in initiating and executing local actions is stressed;

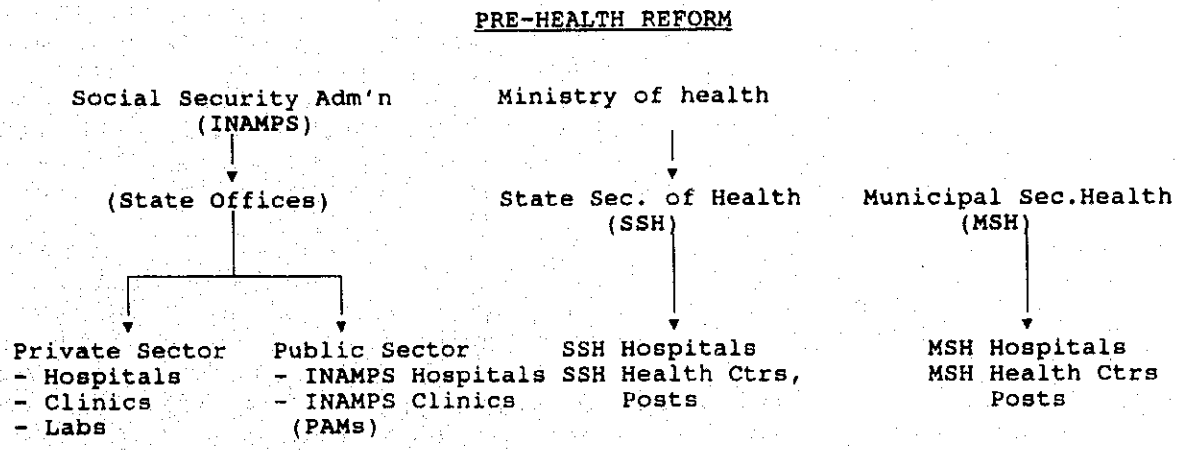
- Integration of governmental institutions, eliminating multiple authorities in each sphere of government and the establishing a single authority at each management level of the federal, state and local systems;

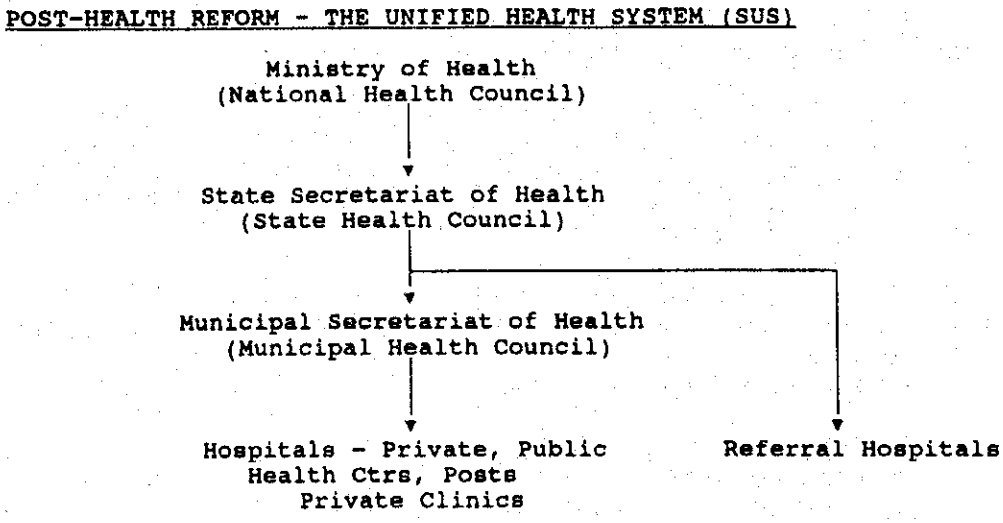
- Social control, with the participation of different social organizations in the identification of problems, the search for solutions, and the monitoring and evaluating of rendered services constitutes a backbone of the system, with community empowerment in the decision making process affecting the health sector;

- Comprehensive health care in which health activities should include collective actions - such as health promotion and disease prevention - as well as individual and curative medical care;

These changes represented a huge reform of the system. (See fig 1) Municipalities would not be held dependent on State or Federal Governments, but, on the other hand, would have to share responsibilities with the community as a whole. The State Governments would now have the responsibility of assisting municipalities in larger programs and in the provision of secondary and tertiary levels of care. (kisil, 1993)

FIGURE 1 - THE BRAZILIAN HEALTH SYSTEM BEFORE AND AFTER ITS REFORM





3. PROAIS: CONTEXT, IDEAS, PHILOSOPHY

3.1. THE CONTEXT

From this overview of the Brazilian health system, let us return now to Ceará and the Context in which PROAIS was to begin. The program was developed in Ceará where the rural population used to be particularly disadvantaged in access to health care. About 76% of the hospitals and 85% of the doctors and nurses were in the capital city compared to only 30% of the State's population, with physician training being over specialized, oversophisticated, highly technical and therefore inappropriated to the conditions in poor rural areas. (Freedheim, 1993)

In many municipalities, in rural areas, the only health facility may be as much as 30 km from a family's home, while very few people have private transportation (Freedheim, 1993). Also in rural areas, health services generally amount to only a basic health post offering first AID, immunizations and a weekly visit from a physician or nurse. Another characteristic is that a lot of people in Ceará consult traditional healers such as TBAs, catholic healers, and herbalists to deliver infants, perform spiritual ceremonies, and to prepare herbal teas and other homemade remedies.

One important obstacle to social development in Ceará, as in many parts of Brazil, especially in the Northeast, was the political system. Until 1986 the state of Ceará was governed by "Coronéis" (the rural elite that dominated the state politics). Political interference existed at all levels. Health services were one of the most used political tools to influence the population. This used to be most apparent at the local level, where many mayors secured

political support from constituents by providing health care to selected individuals, rather than providing universal services. "The patron-client system was maintained by a population that was used to it and expected it". (Freedheim, 1993)

In 1987 a baseline study supported by UNICEF, in Ceara, showed the infant mortality rate to be 102/1000. Diarrhoea, acute respiratory infections and complications during births were identified as the majors causes of infant and child deaths. Almost 28% of children under three years of age who were evaluated were found to suffer from chronic malnutrition as measured by height for age. (PESMIC I, 1987)

The main causes of maternal deaths were: hemorrhage, toxemia and infections. In rural areas almost 40% of the child births used to happen at home and were not assisted by someone able to give health care.

What follows is a description of an alternative proposal to this unfair health situation in which the idea was to "build" the community capacity to create and manage the health care that they felt was needed.

3.2. THE BIRTH OF PROAIS

PROAIS was a result of the work and vision of Dr. Galba Araújo, an outstanding obstetrician and professor of the Federal University of Ceará (UFC). As director of the University Maternity Hospital, he witnessed the severe obstetric and perinatal complications resulting from delayed referral of complicated cases from distant communities with limited health services. As someone who loved the Interior, he also came to recognize the importance of the traditional birth attendants, and to admire their work, their dedication and their humanity. For many years, Dr. Galba studied the problems of lack of formal health services in his State, the methods used by traditional birth attendants and the benefits of traditional practices during delivery.

In 1975 he decided to establish a cooperative program with some of those traditional birth attendants. Dr. Galba, with a group of teachers and students from UFC, trained them to detect early problems during pregnancy, properly referring cases which needed hospital care and to employ adequate procedures for newborns and maternal care.

To start the alternative project Dr. Galba chose Guaiuba, a village, 30 km south of Fortaleza, where he discussed with its community leaders the possibility of reducing the rate of maternal and infant mortality by bringing, at low cost, appropriate training and technology to the people, and using local human resources, like the traditional birth attendants.

After some time he had established an excellent relationship with the community. The traditional birth attendants (TBAs) had a deep respect for Dr. Galba and felt that he, also, had respect for their work.

As a result of his work, less than three years after the beginning of the project, the incidence of neonatal tetanus and other common problems related to pregnancy and delivery had dropped drastically. The TBAs now represented a non-formal health resource instead of a problem, as was the perception of some obstetricians from the capital. In fact Galba oversaw a "reverse transfer of technology" in which UFC's obstetrics clinic adopted some procedures deeply rooted in those women's culture like the vertical position for delivering, the humanization of delivery and breastfeeding immediately after birth.

In later years because the paediatric side of the program was not as well developed as the obstetric side, the team began to reach for ways of providing better health care for children after birth. Since diarrhoea was the principle cause of infant mortality, the project started to work with faith healers that were also highly respected by the community and were taught to give oral rehydration solution to the child with diarrhoea, after the traditional prayer ritual. This activity was based in some studies, made by a member of the program a medical anthropologist, that identified that faith healers were the first resource sought by poor mothers when their children sicken of diarrhoea.

3.3 AN EXPERIENCE BECOMES A PROGRAM, WITH A PHILOSOPHY

Dr. Galba and his followers initially received technical support from UFC. In 1981 they started to receive technical and financial support from the W. K. Kellogg Foundation. The project gradually shifted from an project to assist the traditional birth attendants of rural areas surrounding Fortaleza, to a model Primary Health Care Program. The basic ideas underlying the program were:

Non-formal Health :

a. Popular beliefs and local culture should be taken into account and respected if one aimed at bringing populations close to the formal health care system;

b. Traditional birth attendants and faith healers are important figures in their communities and many of their practices are useful for incorporating into the health care system.

c. Instead of competing with non-formal health workers, the formal health system should seek an alliance with them since their proximity to the population is greater;

d. When properly trained, and supervised traditional birth attendants and faith healers will abandon potentially harmful practices and accept basic principles of scientific medicine;

e. Properly organized, oriented and backed by the formal system, non-formal health workers represent a significant resource to help alleviate the scarcity of health services, help to decrease the mortality of mothers and children, and strength the development of the community.

Teaching:

f. If the university is to prepare students to adequately deal with the problems of the population, it should fully use the experiences within the natural human resources of the community.

3.4 THE FIRST STEPS TO THE INSTITUTIONALIZATION OF THE IDEA

In 1984, the program extended its goals, addressing the needs of the entire population in the project area.

The main objectives of this new phase of PROAIS were to promote better primary health care; to obtain community participation in health programs; to develop appropriate primary health care technology; to set up a referral and cross-referral system for patients ar risk; to train formal and non-formal personnel in proper primary health care and to establish a functional PHC model. As in the beginning PROAIS proposed the integration of the informal or folk-health system with the formal or scientific health care system. Total respect for local customs and traditions plus the involvement of traditional leaders and especially community participation were hallmarks of the program.

PROAIS progressed gradually from an articulation with community leaders to an institutional leadership involving local, regional, and national health organizations. At the local level, PROAIS started direct contact not only with community leaders, TBAs, faith healers, herbalists, but with primary school teachers, religious personnel, politicians, and health professionals.

In 1985, PROAIS also started to work with community health agents to promote the GOBI Strategies (growth monitoring, oral rehydration therapy, breastfeeding, immunization) through home visits.

PROAIS also helped communities to build community-managed primary health care units and facilited their relationship with the formal health services, like the State health posts, regional hospitals and the UFC tertiary medical center. Some of those health care units, began a one-room annex to a the TBA's or faith healer's home or birthing centers.

A referral system under PROAIS supervision created new techniques and methodologies in health care for patients at risk. The TBAs, the faith healers and the community health workers were trained and supervised by doctors and nurses and were oriented to refer cases, using well defines risk criterias. To guarantee some aspects of the referral system PROAIS encouraged each community to raise funds for the care and maintenance of the necessary transportation. After this, for example, 90% of the units in the project area, had their own ambulance and driver.

In 1990 there were 33 birthing centers and more than 560 TBAs had been trained by the program.

To achieve even greater community participation, PROAIS encouraged local leaders to create a unique, formally registered, NGO-type association to legally represent the community. These organizations were established to administer the community-based health care units. Financial administration and maintenance of the unit's property and personnel were in the hands of these local leaders. The community organizations were registered with the National Social Security Institute for Medical Assistance which provided funding used for salaries as well as for the purchase of food and supplies.

This system of local management for community health care proved to be an effective strategy. It provided continuity for health care programs as well as better productivity and lower operational costs compared to formal health services.

PROAIS made arrangements and community health administrators had access to the appropriate level participation in Local, State and Federal level of government.

In terms of medical education, PROAIS provided unique learning experiences to UFC students of the health sciences. As part of the formal curriculum, many students spent 1-2 month externships in PROAIS communities, interesting and participating in the alternative health care model developed by PROAIS. In addition a smaller number of students were able to develop small projects of their own as an extra-curricular activity over 6-12 month periods. These experiences, as well as these of the staff, provided invaluable experiences validating the PHC approach to a large contingent of health professionals.

4. PRIMARY HEALTH CARE AS A STATE HEALTH CARE POLICY

4.1 MOVEMENT FOR CHANGE

Let us now examine the changes in health care that occurred in Ceará State. The process began in 1986 when a progressive-minded,

young, successful businessman won the state elections for governor. By winning he overturned a dynasty of rule by the "coroneis," known for their paternalistic and self-benefitting political practices.

During the campaign a group of progressive, highly motivated health professionals became responsible for elaborating the health plan for the new government. This group agreed that the current health system was not improving the people's conditions or responding to the real needs of the poor. Reduction of the Infant Mortality Rate became a central goal of the new governor's administration. One member of the group Dr. Carlile Lavor, that had a great experience with Public Health, was chosen as head of the State Department of Health (SHD).

4.2 THE IMPLANTATION OF A NEW HEALTH CARE MODEL

Although the general lines of health reform for Brazil had been delineated, there was and continues to be considerable resistance to implanting them in many states of Brazil. Ceará, however, embraced the changes more than most states and earlier in the process.

As part of the national health reform, one of the first major changes to occur was the decentralization of health care delivery to the municipal level. Under this new arrangement, the Municipal Secretariat of Health would be responsible for the management of all public health services to the municipal population, eliminating the dichotomy of state and municipal health services. The municipalization of health care began in 1989 and has now reached 120 of Ceará's 184 municipalities.

A mechanism for community participation in health was created by establishing Community Health Councils in which half of the representatives are from the community, while the other half represent government and health care providers. These Councils, in principle, have the power to define health care policy at the local level.

A Child Survival Program was created in the State Secretariat of Health, known as "Viva Criança" (Viva Child). Aided by data from a first state-wide Maternal-Child Health Survey conducted in 1987, the program carried out effective training programs, focussing initially on the use of Oral Rehydration Therapy for diarrhea, the primary cause of death among children. Strategies of broad community involvement were central to their success. Viva Criança received technical and financial support from UNICEF, Project HOPE, the Ministry of Health and PAHO.

The state also established several TBA-based birthing centers on the periphery of Fortaleza, though a full-scale women's health program is only now, in 1994 being formed.

Based mainly in the previous experience of the head of the SHD, was created in Ceará, the first state Community Health Worker (CHW) Program in Brazil. There was one CHW program carried out by the catholic church in Brazil and also the PROAIS experience. Perceiving the need to improve access to health care for the rural population, CHWs were selected from their own communities and have been instrumental in passing along basic concepts of health care to the rural poor, and promoting breastfeeding, ORT, immunizations and numerous other health interventions.

A second Maternal-Child Health Survey was carried out in 1990 and demonstrated important improvements in essentially all indicators of child health: (PESMIC 2, 1990)

- *infant death rate reduced by one third;*
- *child deaths from diarrhoeal diseases by at half;*
- *immunization levels increased from less than 40 to more than 80%;*
- *child malnutrition reduced by one third;*
- *the number of children, under one year of age, with the weight noted on growth chart increased from 9% to 25%.*

This information served as the basis for the recognition which the state has won from UNICEF, highlighting the state in the 1992 State of the World's Children Report, and later selecting Ceará for the Maurice Pate Award, the first time the award has been given to a governmental entity. In addition, the CHW Program has now been adopted by the Ministry of Health, and is being implanted in most states of the North and the Northeast.

5. PROAIS AND THE CEARÁ SUCCESS STORY

What was the link, between the PROAIS experience and the success story of Ceará? Or, in more generic terms, how did a pilot program influence the institutionalization of new health policies?

PROAIS was carried out under the aegis of the University which traditionally had never had an effective collaboration with the State Department of Health (SDH). But it had developed important know-how, had documented this experience and had allowed students and staff to participate in it.

In the period of traditional politics, no significant collaboration came to achieved. However when the new government took office, many of the new professionals who took charge were aware of PROAIS or had participated in it and its collaboration was sought in areas perceived to be its strengths. Some of the specific contributions were:

A - Community Health Workers

The PROAIS experience with CHWs was one of the largest in the state. There had been some others carried out by many institutions the UFC, the catholic church and a very special one developed in a small country and that was coordinated by Dr. Carlile Lavor. These experiences served to shape the selection, training and definition of tasks of CHWs for the state program, which now number over 7,000. The PROAIS CHWs were uniformly absorbed by the State Program through the local selection processes, and they were able to share their previous experience with their new colleagues.

B - Child Health Care

The PROAIS strategy for Oral Rehydration Therapy (ORT) was partialy adopted by the State child survival program. The use of faith healers for the distribution of oral rehydration salts was encouraged throughout the State CHWs, as well as the other GOBI strategies, carried out by the community health workers.

C - Maternal Health Care

The SDH women's health care program has incorporated the PROAIS system of delivery units (community birthing centers) operated by Traditional Birth Attendants under programmed supervision by physicians and/or nurses. The functional structure of the units, as well as the care provided follow PROAIS methodology. Training for the TBAs staffing new birthing centers was undertaken at PROAIS units under the joint supervision of PROAIS and SDH doctors and nurses.

D - Community participation

Community participation was a hallmark of PROAIS, the primary mechanism being the community organizations which ran the birthing centers. The introduction of institutionalized forms of community participation in health, with the creation of municipal health councils, occurred at a national level and it is unlikely that PROAIS had any significant influence on this. On the other hand, at the local level, in the municipalities where PROAIS was active, through these local NGOs which it had helped create, the program contributed to the development of important community leadership to participate in these councils.

The leaders of these NGOs had gained administrative experience, had come to understand the key health questions of their communities and appropriate solutions, had learned how to deal with politicians with their own prevailing interests.

All this, together with their own personal qualities, transformed these people into important community leadership.

The health councils which benefitted from the participation of these individuals and the continuing support of PROAIS demonstrated significantly better levels of functioning, in the true participation of the community and in the balance of power with local political forces, providing examples to the State and other municipalities on how to effectively implement community participation.

In these experiences one perceives an influence of the project at two levels. The first is the technical know-how that was well documented, appreciated and adopted in the different health programs. The other level is the key leadership that was provided by individuals who had participated in PROAIS, and whose thinking in regard to health was strongly shaped by that experience. It is not the overpowering leadership of a single person such as that of Galba's PROAIS' founder, but instead that of multiple, committed individuals who had passed through the PROAIS experience and had now come to assume roles within the broader health system where they could influence health policies.

THE CASE OF CEARÁ
CHRONOLOGY OF THE PROCESS

YEAR	PROAIS	CEARÁ	HEALTH CONTEXT (WORLD/BRAZIL)
1975	Phase 1: Initiation of TBA		
1976	First Birthing Center Adm.by community Ass'n		
1978			PHC Conference-Alma Ata
1979	Implantation of New Birthing Centers		
1982	Community Ass'n recognized by National Social Sec.System		
1984	Phase 2: PHC Program based on comm. birthing centers/CHW Program		
1985	PHC/Child Survival Prog.		
1986	Phase 3:Comprehensive - GOBI activities	State elections: Infant Mortality as a central issue	VII National Health Conf.
1987		New State Government - State MCH Survey	Major health reform proposal
1988		- Viva Child Program	New Federal constitution
1989		- CHW Program - Comm. Birthing Ctr/ Midwife Prog. - Decentralization of health services	Unified Health System
1990	Phase 4: Technical Assist. to municipal health serv.	- 2nd State MCH Survey	
1991	- Training of Mun.Health councils	New State Government	The Ministry of Health adopted CHW program
1992			UNICEF highlights Ceará
1993		- Viva Woman Program	Ceará wins Maurice Pate Award

6. LESSONS LEARNED

What can we conclude from the case of PROAIS regarding the relevance of pilot projects in Community Health? Or, in more general terms, what influences the degree to which such projects lead to the adoption of sound primary health care policies at the institutional level?

A) Pilot projects such as PROAIS are important to confirm the principles of PHC in settings with limited experience in this area. For example, the empowerment of the community, as carried out by PROAIS, entrusting the management of its health facilities to a community organization, continues to be one of the clearest demonstrations of the ability of the community to participate effectively in managing its health care needs.

B) Pilot projects are important mechanisms for gaining experience in new health care activities. In all of Brazil, PROAIS is widely recognized as the single program with hands-on experience in working with TBAs. These "parteiras" will only be integrated into the health system if there are experiences such as this one on which to base it.

C) It is essential that pilot projects document and evaluate their work very carefully, since this is a fundamental part of their role to promote the transfer of new technologies. There are many skeptics of PHC strategies, and clear documentation of processes and results are important instruments for overcoming such resistance.

D) People make the difference. Projects of this type must place a great importance on having as many people participate in their activities as possible, since it is most likely that its eventual influence will occur largely through such individuals.

E) University settings for such projects have their advantages and disadvantages. Though they generally assure freedom for experimentation and from political interference, universities are often extremely conservative in the area of health and disassociated from health services.

F) Political will is crucial. Perhaps the most important factor for the influence that PROAIS was able to exert on health policy was the political will of the governor, ie. a factor entirely external to PROAIS. In other settings in Brazil it is possible that the influence of PROAIS would have been much less, for lack of such political will.

7. FINAL COMMENTS

The health care model developed by PROAIS is an excellent example of community participation in primary health care and the utilization of simplified technology by the formal health services.

Community participation was the most important structural element in the program and it assured effective distribution of knowledge and development of some instruments which permitted individuals, families and the entire community to share responsibility for their health and well being.

PROAIS strategies emphasized collective actions, preventive care and delegation of care to mid-level staff, resulting in a low cost/benefit ratio compared to the individualized curative modern health care patterns which predominate in the state.

Unfortunately PROAIS was never totally institutionalized by the university. Numerous barriers kept the program from being used for curricular learning experiences. However what it did provide was an opportunity for students who were interested to acquire experience in community health care. For staff it provided a space for a minority who were committed to a different vision from the prevailing clinical/curative health care model to acquire important experiences themselves, to test the beliefs they had and to be creative in searching for new solutions.

PROAIS no longer exists as an university project. However with many of its staff now in key positions of the State Department of Health, with its strategies and experience now incorporated into the routine of health care, PROAIS has become a key instrument in providing what has been highly successful health policy in the state of Ceará.

ANNEX

TRADITIONAL BIRTH ATTENDANTS (TBAs) AND THE BIRTHING CENTERS

Community participation was always the essence of PROAIS activities. In that sense, the first initiative of PROAIS when approaching a new village was to encourage the foundation of a community association (CA), with proad participation of local leaders. The CA had the role of coordinating and managing the local program's activities, such as to mobilize TBAs, group of mothers, religious people etc. on health promotion activities, or to run the local birthing center. The birthing centers (BC) were an outstanding experience of participation of local people in delivery of appropriate health care. The CAs were in charge of identify, among the village's buildings, the place were the BC should be set up. They had also the task of gathering furniture and some equipments, like refrigerators, among the local elite. Sometime in very poor communities, they had to buy themselves such a material, promoting events to raise funds. Usually people enjoyed to participate, especially donating personal gifts like newborn clothes.

At the sometime the BC were set up, the CA with the technical support of PROAIS team, recruited the local TBAs for training, and selection of the most skilled ones to work in the BC. Usually the TBA chosen were those who had either more experience in their job and great respect among local people. Such approach contributed too much for the prestige of the BC. Thus, the BC that in fact was a quite innovative service in the community, seemed a familiar place, for mothers and mothers-to-be. The "parteira" as the TBAs are called, was then a symbolic person in the BC, besides the concrete activities attending deliveries and caring for mothers and new-born. In relation to community health workers they were also appointed by the locals, and this happened to be one of the most important criteria for selection.

The managerial activities in the BC were all carried out by the BC director, a member of the CA. Apart from technical monitoring, the PROAIS team would not interfere in domestic matters. Related to the management of the BC, but they would all give the support needed when asked for.

Indeed the most important feature of the community participation strategy in PROAIS was that local people did not only participate using intensively the health services, but they also had the power to decide which, how and when such services should be provided and by whom. To reinforce this participation the CA were stimulated to periodically promote elections of this members, giving opportunity to a broad variety of people of different social back ground to participate.

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S ' ' M Á R I O

SECRETARIA DE SAÚDE DE BEBERIBE

INTRODUÇÃO

O processo de descentralização do setor de saúde no Brasil teve suporte legal a partir da aprovação da Lei Orgânica da Saúde nº 8.080. No Capitulo III desta lei, Parágrafo Segundo do Artigo 10 diz "no nível municipal, o Sistema Unico de Saúde - SUS poderá organizar-se em distritos, de forma a integrar e articular recursos, técnicas e práticas voltadas para a cobertura total das ações de saúde.

Considerando valiosas e exequíveis as diretrizes emanadas da lei orgânica da saúde, resolvemos aceitar o desafio de contribuir de uma forma significativa no processo de descentralização em um Sistema Municipal de Saúde, visando obter como resultado uma melhor cobertura da assistência de saúde através da implantação dos Distritos Sanitários.

VILAÇA comenta que.. " o Distrito Sanitário é o argumento mais convincente de sua adequacidade enquanto processo social de mudanças das práticas sanitárias no Sistema Unico de Saúde ". (1)

Tendo como instrumental a minha vivência profissioanl que foi sempre voltada para o planejamento e gerenciamento em saúde e um suporte teórico obtido no Mestrado de Enfermagem de Saúde Comunitária do qual sou aluna, resolvi aceitar o convite para integrar-me a equipe técnica de saúde de um município, que já possui um bom nível de organizaçãao, ocupando a Coordenação da Assessoria de Planejamento e Departamento de Coordenação Técnica e de Controle e Avaliação, consciente de que o meu desempenho poderia ter um impácto positivo na gerência municipal.

GASTÃO WAGNER diz que " a questão da gerência de Sistemas de Saúde transformou-se, hoje, em um desafio estratégico, um dos elementos centrais para a recuperação dos Sistemas Públicos, para sua transformação em um instrumento de defesa da vida ". (2)

Para mim o bônus desta experiência é ter o prazer de sentir-me cidadã e participar do processo de implantação do SUS e da democratização no setor de saúde.

Nosso trabalho desenvolve-se no município de Beberibe do Ceará, que dista 81 Km da Capital Fortaleza, tem 39.000 habitantes e uma extensa área geográfica de 1.617 Km2, um dos municípios avançados no processo de municipalização.

Nossa preocupação inicial ao assumirmos foi realizar um diagnóstico da situação da saúde, nos aspéctos: gerencial, de organização dos serviços, condições da rede física e de recursos humanos, sistema de referência e contra-referência e de alguns indicadores de saúde. Observamos que a assistência de saúde ainda era muito centralizada na sede e a gerência municipal no Secretário de Saúde. Nos propomos junto ao gestor municipal trabalharmos no sentido de implantar um novo modelo assistencial que tivesse no seu bojo: a descentralização técnico-gerencial e administrativa aos Distritos.

(1) VILAÇA, 1993, pag. 8
(2) GASTÃO WAGNER, 1992, pag. 91

Sanitários através de uma implantação gradativa, sendo garantido um suporte legal com a criação dos cargos de gerentes distritais na estrutura administrativa da Secretaria Municipal de Saúde; os gerentes destes Distritos Sanitários seriam preferencialmente enfermeiros por estes profissionais terem uma formação mais voltada para a saúde comunitária; as açóes de saúde a serem desenvolvidas nos distritos seriam preferencialmente de promoção e prevenção da saúde; a assistência de saúde deveria ser dirigida às famílias e a coletividade não se centrando somente no indivíduo; a população teria um papel importante no gerenciamento dos distritos, sendo prioridade a formação e criação dos conselhos locais e distritais de saúde; o trabalho ofertado deveria ser feito por uma equipe integrada, garantindo a interdisciplinariedade; o plano de saúde deveria ser participativo, utilizando a metodologia estratégico - situacional; a avaliação do desempenho dos Distritos Sanitários e dos indicadores de saúde seria realizado junto aos Conselhos Distritais e posteriormente ao Conselho Municipal de Saúde.

Coincidindo com a implantação deste novo modelo assistencial, surgiu o Programa Saúde da Família, que tem como objetivos centrais: a priorização das ações preventivas; a interiorização da equipe de saúde visando uma maior integração com a população local, pois, morando nos locais de atendimento os profissionais passariam a conviver e absorver o estilo de vida, identificar problemas e propostas de solução; uma maior extensão de cobertura com consequente impácto nos indicadores de saúde locais, e uma redução da hospitalização.

A filosofia do Programa Saúde da Família se adequou perfeitamente ao modelo assistencial proposto. Recebi a incumbência de coordenar o programa no município e conduzir o processo de implantação. Foi um oportunidade impar, pois, conduzimos simultaneamente o processo de implantação dos Distritos Sanitários e das equipes do Programa Saúde da Família.

SECRETARIA DE SAÚDE DE BEBERIBE

METODOLOGIA

Iniciamos a implantação dos Distritos Sanitários garantindo a sua legitimação legal, para isto propomos uma reformulação no organograma da Secretaria Municipal, sendo incluído os Distritos Sanitários (anexo 1) e uma estrutura mínima para o próprio Distrito Sanitário (anexo 2).

O segundo passo foi o da territorialização, a divisão da área geográfica do Município em 6 Distritos, com a localização das áreas de risco e áreas de maior concentração populacional. Fizemos o estudo das barreiras, o levantamento das famílias cadastradas e acompanhadas pelos Agentes de Saúde e identificamos as áreas descobertas.

A próxima etapa foi uma visita as Unidades de Saúde de cada Distrito para selecionarmos qual seria a Sede Distrital, pois, esta seria reformada para receber a equipe e gerente que se responsabilizaria pelo Distrito, como também para estocar medicamentos, insumos e material de expediente para todas as Unidades pertencdentes ao Distrito.

Neste contexto entra a implantação do Programa Saúde da Família. Foi solicitado ao Ministério da Saúde o convênio de 6 equipes que seriam vinculadas respectivamente a cada Distrito Sanitário. As equipes são compostas por: 1 Médico e 1 Enfermeira, que desenvolvem as ações junto aos Auxiliares e Agentes de Saúde que moram nos seus distritos de origem. Cada equipe se desloca para 10 localidades dentro de seu distrito, objetivando levar saúde para os locais de moradia das familias cadastradas.

Cada equipe cobre em média 1.000 a 1.200 famílias, e oferecem ações preventivas e curativas em cada local de atendimento. Dentre as ações mais importantes realizadas pela enfermeira destaca-se: Prevenção do Câncer, Planejamento Familiar, Pré-Natal, acompanhamento ao desnutrido, atendimento e acompanhamento à criança de 0 a 5 anos, Imunização, Socorros e Urgência, Consulta de Enfermagem dirigidas a programas especiais, sessões educativas com diversos grupos e em especial aos escolares, visita domiciliar, reuniões com lideranças e conselhos de saúde. O médico também executa ações preventivas junto ao enfermeiro realizando também visita domiciliar , sessões educativas e ações curativas como: pequena cirurgia, atendimento de urgência , entre outros. As ações conjuntas do Médico, Enfermeiro, Auxiliar de Enfermagem e do Agente de Saúde a nível de distrito, possibilita uma resolutividade aproximada a de unidades de complexidade secundária a nível municipal, representada pelos centros de saúde.

Procuramos conduzir a implantação do Programa Saúde da Família, de uma forma criteriosa, participativa e planejada.

Envolvemos os vários segmentos da comunidade, para que com o esforço conjunto, o programa tivesse êxito desde a sua concepção, pois de fato as equipes do P.S.F., é que viabilizariam os Distritos Sanitários.

SECRETARIA DE SAÚDE DE BEBERIBE

Em Beberibe tivemos as seguintes etapas para implantação do P.S.F.

1- Definição dos salários dos profissionais das equipes e da Coordenação Municipal.
2- Divulgação para profissionais de saúde do P S.F., e abertura de inscrições aos interessados.
3- Processo de seleção dos profissionais.
Sugestões de critérios:
- Experiência profissional;
- Formação generalista (Especialização em Saúde Pública);
- Disponibilidade para dedicação exclusiva;
- Responsabilidade profissional.
4- Identificação das localidades cobertas pelos Agentes de Saúde e o número de famílias cadastradas de cada localidade (coordenação dos Agentes de Saúde).
5- Reunião da coordenação/profissionais do programa e Agentes de Saúde líderes comunitários, objetivando:
- Selecionar em todo o município as localidades que serão visitadas pela equipe uma vez por semana, um turno, utilizando os seguintes critérios:
- Maior número de famílias;
- Mínimo de infra-estrutura (Posto);
- Difícil acesso a Unidades de Saúde;
- Localizar no mapa do município os locais de visitação sistemática e identificar a necessidade de contratação dos Agentes de Saúde para as localidades selecionadas que não disponham destes profissionais;
- Elaborar o cronograma de trabalho da equipe por localidade e/ por dia / por turno;
- Apresentar o P.S.F.

Treinamento da equipe

Apresentação do P.S.F., diretrizes e operacionalização do Programa:
- Planejamento das Ações;
- Reciclagem - Programas: Viva Mulher, Viva Criança, Diabetes e Hipertensão, Saúde Escolar e Sistema de Informação, entre outros.
- Discussão sobre o papel dos Conselhos de Saúde.

Reunião com a equipe para definição das relações padronizadas de material permanente:

- para Sede do Distrito;
- para Unidades Satélites;
- para Unidade Móvel (carro).

Material de consumo e de expediente:
- para Sede do Distrito;
- para Unidades Satélites;
- para Unidade Móvel.

Medicamentos:
- para Sede do Distrito;
- para Unidade Móvel.

Reunião com a equipe para decidir:
- Sobre o cronograma das ações preventivas e assistenciais do mês;
- Questão de férias e faltas;
- Questão dos instrumentos de acompanhamento, controle x avaliação do P.S.F.

Reunião com a equipe para programar o lançamento do Programa oficialmente para a população.
- Participantes: autoridades municipais, lideranças distritais, agentes de saúde, associações, autoridades estaduais, federais e imprensa.
- Providenciamento das moradias das equipes;
- Providenciamento paralelamente da:
: Compra do material permanente, de consumo, expediente e medicamentos.
- Deslocamento de cada equipe para cada Distrito Sanitário, objetivando:
: Reconhecimento da área;
: Levantamento das necessidades e diagnóstico da situação dos equipamentos, das instalações físicas das Unidades da Sede Distrital e Unidades Satélites;
: Seleção dos motoristas das equipes e treinamento;
: Consolidação da situação geral das Unidades de Saúde e planejamento das reformas, consertos, compra de equipamentos, visando viabilizar uma infra-estrutura mínima para o trabalho das equipes;
: Distribuição do material adquirido ou comprado (equipamentos, material de consumo, material de expediente, material educativo e medicamentos) para cada Distrito Sanitário;
: Reunião com a equipe para elaborar o cronograma de utilização de transportes para iniciar efetivamente a operacionalização do Programa;
: Início das atividades programadas para as equipes;
: Apresentação do cronograma das reuniões semanais de acompanhamento e avaliação, da cooordenação com todas as equipes e das reuniões trimestrais da coordenação com os Conselhos Distritais para avaliação do desempenho das equipes e impácto na saúde local.

Para a operacionalização do Programa estruturamos as sedes distritais (reformas físicas e reequipamentos), e destinamos a cada equipe um veículo NIVA, que chamamos de Unidade Móvel, contendo equipamentos e insumos que viabilizam um suporte resolutivo para as equipes, principalmente para os locais alternativos de atendimento como escolas, clubes, igrejas, sedes de associações, entre outros.

As relações de equipamentos da Unidade Móvel e de medicamentos, estão nos anexos 3 e 4 respectivamente.

Formulamos diretrizes locais visando uniformizar o atendimento e elevar a oferta de serviços às famílias adscritas a cada distrito (anexo 5) e com a mesma finalidade programamos as atividades a serem desenvolvidas pelas equipes a cada mês. (anexo 6).

SECRETARIA DE SAÚDE DE BEBERIBE

COMENTÁRIOS E CONSIDERAÇÕES

Com apenas 2 meses deste processo simultâneo de implantação dos Distritos Sanitários com as equipes do P.S.F, já obtivemos avanços significativos; entre eles:

- Redução em 38% das internações hospitalares, mostrando que a demanda está se fixando nos distritos, e que as ações primárias estão impactando no processo da doença evitando agravamentos que necessitariam de internação.
- Os gerentes dos Distritos já possuem uma razoável autonomia administrativa e técnico-gerencial, pois já resolvem questões relacionadas a pessoal, a medicamentos e material de consumo das Unidades de Saúde que integram a Rede Básica Distrital.
- Já é destinado uma verba mensal para as despesas mínimas de cada Distrito.
- O pagamento dos funcionários e dos Agentes de Saúde será descentralizado aos Distritos, evitando os gastos de deslocamento.
- A distribuição de medicamentos, material de enfermagem fichas e outros insumos para o almoxarifado das Sedes Distritais permite que todas as Unidades renovem seus estoques dentro do seu próprio Distrito, sem se deslocarem para a Sede.
- Racionalização de combustível e pagamentos de fretes para locomoção das pacientes.
- Aumento da cobertura assistencial nos vários programas; Pré-Natal, Assistência, Prevenção do Câncer, Imunização.
- Uma excelente integração e envolvimento das equipes com as comunidades nas quais residem, com participação efetiva nas reuniões de moradores, de grupos das comunidades eclesiais de base, com os conselhos locais e distritais de saúde.
- Um bom nível de satisfação dos membros das equipes pelo ineditismo da experiência.
- Um impácto positivo nos usuários, tendo alguns depoimentos que nos incentivam ao aperfeiçoamento, como de uma senhora que falou a uma enfermeira que parecia um sonho ela está morando ali pertinho dela protejendo a saúde deles.
- Existe alguns aspéctos negativos entre eles estão:
  : A excessiva carga de trabalho para os gerentes que procuram conciliar ações assistenciais com os gerenciais;
  : O distanciamento de alguns profissionais de suas famílias, pois é uma exigência do programa a moradia no local de atendimento.
  : As dificuldades de suporte para exames laboratoriais a nível de Distrito (já estamos planejando implantar pequenos laboratórios, utilizando o trabalho do Auxiliar de Laboratório).
  : As necessidades de treinamento que são grandes e precisamos agilizar para não termos problemas na qualidade da assistência.

Como condutora desta experiência explicitada um tanto amadoristicamente, eu faço as seguintes considerações finais:

- Precisamos aceitar desafios para podermos crescer como profissionais e exercitarmos a cidadania.

SECRETARIA DE SAÚDE DE BEBERIBE

- Precisamos aprender fazendo, pois só descobrimos caminhos corretos se nos propusermos a caminhar em uma direção mesmo sem termos certeza de que seria a mais perfeita, pois a experiência e a troca destas experiências é que nos permitirão acertar. Nosso relato é uma contribuição para aqueles que gostam de desafiar e acreditam em um sistema de saúde mais democrático, mais eficiente e que antes de qualquer coisa atenda as necessidades da população de uma forma adequada e mais humana.

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SECRETARIA DE SAÚDE DE BEBERIBE

A DISTRITALIZAÇÃO ASSOCIADA A IMPLANTAÇÃO DO PROGRAMA SAÚDE DA FAMÍLIA

Maria Imaculada Fônseca Queiroz

INTRODUÇÃO - O processo de descentralização do setor de saúde no Brasil teve seu suporte legal a partir da aprovação da Lei Orgânica da Saúde (Nº 8.080). No capítulo III desta lei, o parágrafo segundo do artigo 10, diz: " No nível municipal, o Sistema Unico de Saúde - SUS poderá organizar-se em distritos de forma a integrar e articular recursos, técnicas e práticas voltadas para a cobertura total das ações de saúde.

VILAÇA comenta que ... " O Distrito Sanitário, é o argumento mais convincente de sua adequacidade enquanto processo social de mudanças das práticas sanitárias no Sistema Unico de Saúde. (1)

Considerando exequíveis as diretrizes emanadas da Lei Orgânica da Saúde e reafirmada por renomados especialistas em gerenciamento, e sendo uma defensora do SUS e de sua filosofia doutrinária, resolvi assumir a coordenação do Departamento Técnico e da Assessoria de Planejamento da Secretaria de Saúde de um município, responsabilizando-me pela condução do processo de distritalização e de implantação do Programa Saúde da Família.

METODOLOGIA - Nossa expêriência se dá no município de Beberibe no Ceará, um dos mais avançados no processo de municipalização. Para implantarmos de uma forma simultânea a distritalização e o Programa Saúde da Família utilizamos a estratégia de vincular cada equipe a cada distrito, tendo o enfermeiro como gerente. Após treinamento das equipes, iniciamos as etapas de trabalho de territorialização, cadastramento de famílias por equipe, estruturação das sedes distritais, programação das ações e definição das diretrizes locais.

COMENTÁRIOS - Em 2 meses de impalntação já obtivemos avanços significativos como: Organização das sedes distritais, autonomia gerencial e técnico - administrativo dos distritos sanitários, redução de internações hospitalares e aumento da cobertura assistencial.

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Aluna do Mestrado de Enfermagem de Saúde Comunitaria.

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FAX: (085) 338.1233

PROGRAMA SÁUDE D FAMÍLIA

Equipe saúde da família de quixadá

SECRETARIA MUNICIPAL SAÚDE DE QUIXADÁ

ADMINISTRA(

QUIXADA

NOVO TEMP

Em março de 1993 a Secretaria de Saúde de Quixadá realizou o 1º diagnóstico epidemológico do município, quando foi detectado uma população pobre, desassistida de serviços essenciais como água tratada e saneamento. Em contraposição o modelo assistencial era baseado na relação médico - hospitalar e nas ações curativas.

Além disso o serviço era centralizado na área urbana central, deixando a periferia da cidade e a zona rural desassistida.

Este modelo caracteriza-se principalmente por negar as causas verdadeiras das doenças, reproduzindo na população a mítica médico/ remédio / hospital como solução para seus problemas de saúde.

Em coerência com os princípios, norteadores do sistema único de saúde (universalidade, acessibilidade, eqüidade, descentralização, integralidade e participação popular), a Prefeitura de Quixadá, através da Secretaria de Saúde, propôs ao Ministério da Saúde a implantação do **PROGRAMA SAÚDE DA FAMÍLIA** no Município. Isto motivou o governo federal a propor a implementação da proposta em todos os município do País.

Este programa pretende transformar o atual modelo assistêncial, num modelo de prevenção e proteção à saúde, priorizando a população com maior risco de adoecer e morrer e estimulando o auto-cuidado.

Esta proposta se materializou em Quixadá através da impantação de 13 (treze) equipes compostas por um médico (a), um enfermeiro (a), os agentes de saúde e os auxiliares de enfermagem das unidades de saúde.

Estas equipes conhecem profundamente o território e a população pelo qual são responsáveis do ponto de vista da saúde. Elas planejam estrategicamente, juntamente com a comunidade, as ações capazes de melhorar os indicadores de saúde da área de atuação.

OBJETIVOS

I. Implantar um modelo assistencial fundamentado no conhecimento real das condições de vida e saúde da população, vendo saúde como qualidade de vida.

II. Organizar na medida do possível a demanda dos serviços de saúde, com base em critérios epidemiológicos, privilegiando a população com maior risco para adoecer e morrer.

III. Aumentar o conhecimento da população sobre sua própria saúde, combatendo a mítica médico / hospital / medicamento do imaginário popular, estimulando o auto-cuidado e a compreensão sobre as causas,das doenças e formas de combaté-las, como no caso dos problemas ambientais.

IV. Melhorar os indicadores de saúde coletiva do município de Quixadá.

V. Reduzir a relação consultas / internações no SILOS - Quixadá, diminuindo os gastos com as ações curativas.

VI. Garantir acesso a partir da porta de entrada do atendimento de saúde à população no local onde ele mora.

VII. Participação da família nos cuidados de saúde e reabilitação dos excepcionais, doentes mentais, alcoolatras e usuários de drogas.

VII. Intergração dos grupos de idosos na sociedade.

IX. Garantir o acesso a todas as família do município às informações e serviços necessários para o planejamento familiar.

X. Capacitar as agentes de saúde do município para desenvolverem ações integrais a nível da família.

XI. Constituir equipes Inter disciplinares em cada Área Descentralizada de Sáude.

DEPOIMENTOS

"O programa saúde da família representa a instalação de um novo modelo. Tinhamos um modelo onde o médico atendia no hospital ou, esporadicamente, num posto de saúde, sempre em periodos espaços e, fundamentalmente, se aproveitando da carência para transformar o atendimento médico-odontológico em mercadoria de troca por votos.

O programa saúde da família, não tenho dúvidas, deverá ir além do programa agentes de saúde por que supera as ações básicas deste. O agente também faz parte da equipe e a convivência diária com um médico lhe trará muitos conhecimentos".

Ilário Marques
PREFEITO DE QUIXADÁ

"A implantação do PSF em Quixadá significou um grande salto de qualidade na reversão do modelo de saúde a décadas instalado. Com o PSF criamos condições de viabilizar todos os princípios norteadores da Reforma Sanitária Brasileira prevista no SUS. Com o PSF temos a eqüidade e a universalidade no atendimento. Garantimos a integralidade quanto a uma perfeita articulação das ações de promoção e recuperação da saúde.

A acessibilidade de todos ao sistema de saúde é uma realidade e por último, prevalece a hierarquia no atendimento quando todos passam primeiro pela porta de entrada do sistema de saúde. Além disso ainda ocorre a descentralização e propicia-se a participação popular e o controle social sobre o sistema".

Luis Odorico Monteiro de Andrade
SECRETARIA DE SAÚDE DE QUIXADÁ

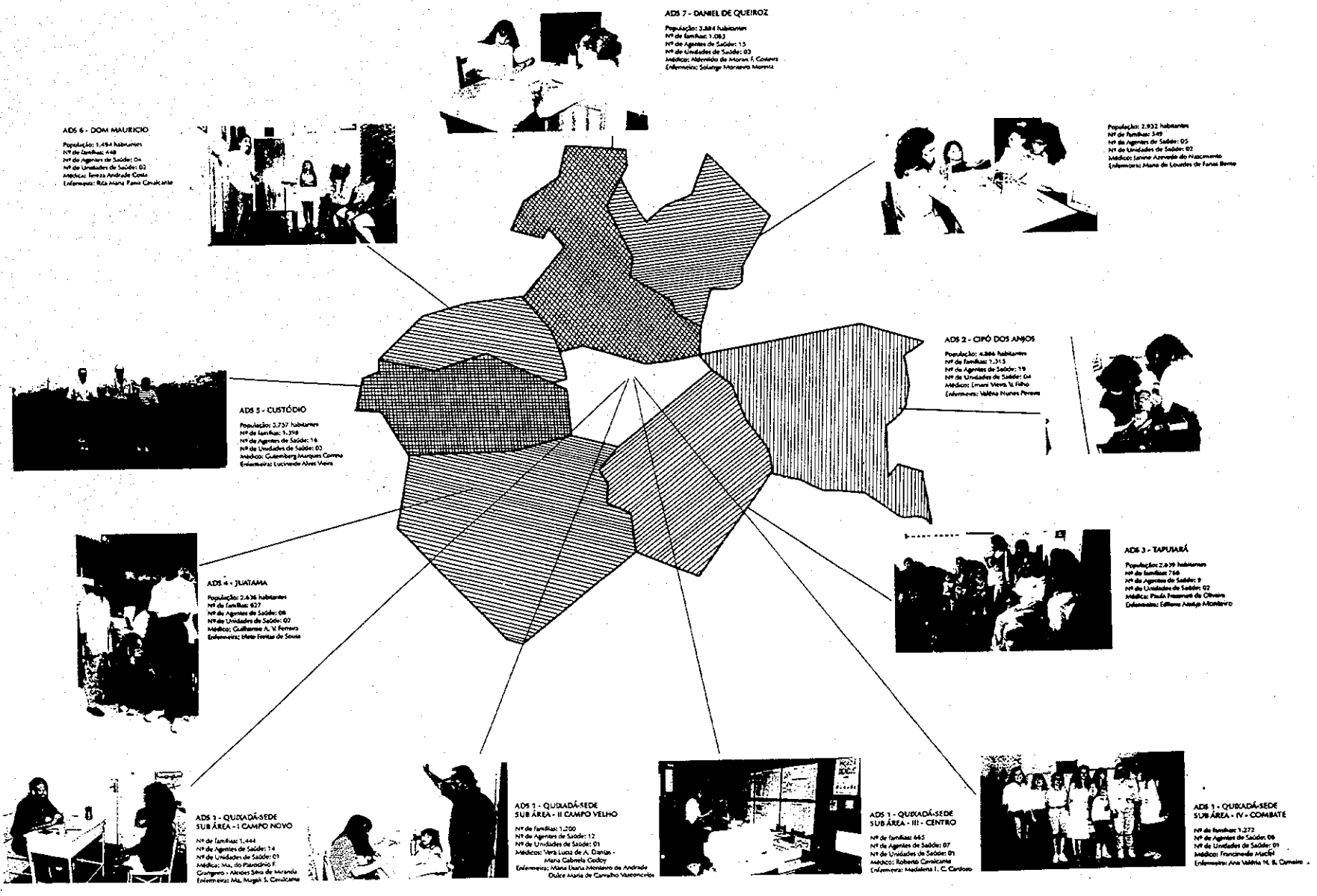
"Quixadá teve um papel fundamental junto ao ministério da saúde para elaboração e implantação do programa saúde da família. Pensavamos apenas no médico da família quando Quixadá apresentou uma proposta bem mais ampla, envolvendo, além do médico uma enfermeira, uma auxiliar de enfermagem e os agentes de saúde.

Já na nossa primeira grande reunião em Brasília, aceitamos a prosposta de Quixadá. Não temos dúvidas que daremos um salto de qualidade na saúde da população brasileira com este programa".

Halin Girade
ASSESSOR ESPECIAL DO MINISTÉRIO DA SAÚDE.

A implantação do **PROGRAMA SAÚDE DA FAMÍLIA** é mais uma ação da Prefeitura de Quixadá, através da Secretaria de Saúde do Município.

APOIO:
— Ministério da Saúde
— Secretaria de Saúde do Ceará


ADS 7 - DANIEL DE QUEIROZ
População: 3.884 habitantes
Nº de famílias: 1.083
Nº de Agentes de Saúde: 15
Nº de Unidades de Saúde: 03
Médicos: Aldenisio de Moraes F. Caetano
Enfermeira: Solange Monteiro Moreira
ADS 6 - DOM MAURICIO
População: 1.494 habitantes
Nº de famílias: 448
Nº de Agentes de Saúde: 04
Nº de Unidades de Saúde: 02
Médicos: Ireneu Andrade Costa
Enfermeira: Rita Maria Pena Cavalcante
População: 2.932 habitantes
Nº de famílias: 549
Nº de Agentes de Saúde: 05
Nº de Unidades de Saúde: 02
Médicos: Lenine Azevedo do Nascimento
Enfermeira: Maria de Lourdes de Farias Bento
ADS 2 - CIPÓ DOS ANJOS
População: 6.886 habitantes
Nº de famílias: 1.315
Nº de Agentes de Saúde: 19
Nº de Unidades de Saúde: 04
Médicos: Emani Vieira V. Filho
Enfermeira: Valéria Nunes Pereira
ADS 5 - CUSTÓDIO
População: 3.757 habitantes
Nº de famílias: 1.398
Nº de Agentes de Saúde: 16
Nº de Unidades de Saúde: 03
Médicos: Guaemberg Marques Correa
Enfermeira: Lucineide Alves Vieira
ADS 3 - TAPUIARÁ
População: 2.639 habitantes
Nº de famílias: 766
Nº de Agentes de Saúde: 9
Nº de Unidades de Saúde: 02
Médica: Paula Frassinetti de Oliveira
Enfermeira: Edilene Araújo Monteiro
ADS 4 - JUATAMA
População: 2.636 habitantes
Nº de famílias: 827
Nº de Agentes de Saúde: 08
Nº de Unidades de Saúde: 02
Médico: Guilherme A. V. Ferreira
Enfermeira: Inês Freitas de Sousa
ADS 1 - QUIXADÁ-SEDE
SUB ÁREA - I CAMPO NOVO
Nº de famílias: 1.444
Nº de Agentes de Saúde: 14
Nº de Unidades de Saúde: 01
Médica: Ma. do Pasordino F.
Enfermeira: Ma. Magali S. Cavalcante
ADS 1 - QUIXADÁ-SEDE
SUB ÁREA - II CAMPO VELHO
Nº de famílias: 1.200
Nº de Agentes de Saúde: 12
Nº de Unidades de Saúde: 01
Médicos: Vera Lucia de A. Dantas -
Maria Gabriela Godoy
Enfermeira: Maria Lucia Monteiro de Andrade
Dulce Maria de Carvalho Vasconcelos
ADS 1 - QUIXADÁ-SEDE
SUB ÁREA - III - CENTRO
Nº de famílias: 665
Nº de Agentes de Saúde: 07
Nº de Unidades de Saúde: 01
Médico: Roberto Cavalcante
Enfermeira: Madalena I. C. Cardoso
ADS 1 - QUIXADÁ-SEDE
SUB ÁREA - IV - COMBATE
Nº de famílias: 1.272
Nº de Agentes de Saúde: 06
Nº de Unidades de Saúde: 01
Médico: Francinaldo Mucêli
Enfermeira: Ana Valéria N. B. Carneiro

⑦　収集資料一覧

収集資料一覧

＊セアラ州概要
・セアラ州公衆衛生学校概要
＊セアラ州女性保健プログラム概要
・セアラ州保健局職員研修計画
＊コミュニティレベルでの保健プログラム（ザルツブルグセミナー提出資）
・青少年への保健プログラム概要
＊保健省機構図
・セアラ州でのSUS計画（病院関連）マニュアル
・家族計画関連資料（議事録）
・セアラ州保健局母子保健基礎計画
・セアラ州保健委員会活動報告
・ベベリベ市保健局マニュアル
＊青少年人口統計
・キシャダ市保健概要
・ベベリベ市概要
＊女性のための保健プログラム関連機関
・母子保健プログラム関連機関
・農村での小規模生産活動
・中南米での中絶関連データ
・セアラ州識字率
・学年ごとの就学率

ー以上、簡易製本「ブラジル家族計画母子保健プロジェクト事前調査団収集資料その１」に収録ー

・ブラジル連邦共和国憲法保健医療分野抄訳
・国連人口基金とセアラ州による青少年保健支援プログラム関連資料
・セアラ州保健局各種予算

ー以上、簡易製本「ブラジル家族計画母子保健プロジェクト事前調査団収集資料その２」に収録ー

・教育関連統計
・ピアウイ州青少年事情ー健康、教育、仕事ー（ユニセフ）
・パライバ州青少年事情ー健康、教育、仕事ー（ユニセフ）
＊セアラ州青少年事情ー健康、教育、仕事ー（ユニセフ）
・保健省母性保護マニュアル
・保健省家族計画マニュアル
・ブラジル国統計年鑑１９８４
・ブラジル国憲法

ー以上、先方製本資料ー