In the 1980s the socioeconomic indicators in Ceará, a state of about 7 million people in northeast Brazil, were among the worst in the country. The infant mortality rate was around 100 per 1,000 live births. Fewer than 30 percent of municipalities had a nurse. And essential health services reached only 20–40 percent of the population. In 1986 the state government began a massive effort to reduce infant deaths. It succeeded. By 2001 infant mortality was down to 25 per 1,000 live births.

Sending health workers to poor households

The Ceará state government began in 1987 to recruit, train, and deploy community health agents. By the early 1990s health agents were visiting 850,000 families a month, the first public service to regularly reach nearly all local communities.

The monthly family visits and family records improved oral rehydration therapy, breastfeeding, immunization, antenatal care, and growth monitoring—as well as treatment of pneumonia, diarrhea, and other diseases.

By 2001 more than 170,000 community health agents covered 80 million Brazilians (figure 1). In 1994 the teams of community health agents were gradually expanded to include a doctor, a nurse, a nurse’s aid, and five to six community health agents for every 800 families.

This Family Health Program was based on the success of the São Paulo, Porto Alegre, and Niterói municipalities with “family physicians.” It added follow-up of at-risk families and home care for chronic diseases to the existing services. The family physicians and nurses’ aides also provide curative care and referrals to hospitals. By 2002, 150,000 Family Health teams were reaching 45 million people.

Health outcomes, 1987–2001

Some of the decreases in infant mortality and malnutrition can be attributed to the increased coverage of immunization, oral rehydration therapy, and breastfeeding (figure 2). Socioeconomic inequalities in coverage were also reduced, and the greatest improvements were made among the poorest of the population.\(^541\) Output measures—such as immunization, oral rehydration therapy, breastfeeding, and child weighing—have also improved.

Anecdotal evidence points to impacts in other states. Implementing the Family Health Program in the town of Camaragibe brought infant mortality down from 65 per 1,000 live births in 1993 to 17 at the end of the 1990s, and in Palmas the incidence of diarrhea fell by half, with antenatal care coverage doubling between 1997 and 1998.\(^542\)

Balancing decentralization with a results orientation

Mobilizing actors

Using matching funds to motivate municipalities to implement new programs, Ceará state policymakers struck a balance between decentralizing responsibilities to the municipalities and keeping a results focus through state control over key aspects of the program.

Strategies were also developed to strengthen community leverage over health providers and to strengthen community voice. The widely publicized selection of a large number of community health agents from the communities helped to “socialize” the program. Community organizations were involved in the second round of assessments for the Municipal Seal of Approval—a program to give incentives to municipalities to improve outcomes (box 1).

Financing

Several financing mechanisms covered annual program costs of roughly $1.50 per beneficiary. In line with the 1988 constitution and 2001 health funding laws, municipalities can retain tax revenues but must spend 25 percent on education and 10 percent on health. The salaries of community health agents ($60 a month), and the costs of supervision and drugs are paid directly by the state. Municipalities are required to cover only the salaries of nurse-supervisors ($300 a month), but many voluntarily support other costs.

The national government offers matching block grants to municipalities for education and health as an incentive to implement priority programs. The grants for minimum basic health care amount to 10% of the 1997 health funding law’s annual program costs.
its benefits, and they lobbied mayors to join the program. Implementation was phased in, beginning with municipalities that demonstrated interest and readiness, stimulating competition among municipalities.

Innovative social mobilization strategies expanded public awareness of the Seal of Approval and broadened understanding of the social indicators needed for certification. These included compact discs to guide radio coverage, elections of “child mayors,” and scorecards of municipal indicators. The Seal of Approval required that municipalities have better-than-average health indicators for the group in which the municipality was classified, based on socioeconomic criteria. Color-coded maps facilitated monitoring and recorded the evolution of indicators.

**Enforcement through hiring and firing**

Although the program was decentralized to municipalities, a special team attached to the state governor had control over the hiring and firing of the community health workers, and over a special fund created for the program.

Many community health agents were recruited from the community through a high-profile selection process that contributed to a sense of ownership and empowered communities to demand better services from the mayors. Candidates not selected become public monitors of the performance of the community health agents.

**BOX 1 The Ceará Municipal Seal of Approval**

In 1990 Brazil enacted the Statute for Children and Adolescents, one of the world’s most advanced laws on child rights, introducing local rights councils and guardianship councils to help define, implement, and monitor public policies for children.

In 1997 Ceará introduced Municipal Seals of Approval with support from UNICEF. The seals were awarded to municipalities based on performance indicators of child survival and development and on administrative management of health, education, and child protection.

No monetary award is attached to the seals, but the municipality may display the seal on official stationary and in health centers, schools, and other official services. Mayors, showing interest in the seal, like being viewed as “child friendly” and good managers.

To encourage municipalities to participate, Ceará state officials tried to create a strong “image” program. Citizens were informed of

reals per person per year, 2,400 reals per health agent per year for municipalities implementing the Community Health Worker Program, and 28,000 to 54,000 reals per year per team when the municipalities implement the Family Health Program.

**Monitoring and information dissemination**

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