

GLOBAL CHANGE LEADERS CASE STUDY



Dr. Zilda Arns Neumann

Humanizing the Health Care System in Brazil

Nanci Lee

INTERNATIONAL CENTRE FOR WOMEN'S LEADERSHIP
COADY INTERNATIONAL INSTITUTE
ST. FRANCIS XAVIER UNIVERSITY
Antigonish, Nova Scotia, Canada • 2012

COADY
INTERNATIONAL INSTITUTE
ST. FRANCIS XAVIER UNIVERSITY
Igniting Leadership

Igniting Leadership

The Coady International Institute is a unique, world-class leader in community-based, citizen-driven development education and research. In collaboration with global partners, the Coady Institute is committed to advancing community self-reliance, global security, social justice, and democratic participation. Through innovative and effective adult education approaches, research and pilot programs, the Coady Institute provides citizen leaders with the knowledge and practical tools needed to bring about the change they want for themselves. Today, thousands of Coady graduates and partners are working with people in 130 countries to build a fair, prosperous, and secure world.

The Coady Institute's International Centre for Women's Leadership is a global hub that inspires and equips women change leaders at the community, national, and international levels. The Centre's focus is on the worldwide development of women's leadership in social, economic and civic arenas, inclusive of grassroots and disadvantaged communities. The Centre achieves its objectives through leadership education and development, action-oriented research and dissemination, and partnership and network development. Our programs target women leaders, both emerging and established, working for public or private organizations, from developing or developed countries, in Canada and overseas. We work with partners to research, monitor and report on women's empowerment and leadership, and provide expert consulting to a range of agencies and institutions.

ISSN 1929-3453 (Print)

ISSN 1929-3461 (Online)

© Coady International Institute

Creative Commons Attribution-NonCommercial-ShareAlike 2.5 Canada License

<http://creativecommons.org/licenses/by-nc-sa/2.5/ca/>

All or parts of this publication may be copied and distributed for non-commercial purposes without requesting written permission, provided the author(s) and the Coady International Institute are explicitly acknowledged as the source of the material. Any work adapted from this material must also be made available to others under identical terms.

International Centre for Women's Leadership
The Coady International Institute
St. Francis Xavier University
PO Box 5000
Antigonish, NS, Canada B2G 2W5

Phone: (902) 867-3676
Phone: 1-866-820-7835 (within Canada)
Fax: (902) 867-3907
Web: www.coady.stfx.ca
Email: womenlead@stfx.ca

**GLOBAL CHANGE LEADERS
CASE STUDY**

**Dr. Zilda Arns Neumann
Humanizing the Health Care System in Brazil**

Nanci Lee

April 2012

Table of Contents

Introduction.....	1
Context.....	2
Life Journey.....	2
A Vision of Peaceful, Loving, Healthy Homes.....	6
Pastoral da Criança, the Organization.....	6
Lessons Learned.....	10
Critical Enabling Factors	10
Strategies for Overcoming Challenges.....	11
Perspectives on Leadership	12
Final Message.....	12
References	13

Dr. Zilda Arns Neumann

Humanizing the Health Care System in Brazil

Introduction

Children are the seed for peace or violence in the future, depending on how they are cared for and stimulated. Thus their family and community environment must be sown to grow a fairer and more fraternal world, a world to serve life and hope.

Dr. Zilda Arns Neumann

Brazilian pediatrician Dr. Zilda Arns Neumann died in the 2010 Haiti earthquake at 75 years of age, doing what she had done for most of her adult life: humanizing health care. A renowned public health care advocate, she transformed the lives of millions of children and their families. Her decades of work led to the creation of Pastoral da Criança, one of the world's largest organizations dedicated to child and maternal health and nutrition. Her vision and her work embraced rare and powerful combinations. She brought together community solidarity networks with large-scale public health reform. She combined a philosophy of love and belonging with a highly successful, entrepreneurial approach to outreach.

Zilda Arns was recognized in Brazil and internationally with numerous awards, including the \$1 million US Opus Prize¹ that she donated to Pastoral da Criança. In recognition of her leadership, she was made an honorary citizen of 11 Brazilian cities and more than 30 municipalities. She was nominated three times for the Nobel Peace Prize by the Brazilian government. Her life's work has demonstrated what is possible in terms of large-scale, decentralized, community-based health care.

Pastoral's work has reached populations as diverse as urban favelas to Amazonian river communities in some of the most remote corners of Brazil. According to October 2011 data, Pastoral da Criança's wide network boasts 128,501 community leaders, 223,246 volunteers supporting more than 1.5 million children and their families in 40,474 urban and rural communities across Brazil (Pastoral da Criança, 2011). Many of the core health indicators in these communities are significantly better than national averages, particularly declines in infant mortality rates (Pastoral da Criança, 2003). The Pastoral health care model is now being implemented in many other countries.²

¹ This faith-based humanitarian award, founded by the Opus Prize Foundation in 1994, is given annually to a person who "combines a driving entrepreneurial spirit with an abiding faith to combat poverty, illiteracy, hunger, disease and injustice" (University of Notre Dame, 2006).

² Through sister organizations, the Pastoral model is operating in Latin America/Caribbean (Argentina, Bolivia, Chile, Colombia, Ecuador, Haiti, Mexico, Paraguay, Peru, and Venezuela), Africa (Angola, Guinea Bissau, and Mozambique), and Asia (Philippines and East Timor) (Pastoral da Criança, 2011).

Context

To provide some context for Arn's work, it is helpful to paint a picture of rural Brazil in the early 1980s before the work of Pastoral da Criança had begun. The Catholic Church was a significant presence in rural areas of the country, involved in extension work in education and health care that the Jesuits had begun with the first schools in the 1970s and the Portuguese in the colonial period. The early 1980s also saw changes in health care with a healing, or reactive, approach to services giving way to greater emphasis on prevention. Two events were largely responsible for driving this change: the meningitis epidemic in 1974-75, considered the deadliest disaster to have ever been recorded in the country's history³ and the polio outbreak in 1979 which spurred a nationwide vaccination campaign (Hampton, 2009). In Brazil, efforts to combat infectious disease outbreaks such as these were complicated by the sheer vastness of its rural areas, many of which lacked sufficient services to meet their residents' health care needs. Even small, underequipped medical clinics were hours of travel away for many people.

Mostly agricultural labourers, families in the rural area where Arns was raised were dependent on sugarcane, cotton and coffee. On average, working days could be 12 to 16 hours long. Many of the poor suffered social conditions that led to prostitution, alcoholism, violence and family disintegration. Families coped by assisting each other and looking to local untrained women to help with birthing and basic supports. However, this was not enough for emergencies when medical attention was needed and was either too far or too expensive. Children were one of the most vulnerable and affected groups in this context. An early Pastoral volunteer recalls a time in the early 1980s when families often attended two child burials per month (Pastoral da Criança, 2003).

Life Journey

In many ways, the early days of Zilda Arns' life pointed to the directions that she would later take with Pastoral da Criança. Born in 1934, she was raised in the small rural community of Forquilha in Santa Catarina State. Her parents, like those in most families in the area, were German immigrants who had regular contact with Europe. Zilda was the thirteenth of 14 children. As many as nine of her siblings pursued teaching as their vocation, including the five who chose religious life (three of Zilda's sisters became nuns and two brothers Franciscan priests). One of her brothers, Cardinal Dom Paulo Evaristo Arns, who served as Archbishop of São Paulo between 1970 and 1998, is considered one of the most important Brazilian religious figures of the 20th century, known for his uncompromising advocacy for the poor and oppressed.

The parents of Zilda Arns had a spirit of service that proved to be an inspiration for her future. Some of her earliest memories were sitting beside her mother, who would be applying dressing to injured neighbours or teaching them home remedies. Young Zilda often accompanied her mother on visits to local mothers. Her mother drew from a traditional German medicine book and referred neighbours to the hospital for more complicated cases. When the smallpox epidemic broke out,

³ According to the Columbia Encyclopedia, this epidemic claimed 11,000 lives and left more than 75,000 people with permanent neurological complications (The Columbia Encyclopedia, 2004)

her father visited many families, giving them instruction about how to prevent the spread of the disease. She recalled that when the vaccine arrived, the coverage rate was 100 percent:

That was my first contact with public health: the community organized with motivated leadership. The church and school were essential to ally themselves with the health team for the eradication of smallpox (Arns Neumann, 2002, p. 153).

Zilda was raised a devout Catholic, and her faith played a vital role in her life and her work. In many ways, a career serving her community was a natural choice for her. However, it was not only the values of charity and neighbourly love that she got from her family. She also learned the power of play. Growing in a modest-income household, Zilda and her siblings often created their own games. They spent a great deal of time, for example, doing improvisational theatre, and young Zilda was highly imaginative and playful (Sister Helena Arns, personal communication, December 13, 2011).

Because education was such a high priority for her parents, Zilda was sent away to Curitiba in Paraná State at the age of 11. Later she decided that she would like to become a doctor. At first, her father was opposed to the idea. In those days, it was not common for a woman to practice medicine in Brazil. He preferred that she become a teacher since “education was the most needed thing in the world” (Arns Neumann, 2002, p. 153). However, he relented after persuasion from her elder brother Dom Paulo who could refer to female doctors in Europe where he was studying. She entered the Federal University of Paraná and became one of six women in a class of 100 medical students (Nelson Arns Neumann, personal communication, 2011).

While at university, Zilda started working as a volunteer at the César Pernetta Children’s Hospital, a philanthropic institution which accepted only children of poor and jobless parents. Many of the patients were hospitalized with infectious diseases. Watching them suffer from both physical pain and separation from their families, she couldn’t help but wonder: “Which of these children would be in the hospital if families had more knowledge about [disease] prevention and if public health care were brought close to the heart of those in need?” Zilda’s father, who had developed an active interest in her studies, shared her concerns and insisted that she should focus on learning about the prevention of diseases, nutrition, vaccination and community participation (Arns Neumann, 2002, p. 153).

After graduating in 1959, Zilda Arns gained a position on staff at the César Pernetta Hospital, assuming responsibility for the provision of outpatient services for children under 12 months of age. She spent most of her time teaching mothers how to raise their babies, and soon had a very large clientele. All too often, the mothers whom she was referring to the more experienced specialist doctors would tell her that they preferred to consult with her because she had a knack for explaining things in easy-to-understand ways. She came across frequent cases of contagious diseases such as pertussis, diphtheria and measles. Even though mothers were advised to inoculate their children at the city’s health centre, many of them opted out of vaccinations. As it turned out, one of the hospital orderlies was warning parents that vaccinations put children at risk of “catching paralysis.” That episode taught Zilda Arns that she should educate her own associates in the first place (Arns Neumann, 2002).

Early 1965 marked the beginning of a new chapter in her career. Just three weeks before she was to go on leave for the birth of her second child, she was invited to work at the Paraná State Secretariat of Health. There she supervised a network of health clinics covering 21 communities

on the impoverished outskirts of Curitiba. A firm believer in the importance of engaging parents in sustaining their children's health, she implemented 27 mothers' clubs that offered training in parenting skills.

A hallmark of Zilda Arns' leadership style, already evident in those early years, was her ability to create strategic partnerships focused on practical results. For example, she brought together diverse players to understand barriers to health for the poorest women. She worked with doctors to research which diseases were the most common in her area of supervision and which medicines might be manufactured by the laboratory at the National Health Department. They found that for many of the drugs, packaging was more expensive than the content, so they initiated an empty container return policy to make essential medicines more affordable for the poor. She then partnered with the Pontifical Catholic University of Paraná to conduct socioeconomic analyses of her clientele, which included household income rankings. Based on this instrument, the Secretariat of Health established a subsidy system that enabled poor families to reduce their out-of-pocket health care expenses to a fraction of their actual cost. This was the beginning of Brazil's national drug plan.

Reflecting on this period of her career later, Zilda Arns identified the importance of combining policy instruments with health education, especially for poor mothers who are usually excluded. She also noted the time and commitment that it took from a diversity of stakeholders to accomplish such impacts. "I noted those 13 years of continuous leadership, a team that was qualified and motivated for the mission...improves the quality and humanization of [health care] services" (Neumann, 2002, p. 154).

During her time in the government, Zilda Arns had opportunities to upgrade her education. First, in 1972, the government sent her to Colombia to study social pediatrics. It was there that she saw the importance of cross-sectoral planning to overcome delicate health issues such as drugs and teenage pregnancy. These issues hit home; she had teenagers of her own at home and was pregnant with her youngest daughter. Later, in 1977, she studied public health at the University of São Paulo. She recognized the importance of dialogue with the public health officials and "wanted to learn more and to have equal footing in discussions with the leaders of the Public Health Department" (Arns Neumann, 2002, p.153). However, in 1978 when her husband died trying to save a child from drowning, she was encouraged by her family to step down from her demanding work with the health clinics to care for her five children, all of whom were still minors.

As a result, she returned to the planning department in the National Ministry of Health. In 1979, she was tasked with coordinating the International Year of the Child, sponsored by the United Nations Children's Fund (UNICEF) and the Ministry of Health. She approached her work in a spirit of entrepreneurship and collaboration:

I asked for creative freedom, which was given to me since it did not require financial resources. I called the main leaders of institutions with outreach potential: churches, municipalities, agriculture and education departments and the Technical Assistance and Rural Extension (EMATER) (Arns Neumann, 2002, p.154).

Together, they identified four key areas for the awareness-raising campaigns: breastfeeding, vaccination, school sanitation and nutrition. The campaigns were a huge success, and her facility with broad-based education was pivotal.

Then, at the end of 1979, polio broke out in a small city about 240 kilometres away from the state capital Curitiba where she was based. Following an emergency task force meeting, Zilda Arns was asked by the State Secretary of Public Health to coordinate a polio campaign for the State of Paraná. In keeping with her previous approaches, the polio campaign that she devised and then coordinated hinged on collaboration and solidarity. Through concerted action by the leaders of various institutions, hundreds of immunization posts were established in easily accessible places throughout the state, and a wide range of media were mobilized to inform the population in advance of vaccination days. Albert Sabin, the American who developed the oral vaccine to combat polio, was advising the Brazilian government at the time. He came to observe the campaign in Paraná together with experts from the federal Ministry of Health, and found it very effective (Arns Neumann, 2002).

As a consequence, she was then called by the National Ministry of Health, where she presented her strategy and its results to a gathering of the states' representatives responsible for disease surveillance. The nationwide polio immunization campaign, which adopted the collaborative partnership-based approach that she had spearheaded in Paraná, was extremely successful: the incidence of polio in Brazil dropped from an average of 2,330 cases per year between 1975 and 1980 to 122 cases in 1981 (Hampton, 2009).

In 1980, Zilda Arns was invited to head the Department of Maternal and Child Health of the State of Paraná. There she designed a strategy to empower and motivate front-line health workers. Consistent with her approaches throughout her career, she began quality training for nurses who were closest to patients and the communities. Then she worked her way outward to doctors and directors. The focus was on prevention of cancer, prenatal care, breastfeeding, immunizations and oral rehydration therapy.

Zilda Arns had only served as department head for two years when politics interfered with her work. The former opposition won state elections and took to reforming the government. "As usually happens in developing countries," she observed, "it seemed to me that the biggest concern of the new leaders was to erase the portrait of the previous government. I was the first to be fired, despite never having been affiliated with any party" (Arns Neumann, 2002, p. 155). As it turned out, however, her sad departure from the government was only a prelude to the brightest part of her career, which commenced with a fateful telephone call from her brother Paulo Evaristo Arns in May 1982.

Dom Paulo Evaristo, Cardinal Arns, Archbishop Emeritus of São Paulo, had by that time earned international renown for his tireless campaigning against torture and other human rights abuses following the 1964 military coup that had thrust Brazil into two decades of dictatorship. In May 1982, he was invited to a meeting of the United Nations (UN) in Geneva on poverty and peace. There, James Grant, then Executive Director of UNICEF, spoke to him about an oral rehydration solution, a simple solution of sugar and salt, which could prevent millions of child deaths from diarrhea every year. Grant contended that the Catholic Church should get actively involved in this cause by teaching mothers to prepare and administer the oral rehydration solution. On the night of his return from Geneva, Dom Paulo telephoned his sister Zilda Arns to think up a way to put this idea into practice in Brazil (Neumann, 2009a, 2009b).

It was as if all of her experience and skills to that point had been preparing her for this instrumental call from her elder brother. That night she gathered her five children in a family conference,

as she was known to do. With their blessings and agreement to help out, she told them, “Now you go to bed because Mommy is going to write a project to save millions of lives.” She prepared strong coffee and set about beginning a proposal to accept her brother’s challenge. Thus was Pastoral da Criança born. (Pastoral da Criança, 2003, p.33).

She had long been involved in maternal and infant health care, but her new project had broader horizons. How could impact be spread dramatically across rural areas? How could health services come to remote rural communities instead of the other way around? How should the work be organized to “humanize” the health care system? She knew that the answer lay in educating local women and creating a solidarity network at the community level.

A Vision of Peaceful, Loving, Healthy Homes

Zilda Arns had a vision grounded in peaceful, loving and healthy homes for children. In her view, health and peace was about caring for one’s neighbour—participating in, and belonging to, a community of care starts with the child and his or her family. It was not just a case of people receiving health care services: health began with each child and spread outward.

She reinforced the idea that a simple, common sense approach to health care makes the most of what people and communities already have. She suggested that solutions to basic nutrition be drawn from a community’s local plants, seeds and fruits. In favelas or poor neighbourhoods lacking land for gardens, she recommended that families could plant vegetables in pots (Arns Neumann, 2009). She saw the capacity of communities to take care of themselves and their children.

At the centre of her vision was a belief in the capacity of women in these communities and the power of these local caregivers or leaders to spread care and knowledge. A colleague of many years, Marcos Kisil, talks about her ability to build leadership in others: “She was a leader [who... was] very humble, with a tremendous respect for others. [Dispensing with] hierarchy... she fought for what she believed in [basing] her decisions on values” (personal communication, 2011). Such a respect for the capacity of others gave her a knack for identifying local leaders. They have been both the heart and engine of the Pastoral methodology.

Zilda Arns believed in building on the assets and values already existing in the community, particularly people’s commitment to faith and neighbourly love. Arns commonly referred to the Biblical story of the “loaves and fishes.” This metaphor for sharing and spreading opportunities and knowledge would later come to represent Pastoral and the values of Christian faith which formed its cornerstone.

Pastoral da Criança, the Organization

In 1983, a year after the call from her brother, Pastoral da Criança was officially launched in Florestópolis, a municipality selected as a demonstration site due to its high rates of infant mortality. The National Council of Catholic Bishops, with the support of UNICEF, provided initial funding for the program.

Partnership with the Brazilian Catholic Church from Pastoral’s inception was vital to its methodology and success.

We are the Church; we are not ‘from’ the Church, we ‘are’ the Church. Our faith is an intrinsic part of our approach at all levels, the way we work with people with love, and our technical training (Arns Neumann, 2009a).

Not only were the virtues of charity and love the main driving force for the Pastoral’s work; it also translated into a very practical support. Aside from providing substantial funding, the Brazilian Catholic Church has been instrumental in dramatically spreading outreach for Pastoral. The Catholic Church’s nationwide network of dioceses and parishes provide a base for operations and key source of volunteers.

Nevertheless, Zilda Arns always stressed that the Pastoral’s work was ecumenical, based on values of neighbourly love and belonging, which were not particular to any religion. She emphasized that people of all faiths were welcome to participate, both as local leaders and staff members.

Solidarity, rather than service delivery, was the key to Pastoral da Criança’s approach to health care. The organization facilitates “community networks of solidarity, in order to multiply the knowledge about health and citizenship, and through this, reduce infant mortality, nutritional and violence problems, and as a result, create more opportunities for the children and their families to fully develop” (Pastoral da Criança, n.d., p. 14).

The Pastoral’s multi-tiered network of health care from the community to the national level that today covers more than one-and-a-half million households across Brazil. The network is organized around the women who are identified as local leaders and caregivers in each community. They are not necessarily formally educated women but are respected by the community and have demonstrated a keen interest to care for their neighbours. A leaders’ toolkit includes a simple health card for pregnant women and children to record their vital statistics for medical clinics, educational materials (such as “love bonds” – guides to prenatal bonding with a baby) a portable scale, a measuring spoon, the leaders’ notebook to conduct monthly health assessments in the community, including 26 key indicators (Arns Neumann, 2009a). Local leaders are the core of Pastoral’s solidarity network.

Next, there are trainers at the municipality and parish levels, “multipliers” working at the level of the state or dioceses, and a national team that coordinates the other levels and monitors progress across the entire network. All of the “multipliers” are volunteers who are already active in their local organizations or bodies. They are trained by Pastoral to educate local leaders.

Zilda Arns always attributed the success of the Pastoral to the local leaders and volunteers. For her, they demonstrate the power of human solidarity and citizenship for change. It is worth noting that the volunteers dedicate a sizeable amount of time to the program. For example, if Pastoral had to assume the expenses resulting from the services of their volunteers in 2001 (some 150 thousand volunteers) it would have cost more than 70 million dollars a year (UNICEF, n.d., p.32).

Pastoral’s work in communities involves three key components: home visits; Celebration of Life days and monthly evaluation meetings. Home visits by Pastoral leaders typically involve discussions on broad dimensions of well-being, including children’s education, prevention of family violence, and so forth (Zilda Arns, 2009b). On average, a Pastoral community leader sees 13 families, usually on a once-monthly basis, which amounts to 24 or so hours of service per month (Arns Neumann, 2009a). In contrast to government-employed family doctors, who typically see 150 families, Pastoral leaders leave more opportunities for establishing personal relationships with the families they visit.

Life Celebration Days are both community celebrations and practical information gathering meetings. These monthly events, held in every community where Pastoral leaders work, are centred around the weighing of children under six years of age and a check-in regarding vital statistics of mother and child. The procedure is imbued with a festive spirit—it is often held in the open air, with families gathered around a simple scale, with a seat hung from a tree that is used to weigh their children. Pastoral leaders then determine whether each child’s weight is outside the norm for his or her age and provide nutrition advice. The weigh-in is typically followed by a communal meal, during which the families are instructed on nutritional mixtures and home care solutions. There are also games and recreational activities with the children. Part of Zilda Arn’s philosophy was the right of children simply to be children, allowing them a chance to play and laugh regardless of their state of health or socioeconomic status but also providing important opportunities for autonomy and socialization.

Pastoral uses a methodology that reinforces community solidarity and the dignity of children. From their approach to local leadership to their philosophy of play, Pastoral supports families and communities in supporting themselves. Life Celebration Days, similar to home visits by Pastoral leaders, serve the purpose that Zilda Arns deemed no less important than basic health monitoring: they “strengthen the social fabric of the communities” (Arns Neumann, 2009b, p. 5). Even the nutritional mixtures are based on community workshops to demonstrate the nutritional benefits of commonly discarded items such as banana peels and eggshells (Arns Neumann, 2009a) found in the community.

The evaluation meetings are held monthly. There, Pastoral leaders working in a particular community meet and discuss the information they have collected during their latest round of home visits and child weigh-ins, and together compile a health assessment of their community, based on the 26 indicators each of them has recorded in their leader’s notebooks. The assessment includes current prenatal data on the mothers and children but also data at the community level such as percentage of children vaccinated or percentage of malnourished children (Arns Neumann, 2002, 2009a) that allow for regional and national comparisons.

These evaluation meetings form the basis of a robust monitoring and information system that has been absolutely vital to the success of Pastoral. The monitoring system is unique because it is complex enough to gather detailed trend data relevant to national infant and maternal health policy markers. At the same time, it is simple and focused enough for local leaders to analyze trends on a regular basis.

The simplicity of the monitoring system has been critical for local ownership. Local leaders and mothers can regularly see how their progress relates to regional figures. Every three months, leaders receive letters hand-signed by the National Coordinator.

The letter might say, “Dear leader: Congratulations! Maternal breastfeeding is at 80 percent,” or whatever the database produced, or it might say, “Be careful! Maternal breastfeeding is weak, at 20 percent.” The letter will advise action, such as visiting pregnant mothers more often, specific timing of visits to mothers after delivery, or limiting use of bottles for feeding. (Arns Neumann, 2009a, p.4)

Based on this information, leaders not only receive timely and regular information but also feel that they are important members of the team in improving health in their communities.

The monitoring system has also helped the Pastoral to demonstrate results in a clear and compelling way. It has shown, for example, that the communities where the Pastoral works experienced, on average, a nearly fivefold decrease in infant mortality rate — from 51 to 11 deaths per 1,000 births — between 1991 and 2008. Nowadays these communities compare very favourably with the rest of the country: the average infant mortality rate in Brazil was reported at 22.5 deaths per 1,000 births in 2008 (Arns Neumann, 2009a). By keeping track of the number of its local leaders, their activities and the resources involved, the Pastoral has also demonstrated the amazingly low cost at which it has achieved this remarkable result: less than one US dollar per month per child. Such demonstrated effectiveness and efficiency has helped Pastoral to secure financial support. From as early as 1985, half of its funding has been coming from the Brazilian Ministry of Health (Arns Neumann, 2009a). The CEO of HSBC Foundation, Helio Duarte, explains that their foundation also donates considerable funds annually due to the Pastoral's impressive impact at such low costs. He finds most charitable organizations are the opposite, low on impact and high on costs (Duarte, personal communication, December 18 2011).

Pastoral, through demonstrated results in communities combined with successful national health campaigns, has been able to directly influence Brazilian health policy. Early on, Pastoral attracted the interest of the Department of Health and international support from UNICEF because it showed hard data on key indicators of health. Pastoral used its data to improve public health institutions. For example, it keeps records of all occasions when pregnant women failed to receive adequate prenatal care at public health centres, and its coordination team inquires about these failures of care. The Pastoral has made recommendations for improvement to the local, state and national Health Councils. In the early 1990s, Zilda Arns was asked to join Brazil's National Health Council directly. This Council is responsible for citizen oversight of Brazil's health care system, specifically how to enhance community participation and inclusion in rural areas. Reflecting on this period, she recalled that Pastoral da Criança, along with an organized civil society⁴, fought hard to improve the framework and specific statutes that affected children and adolescents (Arns Neumann, 2009a).

Beyond child and maternal health, the Pastoral has contributed to policy changes in areas as diverse as indigenous health, prisoners' health and care for the elderly. Perhaps most importantly, local leaders have taken on greater roles in representing their communities in the municipal health councils which form the backbone of the health care system in Brazil (Ana Ruth, 2011, interview).

The decentralised Pastoral health care model played an important role at a time of important changes in Brazilian health care and citizenship. In its transition from military to democratic rule, the public health sector was profoundly transformed in 1988:

The 1988 Citizen Constitution established health service provision as 'the right of all and the duty of the state'. The Constitution and subsequent Basic Health Law (1990) also provided for participation and "social control" (or 'citizen oversight') of health policy through the institutionalisation of management councils. More than 5,500 of these councils were

⁴ It is critical to mention that while the state-implemented Citizen Constitution and decentralization process took place in the 1980s, social mobilization within civil society was active as early as the 1970s. The health movement, indigenous movement and black movement contributed heavily to the 1988 Constitution that was rigorously negotiated for three years (Mohanty et al, 2011).

created over the course of the 1990s, at national, state and municipal levels. Besides participation and social control, another key principle of the new unified health care system is decentralisation, which has led to the progressive transfer of responsibility for managing primary care to the municipalities and their Municipal Health Councils (Mohanty et al, 2011, p. 23).

Overall, the Pastoral model—combining a decentralized network of community health care with a centrally coordinated monitoring system that is able to influence health care policy from municipal to state levels—has proven highly successful. Thanks to her experience with Pastoral, Zilda Arns was able to make key contributions toward a more inclusive and participatory health care system in Brazil.

Lessons Learned

Critical Enabling Factors

The real achievement of Arns and her work with Pastoral da Criança depended on a powerful combination of strengths that resulted in broad-based innovations. With grounded experience as a doctor and pediatrician, she knew the technical side of health issues. However, her informal knowledge and intuition about education and people helped bring her technical expertise to the community level. She had sound knowledge of both urban and rural areas, and an ability to move with ease in very different circles, from grassroots leader training to public policy discussions with national public health officials.

Through this diversity, she was able to create a community-based, decentralized system that fed into national health care policy. She combined individual leadership of local women with family support and community solidarity. She created an approach that married the heart of grassroots organizing with the professionalism of detailed national level monitoring and evaluation. From a regional pilot project, it grew into an organization, which, through innovation, affected national policy and health care and eventually was replicated in dozens of other countries.

No doubt some of the Pastoral's success could be attributed to the developments in Brazil's health sector and political system on the eve of its creation and during the early years of its existence. Nevertheless, Zilda Arns was a pioneer who contributed key innovations and policy reforms, most notably the Pastoral health care model that drew on community networks to complement, not replace, the health care system.

The Pastoral's success had much to do with Zilda Arns' ability to broker genuine and lasting partnerships. Her strong ties to the Catholic Church, and the high reputation and influence that her brother Paulo had within it, were critical in getting early support from the National Council of Brazilian Bishops. Partnership with the Catholic Church also allowed her to tap into its massive network and involvement in communities, and quickly establish the Pastoral's own cohort of leaders on that basis. She had a talent for bringing strategic partners from across sectors and levels to work for the Pastoral's cause.

The solutions built on the assets available in local communities, the most important of which was the local leaders. Zilda Arns created a culture within the Pastoral where local leaders were not just an outreach strategy. There was a genuine belief in their capacity to create localized care

networks. Pastoral leaders were also given a great deal of support to make this happen, including continuous provision of information and encouragement, as well as opportunities to share lessons and gains with each other. Perhaps most importantly, they were able to see the results of their efforts on a regular basis via the quarterly letters from the national coordination office. This provided an ongoing incentive for them to keep up and improve their work. The Pastoral's robust monitoring and feedback system was absolutely critical for this local ownership as well as its contribution to health standards and community health.

Simplicity was essential. The methods used at the community level are based on tracking easily observable indicators and well-being, and also on sharing knowledge and advice in a way that is easy to understand. Zilda Arns once remarked that the obstacles to accessible health care were not technical. The problems are usually not technical. The oral rehydration solution, for example, a simple solution of salt, water and sugar, has been known for decades. But how could this knowledge be spread rapidly and widely to those in remote rural areas? The answer was simple, efficient solutions spread by a massive solidarity network that is sustained at the local level. Simplicity and solidarity are the key to inclusion.

Reflecting on the success of Pastoral, former President Luiz Inácio Lula da Silva remarked, "What is the secret of such good results? Believing in simple solutions and in the solidarity of our people... The Pastoral advances to break the cycle of poverty and exclusion of children and their families, because it goes beyond immediate food security, providing also education on health and citizenship" (Pastoral da Criança, 2003, p.18). The life work of Zilda Arns is an example of practical solutions scaled large.

Strategies for Overcoming Challenges

Like any program of its scale, Pastoral da Criança experienced some serious challenges as well as milestones. Its close alignment with the Catholic Church and government bodies offered opportunities for wide outreach, but also caused complications. Many organizations in Brazil, particularly those involved in promoting women's rights, were critical of the Pastoral's work because of the Catholic Church's stance against abortion. It was always a delicate task to demonstrate the ecumenical nature of the Pastoral's work given its strong ties to the Catholic Church. Similarly, close ties with the government meant Zilda Arns had to deal with changes in government and their priorities as well as years of dictatorship. When Pastoral's patrons within the Catholic Church questioned her close ties with a corrupt government and dictatorship, she replied with a spirit of practical idealism:

Pastoral da Criança reduces suffering and saves lives. The government works with money taken out of our pockets. The money belongs to the people. It's better for this government to spend money through Pastoral than to waste it on...corrupt things. (Arns Neumann, 2009a, p.7)

Zilda Arns was successful in overcoming these challenges by her willingness to engage in respectful dialogue with diverse stakeholders. Many found her a highly charismatic and convincing leader. She also knew how to leverage powerful people by showing them the progress of her work early on. So she convinced with results as much as personality.

Both Zilda Arns and Pastoral were able to overcome challenges through flexibility and foresight. A former Brazilian President, Fernando Enrique Cardoso, captured this Pastoral spirit well: “Affiliated with the Catholic Church but not proselytizing; dedicated to the poorest but not partisan; partnering with the government but with its own autonomy; capable of mobilizing tens of thousands of volunteers in all Brazilian states with very practical results” (in Pastoral da Criança, 2003, p. 19).

Perspectives on Leadership

It is often difficult to attribute the qualities of a strong leader to particular causes; but in Zilda Arns’s case, the formative influence of her family cannot be denied. Observing her parents supporting and serving their fellow community members must have taught her how to listen to people, while demonstrating to her the power of a caring neighbour and friend. Growing up in a large, loving family certainly showed her the importance of belonging and play to a child’s well-being. It is also likely that her siblings – with their varied experiences as educators, clerics, and engineers – left their marks on her multifaceted strategies. And undoubtedly, her devout Catholic upbringing profoundly affected her personal and professional life. She frequently said that she based her work on the values and principles nurtured in her family.

Her leadership style consisted of a powerful mix. On one hand, she was a savvy and strategic entrepreneur who was not only good at envisioning big ideas, but was effective in carrying them through and brokering partnerships with influential people and institutions. This was the side of her that focused on practical action and solid results. On the other hand, she was described as motherly, and her approach to her work was based on caring, mutual support and love. She believed in the capacity of local women, and upheld – at the centre of her philosophy – the right of the child to be cared for, to play and to belong.

At important junctures in her career, Zilda Arns was able to make critical connections. She saw that by fostering leadership qualities in others, she would continue the cycle of care; that is, children would be raised in healthy, supportive families and communities. Also, she seemed to know intuitively that in order for the leadership to spread and for the work to continue, it must be owned locally. She also seemed to understand that leadership is required at all levels in order for change to last. This meant that local ownership at the community level had to be supported by solid, dedicated leadership at policy levels, in the Church, and other key institutions. Only then would the system of local leadership be able to sustain itself. A solid network of leadership from both above and below is necessary for continued success.

Final Message

The life work of Dr. Zilda Arns Neumann is a model of community-based health care, one that is known for more than its work at the local level with the health practices of mothers and families. It has led to nation-wide changes in the health care system, including policy and ministry practices, with an impact that extends beyond Brazil. Former UNICEF Representative for Brazil, Reiko Niimi, summed up the contribution well: “Pastoral da Criança is an example to Brazil and to the

world of how complex and at the same time simple it is to ensure the rights of every boy and girl” (Pastoral da Criança, 2003, p.33).

Dr. Zilda Arns Neumann was a key contributor to what is now known as one of the most decentralized, and perhaps most democratic, health care systems in the world. From the roots that she planted in educating local women, to successful national campaigns and policy changes, she demonstrated humanized health care. It is an approach to health care that goes beyond service delivery, strengthening family love and community solidarity.

In the words of its coordinator, Dr. Zilda Arns Neumann, “The results obtained by the Pastoral da Criança in Brazil show how by developing human solidarity in a systematic and organized way, communities can transform themselves into agents of their own change. That is the way to reduce malnutrition and maternal-infant mortality, to educate families, especially women, and to teach social transformation.” (UNICEF, n.d., p.37). To strengthen the family through local women, as she did, was to strengthen the community, and, in turn, to strengthen the society itself.

References

- Anjos, G. dos. (2007). Motherhood, body care and “civilization.” *Pastoral da Criança* (3)6. Florianópolis, Brazil: Fundação de Economia e Estatística: Estud. Retrieved August 30, 2011, from <https://www.pastoraldacrianca.org.br/>
- Arns, Sister Helena, personal communication, December 13 2011.
- Arns Neumann, Nelson, personal communication, November 21 2011.
- Arns Neumann, Otilia. (2011). *Zilda Arns: A Trejetorioa da Medica Missionaria*. Editora do Chain. Curitiba. Brazil.
- Arns Neumann, Z. (2002). A experiência de fazer acontecer a saúde entre os excluídos da sociedade. (The experience of making health happen among social outcasts.) *Revista Panamericana de Salud Pública* 12(3), 153-156. Retrieved August 30, 2011, from <http://www.scielosp.org/pdf/rpsp/v12n3/12868.pdf>
- Arns Neumann, Z. (2009a). A discussion with Dr. Zilda Arns Neumann, founder, Pastoral da Criança, Brazil. Interview by Berkley Centre for Religion, Peace and World Affairs. Retrieved September 30, 2011, from <http://repository.berkeleycenter.georgetown.edu/090124InterviewNeumannZildaArns.pdf>
- Arns Neumann, Z. (2009b). Human rights, children’s rights. Plenary presentation at the SIGNIS World Congress, Chiang Mai, Thailand, 17-21 October. Retrieved March 15, 2012 from http://www.signisworldcongress.net/2009/IMG/pdf/ARNS_en.pdf
- Brazil Institute. (2010). Brazil Institute mourns the death of Dr. Zilda Arns. Retrieved March 15, 2012 from <http://www.wilsoncenter.org/article/image-rightbrazil-institute-mourns-the-death-dr-zilda-arns>

Duarte, Helio, personal communication, December 18 2011

Hampton, L. (2009). Albert Sabin and the coalition to eliminate polio from the Americas. *American Journal of Public Health* 99(1), 34-44. Retrieved March 15, 2012 from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636601/>

Mohanty, Ranjita, Lisa Thompson and Vera Schattan Coelho. (2011). Mobilising the State? Social Mobilisation and State Interaction in India, Brazil and South Africa. Sussex, United Kingdom. Development Research Centre: Citizen, Participation and Accountability.

Pastoral da Criança. (2003). *Pastoral da Criança: 20 anos de vidas*. Rio de Janeiro, Brazil: PUC.

Pastoral da Criança. (2011). Situacao de Abrangencia da Pastoral Da Criança. Poster. Curitiba, Brazil.

Programa das Nações Unidas. (2003-4). Relatorio Desenvolvimento Humano, Brasil. Retrieved September 30, 2011, from http://hdr.undp.org/xmlsearch/reportSearch?y=*&c=n&t=*&lang=en&k=brazil&orderby=year

Somarriba, M., da Mata Machado, E. N., and Menicucci, T. M. C. (1999). *Universalizing health care access through popular participation in Brazil. Interim report*. United Nations Development Programme. Retrieved March 25, 2012 from http://mirror.undp.org/magnet/Docs/dec/Case_Studies/

The Columbia Encyclopedia. (2009). Meningitis. P. 31781. Sixth Edition. New York: Columbia University Press. Retrieved March 15, 2011 from <http://www.questia.com/PM.qst?a=o&d=117032794>

The Daily Telegraph. (2010). Zilda Arns. 14 January. Retrieved March 15th, 2012, from <http://www.telegraph.co.uk/news/obituaries/religion-obituaries/6990059/Zilda-Arns.html>

University of Notre Dame. (2006). \$1 million Opus Prize to be presented Nov. 8 at Notre Dame. Retrieved September 30th, 2011, from <http://al.nd.edu/news/12550-1-million-opus-prize-to-be-presented-nov-8-at-notre-dame/>

UNICEF and CELAM Consejo Episcopal Latinoamericano (Latin American Episcopal Council).(n.d.). Five Stories. No date. Retrieved April 21, 2011 from www.unicef.org/media/files/5stories.doc



**International Centre for Women's Leadership
Coady International Institute
St. Francis Xavier University
PO Box 5000
Antigonish, NS
B2G 2W5 Canada**

www.coady.stfx.ca