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Health Policy Project Overall Report 2010-2011

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Acronyms

AMPE	Peruvian Municipalities Association
AMRESAN	San Martin Municipalities Association
ANGR	National Assembly of Regional Governments
APPS	Health Agreement Political Parties
ARH	Ayacucho Regional Hospital
AUS	Universal Health Insurance
CDMI	Distribution Centers of Drugs and Supplies
CEPLAN	National Center of Strategic Planning
CIES	Social and Economic Research Consortium
CIGS	Intergovernmental Health Committee
CNS	National Health Council
CPT	Current Procedural Terminology
CTIN	National Health Insurance Implementing Committee
CTIR	Regional Health Insurance Implementing Committee
DHS	Demographic and Health Survey
DIGEMID	MOH Health Supplies General Directorate
DGSP	MOH Persons-Health General Directorate
DGRH	MOH Human Resources Development General Directorate
DO	MOH Decentralization Office
DGPM	MEF Planning General Directorate
ENAHO	National Households Survey
EsSalud	Social Security Institute
FP/RH	Family Planning and Reproductive Health
GDP	Gross Domestic Product
HIS	Health Information System/s
HHR	Health Human Resources
HMN	Health Micro Network
HN	Health Network
IDB	Inter-American Development Bank
IT	Information Technology
ILO	International Labor Organization
JUNTOS	Cash-transference Program in Support of the Poorest
LG	Local Government
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCLCP	Concerted Group for the Reduction of Poverty
MED	Evaluation Tool on Health Decentralization
MEF	Ministry of Economics and Finance
MOH	Ministry of Health
MOU	Memorandum of Understanding
NDI	National Democratic Institute
NGO	Nongovernmental Organization

OGEI	MOH Statistics and Informatics General Office
OGPP	MOH Planning and Budgeting General Office
PAHO	Pan American Health Organization
PAN	Results Based Budget Articulated Nutrition Program
PI	MEF Incentives Plan for the Improvement of Municipal Management
PARSALUD	Support Program of Health Reform
PCM	Prime Minister's Office
PEAS	Health Insurance Essential Plan
REMURPE	Network of Rural Municipalities
RENIEC	National Office for Identity Registration
RG	Regional Government
RHD	Regional Health Directorate
SECCOR	Secretariat for Coordinating the National Health Council
SERVIR	National Authority of Civil Service
SETEC	Technical Secretariat of AUS Implementing Committee
SEPS	Supervisory Instance of Health Providers
SIS	Public Health Insurance
SISMED	Integrated System of Medical products and Supplies Management
SISFOH	Household Focalization System
UPSS	Health Service Production Unit
USAID	United States of America Agency for International Development

Executive Summary

USAID/Peru, through the Health Policy Reform Project, seeks to strengthen five components of the health system: Governance, Financing, Information, Human Resources and Medical products, ensuring that the necessary policies and policy-related capacities to sustain health reform are in place by the end of a 5-year effort. The aim is to promote substantial improvements particularly within primary care.

During the 18 months period, covered by this report, Project activities were simultaneously implemented at the national and regional levels, while new models and strategies were discussed within the staff to guarantee internal coherence between the five project components. At the national level, project activities were addressed to provide technical assistance to the different MOH areas: Persons-Health General Directorate (DGSP), Health Supplies General Directorate (DIGEMID), Human Resources Development General Directorate (DGRH), Statistics and Informatics General Office (OGEI), Planning and Budgeting General Office (OGPP), and Decentralization Office (DO). Close working relationships and coordination at the national level were also maintained with the Ministry of Economics and Finance (MEF), the National Authority of Civil Service (SERVIR) and international cooperation partners.

To strengthen and expand decentralization of the health sector, the Project focused its technical assistance to the MOH Decentralization Office (DO) and the Intergovernmental Health Committee (CIGS). With the DO, the Project contributed to the discussion of local governments health functions matrix, and with CIGS, the Project collaborated in the elaboration of technical proposals discussed within the three CIGS working groups –health financing, health career and health decentralization-. The Project also facilitated the CIGS assembly meetings conducted by the Minister of Health, with participation of all MOH Directors and the 26 Directors of the Regional Health Directorates (RHD). The close participation of the project in the CIGS technical meetings and ordinary assemblies was an opportunity to align project interventions to national and regional priorities.

To support the National Assembly of Regional Presidents (ANGR), the Project appointed a full time advisor in health financial issues. The technical assistance was directly provided to the ANGR President who participated in the CIGS meetings, as well as in the National Health Insurance Implementing Committee (CTIN) and Secretariat (SETEC). On time advice was provided to the ANGR President during the discussion of universal health insurance (AUS) implementation and public health insurance (SIS) payments to the Regional Governments (RG), which ended in successful agreements during the 2010 CIGS meetings.

A new model for primary health care was intensively discussed with DGSP, as well as the update of the Health Insurance Essential Plan (PEAS). With the DGRH, the project discussed the health career path policy and the design of decentralized workforce planning system, including the estimation of human resources gap at the first health care level. At a request of OGEI, the Project worked in updating national data standards of provider health information systems, providing technical assistance in the revision of the catalogue of medical procedures and the development of interoperability standards.

The project fostered the discussion of a financial law proposal under the leadership of OGPP. Project activities were focused in the elaboration of three studies which included alternatives and recommendations for the sustainability of the health financing policy as well as to improve efficiency in the allocation of resources, clarifying formal rules regarding the main health financing functions: revenue mobilization, pooling and strategic purchase. The chapter on fiscal space analysis showed the availability of fiscal resources to cover in a gradual and sustained manner the public financial gap for health.

The Project also provided technical assistance to the Coordination Committee of Political Parties Agreement in Health (APPS) to continue policy dialogue regarding new health issues, as the increase of chronic diseases and the main problems of public health workforce. In preparation of the regional elections, the Project promoted policy dialogue on regional health priorities, obtaining the commitment of those that were elected as Regional Presidents.

At the regional level, the project implemented activities in Apurimac, Ayacucho, Cusco, Huánuco, San Martín and Ucayali. The work plan in each region was adapted to the regional priorities and capacities. In San Martín, the project implemented a complete package of interventions that involved the five project components, combining the implementation of the new organization model and the implementation of a strategy for the reduction of chronic malnutrition.

The technical assistance in decentralization was focused in the reorganization of San Martín RHD, the elaboration of the organizational redesign of Cusco RHD, and the re-delimitation of health networks and micro networks in Apurimac and Huánuco. Within the framework of the Incentive Plan for the Improvement of Municipal Management (PI), the Project fostered in Ayacucho, Huánuco, Cusco and San Martín the analysis of goals accomplishments and budget allocation looking for the reduction of chronic malnutrition. It was also started the diagnosis and elaboration of a health anticorruption plan in Huánuco.

To ensure efficiency and equity in health resource allocation the Project provided technical assistance to Cusco RHD and CTIR in the analysis of financial gaps for Universal Health Insurance (AUS) implementation, and to San Martín RHD in the analysis of financial flows, suggesting some changes to guarantee expenditures quality control. To improve the elaboration of multi-year health investments plans at the regional level, the Project finished the design of a methodology, which includes guidelines and excels worksheets, currently being applied in San Martín. This methodology was approved by the MOH in July 2011, and its application is being supported by the MEF.

GalenHos-Hospital software was expanded to Cajamarca, Huánuco, San Martín and Tumbes, and new software modules were developed by current users. GalenHos-Primary Care was developed with some specific characteristics as: data entry units located at health centers, registration of information patient-based rather than program-based, and registers organized by patients, family and community. GalenHos-Primary Care was installed in two pilot health centers in Cusco, and is currently being installed in all health centers of San Martín.

In supporting the design and implementation of a broad-based system for planning and managing health workforce, the Project advanced in the design of a Health Human Resource (HHR) planning system and a management system based on competencies. This design was shared with local technical teams of Ayacucho, Huánuco, San Martín and Ucayali RHD, where the authorities were committed with the validation and implementation of at least one piece of the system. Main developments were made in the estimation of HHR gap, proved in San Martín using regional data to validate use of time and the ratio of HHR per population standards.

To improve the quality and availability of medicines and supplies, the Project supported the elaboration of regional action plans in six regions, which are currently being implemented. It was also developed a proposal to establish a programming methodology, allowing a better rationale for purchasing, aimed at optimizing the use and availability of financial resources with the physical needs of medicines and supplies. Important advances were achieved in Apurímac in decentralizing the distribution of drugs from the central location to the micro-networks.

1. Introduction

The period of Project implementation was marked by the political campaigns and elections at the regional and national level. During the last quarter of 2010, we had the election of regional and local authorities in 26 regional governments and more than 1800 provincial and district governments. New authorities began their governmental period of four years in January 2011. In the table below are the names of the Presidents and political parties of the regions where the project has worked during the last 18 months. In four of these regions – Apurímac, Ayacucho, Cusco and Huánuco- new Regional Presidents were elected, three of them representing regional political movements and one representing a national political party. In San Martín and Ucayali the Regional Presidents were re-elected..

Table 1: Regional Authorities Starting January 1st, 2010

Region	President	Political Organization
Apurímac	Elías Segovia Ruiz	Poder Popular Andino
Ayacucho	Wilfredo Ocorima Núñez	Alianza para el Progreso
Cusco	Jorge Acurio Tito	Gran Alianza Nacionalista Cusco
Huánuco	Raúl Picón Quedo	Partido Democrático Somos Perú
San Martín	Cesar Villanueva Arévalo	Nueva Amazonia
Ucayali	Jorge Velasquez Portocarrero	Integrando Ucayali

As a result of the new governments, most regional high level officials, including social development managers and health directors –Directors, Deputies and Executive Directors- were changed, even in those regions where the Presidents were re-elected. At the regional level, the appointment of new officials, especially Directors is not usually based in a competitive process, but in a political decision. Although, most of the new Directors are competent health professionals, not all of them have a previous experience in health management and know little of the current health reform processes. In order to sensitize and inform them of the national government health priorities and ongoing decentralization process, the MOH organized with the technical assistance of the Project a meeting of the Intergovernmental Health Committee (CIGS), with the participation of the new health authorities, during the first quarter of 2011.

To raise awareness of the new health authorities about health reform, the project launched two technical dialogue series on decentralization and health financing. The project team organized six conferences on the advances and challenges of the decentralization process

in Apurimac, Ayacucho, Cusco, Huanuco, San Martin and Ucayali, and two conferences on health insurance in Ayacucho and Ucayali.

In April 2011, Peruvians elected the new President that will conduct the national government for a five-year period, and the 130 Congress members that will rule for the same period. The presidential election was defined in a second round two months after none of the two most popular candidates reached the required 50%+1 of the votes. The elected President, Mr. Ollanta Humala won the elections with a very tight difference, which shall force him and his cabinet to moderate his original plan, in order to avoid conflicts and include the different voices of stakeholders around the country.

During June the new government technical teams were introduced to each Ministerial team and received the required information to assume governmental functions. In July 28th, Dr. Alberto Tejada was appointed as the new Minister of Health with the following governmental agenda:

- Develop the emergency mobile care system (SAMU) to reinforce primary health care within the most vulnerable population,
- Set the basis to implement the National Health System,
- Strengthen the first level of care and the health insurance mechanisms, including chronic diseases,
- Build and implement one hospital in each capital province,
- Appoint health personnel in the more remote areas of the country,
- Provide essential medicines in 100% of first level of care facilities.

To date, the Project is expecting a formal meeting between USAID and the Minister of Health to resume activities with the main MOH counterparts. After this meeting, the Project work plan shall be adjusted to better respond to the current government agenda.

2. Main Activities

USAID support has contributed to substantial improvements in the public health system in Peru and to the major advances in Peru's aggregate national health indicators since the 1980s. In spite of these well timed and focused investments, significant challenges remain. Decentralization has progressed significantly but remains incomplete, negatively affecting the ability of the system to respond to diverse regional needs. Financing challenges for the Universal Health Insurance continue to impede access to quality care by the more vulnerable populations. The poor quality of health information compromises the ability of managers and health providers to make timely and effective decisions; the understaffed health workforce is sub-optimally distributed and not managed to maximize performance and retention; and, notwithstanding recent improvements in the logistic supply chain, there is a great need to increase the availability of medical products and supplies at the point of service.

USAID/Peru, through the Health Policy Project (USAID/Peru/Políticas en Salud), is seeking to address these challenges, and ensure that the necessary policies and policy-related capacities to sustain reform are in place by the end of this 5-year effort. The aim is to promote substantial improvements particularly within the primary care level. Main outcomes per each of the five Project components are listed below:

Table 2: Main Project Outcomes per Component

Component	Outcomes
Health Governance	The MOH, regional and local authorities are operating in coordination under the decentralized health system by developing, effectively implementing and enforcing sound policies and regulations
Health Insurance and Financing	Peru has increased its public spending on health to achieve its health insurance coverage goals, and is funding health services to ensure efficiency and equity in the public health system
Health Information	The MOH, regions, and local authorities are generating and using accurate and timely information to manage the health system.
Health Human Resources	Policies for improved human resources management in the public health sector are implemented
Medical Products and Vaccines	The Peruvian health system appropriately procures and manages the pharmaceuticals and supplies needed for all public health services and programs

During this period, the Project trained and/or provided technical assistance to 8,753 participants, who attended our policy dialogue conferences, workshops and technical meetings (Table 2). Dissemination activities about decentralization and financing issues concentrated a great percentage of participants, as well as the activities with political parties. The awareness raising meetings about local incentives also concentrated an important percentage of participants because they were addressed to local governments' authorities. More specialized activities were organized under health information, human resources and

medical products & supplies systems, which were mainly set thru technical workshops addressed to RG health officials.

Table 3: Number of Participants to Project Activities, by Component, Year and Sex of participants

Region	Number of participants				Total	Percentage
	2010		2011			
	Women	Men	Women	Men		
Governance – decentralization	730	777	254	330	2,091	24%
Governance – political parties	632	1,104	18	65	1,819	21%
Governance -local incentives	397	571	34	67	1,069	12%
Governance - anticorruption	81	87	13	24	205	2%
Governance - EBI malnutrition	10	10	67	78	165	2%
Financing & Insurance	148	226	463	623	1,460	17%
Health Information	97	142	135	101	475	5%
Human Resources	167	175	144	153	639	7%
Medical Products & Supplies	269	194	172	195	830	9%
Total	2,531	3,286	1,300	1,636	8,753	100%

Project activities were mainly implemented at the regional level, with 80% of the total number of participation (Table 3). The greater number of participants was concentrated in San Martin where the Project focused activities under the five components. Activities in La Libertad were suspended early during the first year because of changes in the political conduction of the government. In Ucayali, activities started during the second year, and were slowed because of changes of the Social Development Manager and the Regional Health Director.

The implementation of both national and regional activities was more intensive during 2010, with 66% of the total number of participants. The inauguration of regional governments in January 2011 hindered the continuation of Project activities, with the exception of San Martin, where the President was re-elected and most authorities were maintained in their positions. At the national level, a new government started in July 2011, and most of the MOH official counterparts were changed. It is taking a while to reassume ongoing processes with the Directorates and Offices of the MOH.

The attendance of women to Project activities is important, with 44% of the total number of participants. This is explained in the focus of the project, mainly high and mid level health managers, a type of professional profile with a strong presence of men.

Table 4: Number of Participants to Project Activities, by Region, Year and Sex of participants

Region	Number of participants				Total	Percentage
	2010		2011			
	Women	Men	Women	Men		
Lima – National	317	778	198	444	1,737	20%
Apurímac	241	229	76	80	626	7%
Ayacucho	269	356	262	246	1,133	13%
Cusco	382	508	145	183	1,218	14%
Huánuco	530	504	61	47	1,142	13%
La Libertad	77	131			208	2%
San Martín	715	780	480	529	2,504	29%
Ucayali			78	107	185	2%
Total	2,531	3,286	1,300	1,636	8,753	100%
Percentage	29%	37%	15%	19%	100%	

2.1 Health Sector Governance

Strengthen and expand decentralization of the health sector

The Project's work in this component was focused in providing technical assistance to the Ministry of Health (MOH) in developing the 2011 Health Decentralization Plan, in the identification of the health functions for local governments and for the functioning of the Intergovernmental Health Committee (CIGS). At the regional level, technical assistance was focused in the implementation of the new organization of the Regional Health Directorate (RHD) of San Martín, the elaboration of Cusco's RHD organizational redesign and the re-delimitation of health networks and micro networks in Apurímac. Regional Governments were also engaged in discussions about the importance to address health priorities with the Local Governments in order to reach the goals of the Incentives Plan for the Improvement of Municipal Management (PI).

Starting 2011, after the election of the new Regional Governments (RG) Presidents, the Project implemented a plan to disseminate key information about decentralization to new health authorities, officials and representatives of civil society in six regions and in Lima. Two additional initiatives were added to the component: the design of a decentralized management model for key national health priorities, and a specific technical support to RG of San Martín in the elaboration and costing of a plan for the reduction of infant chronic malnutrition.

During July-September 2011, the governance team has focused its efforts in the elaboration of the systematization of the health decentralization process, including activities undertaken, and recommendations for future strategic action to strengthen and expand decentralization of the health sector. This product was concluded and it will be an important tool for revising the health decentralization strategy.

The project has continued with technical assistance to the APPS Committee that coordinates and organizes the activities of debate and consensus building regarding health policy issues among political parties. The appointment of members to this Committee is renewed periodically; in this period it was integrated by representatives of five political parties (APRA, Acción Popular, Partido Descentralista Fuerza Social, Partido Humanista and Partido Popular Cristiano). During this period, two consensus policy documents were elaborated regarding: Health Decentralization of Metropolitan Lima and Non-Communicable Diseases.

2.1.1 Health sector issues have been debated publicly in the political transition at the national and regional level

The Project – partnered with the National Democrat Institute (NDI) and the Social and Economic Research Consortium (CIES) – provided technical assistance to the APPS Committee of political parties (APPS) based on the progress of the health policy dialogue to date, and the main benchmarks of the elections calendar:

- October 2010: Regional and Municipal elections,
- January 2011: Inauguration of Regional and Municipal Governments,
- April 2011: National elections – President and Congress,
- June 2011: Second Round of National Elections -President,
- July 28, 2011: Inauguration of the National Government.

The work plan for this stage of the political parties' policy dialogue included three activities:

- Dialogue among political parties to analyze the progress in the implementation of the health agenda prioritized for 2006-2010, and to define priorities for the government starting July 2011;
- Dialogue to reach a consensus about the health decentralization process in Metropolitan Lima, where the transference of health functions was postponed;

To analyze the progress in the implementation of 2006-2011 health agenda, the political parties invited different stakeholders from the public sector, (such as MOH, ESSALUD and the Ombudsman's office) and civil society organizations (CIES, Group to Build Consensus to Combat Poverty –MCLCP-, National Medical Association, and National Assembly of Regional Presidents (ANGR); to collect their perceptions as inputs in the discussion of a renewed health agenda.

The political parties statements were systematized according to three issues: health determinants, health priorities and health system strengthening, and finally the selected two topics for discussion were non communicable diseases and health human resources. The diagnosis of non-communicable diseases was presented by representatives of the MOH and

the Pan American Health Organization (PAHO); and the diagnosis of health human resources was presented from the perspective of the MOH and the academy. After the presentations of both issues, there were two sessions to discuss and systematize the proposals, identifying the consensus points. The APPS Committee completed the consolidation of these points and elaborated a document that was submitted to the political parties for their approval. Currently the non communicable diseases document has been signed by the main authorities from the following political parties: APRA, Acción Popular, Alianza Para el Progreso, Cambio 90, Partido Descentralista Fuerza Social, Partido Humanista, Perú Posible, Restauración Nacional and Somos Perú. At the present time, this document is to be presented to Congress, the Ministry of Health and other authorities and to be distributed in organizations, institutions among others.

For the discussion of health decentralization in Metropolitan Lima, two new partners were added to facilitate the dialogue: the World Bank with its proposal about megacities, and PAHO with its concepts about urban health. The dialogue about Metropolitan Lima was carried out in six sessions. The objective of the first session was to provide a framework on urban health and the background of health decentralization process in Metropolitan Lima. The second session was aimed at examining the perspective of the stakeholders involved in the decentralization process: the main actors in the Lima Health Directorates and in the Municipalities of Lima province and districts. The third session was to present international experiences, such as the case of Bogotá. Finally, based on the discussions during the previous three sessions, the political parties identified and presented their proposals regarding three issues: health objectives, health functions and the decentralization process, which were later systematized in order to identify the consensus issues. Currently the health decentralization in Metropolitan Lima document has been signed by the main authorities from the following political parties: APRA, Acción Popular, Alianza Para el Progreso, Cambio 90, Partido Descentralista Fuerza Social, Partido Humanista, Perú Posible, Restauración Nacional and Somos Perú. At the present time, this document is to be presented to the mayor of Metropolitan Lima, the Minister of Health and other authorities and to be distributed in organizations, institutions among others.

At the regional level - Ayacucho, Cajamarca, Cusco, Huánuco and La Libertad- the focus during the first half of the period was to foster the organization of local groups for policy dialogue in health and to provide technical assistance to these groups in the elaboration of their activity plans. All planned activities were completed in Ayacucho, Cajamarca, Cusco, Huánuco and La Libertad. In Ayacucho, the political parties analyzed and prepared proposals regarding human resources, health insurance and citizen participation; in Cajamarca, the political parties identified two local priorities: health decentralization and health financing; in Cusco three issues were prioritized: environmental health, health insurance and organization of health services; in Huánuco the political parties selected human resources, local priorities and health insurance; in San Martín education and financing in health were prioritized and finally in La Libertad the group discussed health financing, insurance and decentralization.

The Project and the partners that have been promoting the policy dialogue within the APPS during the last 5 years commissioned the systematization of the process and its effects on strengthening the political parties and in building the health policy agenda. The

recommendations of the performed systematization will improve a following cycle of APPS dialogue.

2.1.2 New health authorities and officials receive key information and policy advice regarding the decentralization process

This activity started in January 2011, after the inauguration of the newly elected Regional Presidents and the appointment of new authorities in most of regional positions. The Project team was involved in preparing key information and policy advice, and elaborated policy briefs. During the first six months of 2011, the Governance team developed several dissemination meetings in Lima and regions presenting a preliminary balance of the health decentralization process:

- Cusco: May 10th
- Ucayali: March 16th, May 13th
- Lima: Annual Conference of Rural Municipalities (CAMUR) March 17th;
- Meeting with key national actors held in May 27th.
- Huánuco: May 18th
- Apurímac: May 24th
- Ayacucho: May 26th
- San Martín: May 27th
- Lima: May 27th

Additionally, the Governance team began the formulation of the assessment and agenda of the health decentralization process, formulating a framework and discussing it with a group of recognized experts.

2.1.3 The Intergovernmental Health Committee (CIGS) has agreed on, approved and is implementing a health agenda

In January 2010, the MOH issued a ministerial resolution constituting the Intergovernmental Health Committee (CIGS), as a mechanism of coordination between the MOH and Regional and Local Governments (LG). In the CIGS, the RG are represented by the Regional Health Directors or the Social Development Managers, and the LG are represented by two municipal associations: the Network of Rural Municipalities (REMURPE), and the Peruvian Municipalities Association (AMPE). The CIGS was installed in February, 2010.

During the last eighteen months, the Project has supported the MOH-DO -that acts as the CIGS's Technical Secretariat-, in the organization and facilitation of the intergovernmental meetings and the elaboration of technical proposals discussed in those meetings.

Moreover, the Project provided technical support to two specific work groups: Human Resources work group to discuss the National Plan to Strengthen Institutional Capacities;

and Health Financing work group to propose a consensus based solution to the Public Health Insurance (SIS)'s debt to regional governments, as well as the revision of the technical proposal of the Health Financing Law. Another topic discussed by the CIGS was the matrix of health competencies and functions for the three governmental levels, elaborated in the process of adapting the Health Ministry sector to the new Law of the Executive Power (LOPE). Finally, during the first quarter of 2011, with the support of the project, the participants of the CIGS carried out an assessment of the CIGS' functioning and organization during 2010 and made recommendations for the adjustment of its by-law with the purpose of strengthening its functionality.

The main CIGS meetings and agreements have been:

2010

- March 19th and 20th, 2010: approval of the annual work plan.
- March 31st: discussion of the SIS' debt to the RG as reimbursements of health services provision.
- May 11th, June 10th and 11th: revision of the National Plan to Strengthen Institutional Capacities.
- May 24th: approval of the calendar for the discussion of the Public Health Career and a norm for human resources redistribution at different levels.
- June 11th and 12th, in Tarapoto, to discuss regional experiences of RG and RHD's reorganization processes.
- June 25th y 26th: discussion of the guidelines and mechanisms of RHD reorganization, and approval of the National Plan to Strengthen Institutional Capacities, the Middle Term Health Decentralization Plan and the work plan to define a Public Health Career.
- July 20th: rapid assessment of the CIGS with the following recommendations: a) to improve the formulation of the meeting's agendas; b) to monitor the accomplishment of the various agreements; c) to strengthen the work groups, promoting the participation of the RHD Directors.
- September 9th and 10th: the main discussion focused in the analysis of SIS' debt to the regional governments and the analysis of the technical proposal for a financial law.
- December 6th and 7th: in this session, the assembly achieved important agreements in order to solve the SIS' debt. The other issues were included in the next CIGS's meeting agenda: a) National Plan for the Strengthening of Primary Health Care; b) Decentralized Management Model of Health Services; c) assessment of CIGS functioning; d) formulation process of 2011 CIGS's plan.

2011

- February 10th and 11th 2011, in Arequipa. This was an orientation session to the new members –recently appointed Regional Health Directors- about the nature, purpose, organization and functions of the CIGS. The assembly approved the methodology to be applied in the formulation of the CIGS’s plan for year 2011 and the assessment of the CIGS functions and organization. The regional application of the monitoring and evaluation tool of health decentralization (MED), developed with Project support, was included in the annual plan.
- March 25th and 26th: approval of the CIGS` s plan for 2011 and of the new proposal of CIGS bylaw, in order to strengthen its functioning and organization. The health competencies and functions matrix for the three governmental levels was approved. The Project assisted the MOH in the identification of local governments’ health functions included in this matrix.
- April 13th: the Executive Secretariat was constituted and installed as a co-direction instance with the participation of MOH, RG and LG representatives.
- May 31st and June 15th: discussion of the health competencies and functions matrix, with the participation of MOH and PCM officers, and ten RHD Directors. The Project team provided technical assistance to the RHD, regarding critical issues of the health matrix.
- June 16th and 17th, in Junín. The assembly ratified the approval of the new CIGS bylaw and the MOH sent it to PCM for its formalization. The debate about the health competencies and functions matrix was postponed for the next governmental period.

To foster a more informed participation of the regional representatives to the CIGS, the Project provided technical assistance to the National Assembly of Regional Governments (ANGR) during 2010. The technical assistance provided to the ANGR Secretariat was decisive in providing key information to the RHD, promoting the discussion of different proposals and arriving to consensus with the MOH. In November 2010, representatives of the regional offices of health insurance agreed with the SIS and MOH officials on the new validation rules to be applied in the assessment of the previous years’ SIS payments. In a meeting held on November 23, there was an additional agreement on the operational definitions of the MOH norm related with health facilities resolution level and service provision fees. In this meeting, the SIS also presented the new payment mechanisms to be implemented during 2011. Finally in December 6, the CIGS members arrived to a consensus in the remaining financial issues related to health insurance reimbursements and the negotiation processes between the RG and the MOH.

The Project also provided technical support to the ANGR President and Secretary in the analysis of 2011 health budget, including the analysis and justification of the regional budgets to be discussed with the Congress Commission of Public Budget, in charge of approving 2011 budget. In this discussion, the ANGR presented the RG’s health requirements, including: (i) the funds for the reimbursement of SIS’ debt, in the amount of S/. 52 millions; (ii) the need to change one article of the budget law guaranteeing the continuation of investments in the transition period, in order to avoid the devolution of non

used resources to the central budget; and (iii) the allocation of additional resources to compensate the reduction of investments resources decided in the budget proposal. Moreover, the Project prepared a detailed analysis of the health budget included in 2011 Budget Law.

Other important instances for technical assistance were the meetings called by the Technical Committee (CTIN) and Technical Secretariat (SETEC) that coordinate the implementation of Universal Health Insurance (AUS) at the regional and national levels. Main issues discussed during these meetings, were the SIS' proposal of the semi-contributive health insurance mechanism, the monitoring of population affiliation under each of the three health insurance regimes: subsidized, contributive and semi-contributive, progress in the implementation of the household focalization system (SISFOH), and the technical norm for the categorization of health facilities.

2.1.4 The MOH has designed and validated a decentralized management model for key national health priorities, including family planning and reproductive health

In August 2010, the Project initiated a review of experiences and lessons learned on models of public health programs addressing national priorities, related to financing, roles, functions, and intergovernmental relations, as well as the effectiveness of interventions in decentralized health systems. Under USAID's advice, the Project prioritized malaria as the case study to this end.

Starting 2011, the Project provided technical assistance to the MOH National Malaria Strategy to establish the technical requirements to design a decentralized management model for malaria control in a decentralized system. This conceptual framework and analysis was used to prepare the terms of reference for the consultants that developed the country's proposal for Round X of the Malaria Global Fund (GF). Based on this first approach, the MOH Vice-Minister requested the technical assistance of the Project to develop a proposal for a decentralized management model for the prevention and control of metaxenic diseases. This technical assistance was coordinated with USAID-Amazon Malaria Initiative (AMI) and PAHO, who formed a work group with the participation of the Project and under the leadership of the MOH. The group approved the work plan proposed by the Project. The Project also developed the SOWs for a systematic review about the impact of decentralization in malaria control, a rapid assessment of the decentralized management of malaria control in Peru, and a review of international experience of decentralized management of malaria control. The systematic review on the effect of decentralization on malaria control was completed.

In August, team members of the Project visited the regions of Loreto and Madre de Dios for research on the status of prevention and control of malaria after decentralization. Key informant identified changes after decentralization in organization, human resource management, management of critical supplies, information management, and budget and investment management in prevention and control of malaria.

Technical assistance to define evidence based goals related to child and maternal survival with the SPECTRUM software

The MOH requested assistance from the Project to establish evidence based goals for national health priorities, defined by "PLAN PERU 2021-National Strategic Development Plan" of the National Center of Strategic Planning (CEPLAN). The Secretariat for Coordinating the National Health Council (CNS-SECCOR) convened representatives of the technical areas related to these priorities, complying in this way a work group under the coordination of the MOH Planning and Budgeting General Office (OGPP), in charge of defining viable goals.

During May and June, 2011, the Project conducted several workshops with MOH staff to establish the methodology for setting goals and data collection. The decision was to use the software Spectrum of USAID¹, that identifies the effective interventions to reach health priorities, and based in coverage targets set by MOH officials define the goals for maternal mortality, infant mortality and malnutrition. These new targets were approved by the National Health Council (CNS) and the MOH, who requested CEPLAN to include these new goals in Plan Peru 2021.

Technical Assistance to San Martin RG in the design of a Regional Program for the Reduction of Chronic Malnutrition

The RG of San Martin has the priority to reduce chronic malnutrition among children less than 5 years and has decided to implement an effective program to obtain a significant reduction by 2014. In this sense, the RG authorities requested technical assistance from the Project to develop a program of effective interventions rigorously evaluated and whose impact can be measured in terms of reducing malnutrition. The Project team, and the technical staff and authorities identified the effective interventions and established the baseline coverage of these interventions in the region. The interventions examined were diverse and included educational and promotional activities to improve nutrition, micronutrient interventions and preventive interventions for multi-sector action. Improving the coverage of more effective interventions, the region of San Martin could reduce child stunting by 10 percentage points in 2014; however this goal will require considerable efforts of the RG in terms of funding and management improvement.

Effective interventions that will achieve the goal set by the RG are grouped into:

- a) Strategies for improving the intake of nutrients and micronutrients (nutritional counseling and micronutrient food delivery),
- b) Strategies for disease prevention (installation of water and sanitation systems, promotion of hand washing with soap, safe disposal of infant feces, vaccination, family planning, institutional delivery, postpartum care),

¹ Spectrum is a system of integrated policy models that provides a tool "Lives Saved" that allows to establish goals for maternal and child survival based on coverage targets of effective interventions. It is based on the work of the Group of Bellagio Child Survival Study, the reference group of child health epidemiology and the Steering Group of international child development, published in the Lancet series of years 2003-2008.

- c) Strategies for disease management (quality care in health services, therapeutic feeding for children with severe acute malnutrition, diarrhea treatment with zinc, treatment of pneumonia with antibiotics, treatment of dysentery with antibiotics, calorie and protein supplements for malnourished pregnant women).

The program includes a cross-cutting strategy, intensive, focused and cumulative to increase coverage of effective interventions and improve the quality of service delivery. The program will protect newborn cohorts and follow their growth and development up to 4 years of age in 33 districts which have been selected due to the number of malnourished children and to the highest prevalence rate of malnutrition. The program will begin serving all pregnant women and newborns in the priority districts because interventions are most effective at this stage of life. Prenatal care and monitoring of children up to four years will increase the institutional delivery and coverage of effective interventions.

**Table 4 Per capita costs to reduce child malnutrition
in San Martin Region
(Nuevos Soles)**

Groups	Per capita cost (N.S.)
Pregnant woman	435
Children under 1 year old	560
1 year old	268
2 years old	200
3 years old	127
4 years old	129

Source: ¿Cuánto costaría reducir la desnutrición en la región San Martín? Lima:

USAID/Políticas en Salud, 2011

The technical team of the San Martin region together with the technical team of the Project conducted a rapid assessment of the operation of effective interventions with emphasis on program management processes and service delivery. The findings of this assessment were discussed with experts, government officials and regional RHD. A manual of operations and the implementation plan has been prepared, which are consistent with the technical standards of the MOH. The operations manual and the implementation plan in under review for its approval by the RG.

Human resource gaps to begin the operation of the program were identified for each service network in priority districts and the additional budget required. Currently the project is providing assistance to solve management bottlenecks regarding hiring the needed health staff as well as the 2012 budget negotiation process between RG San martin , MOH and MOF. At the same time, the component of health information systems of the Health Policy Project is developing the information system that will track pregnant women and children

who participate in the program. The information system is a module of GALENHOS for the first level of care.

2.1.5 Regional Health Directorate and health networks in one priority region have been reorganized and modernized to carry out their new functions under decentralization

The project started providing technical assistance to the RG of San Martin in March 2010, after the RHD assessed the progress and difficulties of implementing the new organizational structure approved in September 2009. To start the implementation of the new organization, the RG formed a change management team that established the road map to advance in its implementation. The Project assisted this team in the elaboration of 2010 annual implementation plan and in the formulation of RHD internal organizational documents (analysis of occupational positions and personnel assignment cadres) in all RHD organic units. The staff was trained regarding the legal framework of decentralization process and especially in the delimitation of the regulatory functions between the three governmental levels.

Another technical assistance area in the region was the organization design of health micro networks on the basis of an up-dated health care model. This activity was developed based in a work plan prepared with MOH Persons-Health Office and USAID/Calidad en Salud Project, with a validation area in San Martin. As part of this plan, the project updated:

- a) Health facilities admission procedures manual;
- b) Technical proposal for the up-dating of primary health care model for the public sector;
- c) Referential charter of services for primary health care.

During 2010, the Project provided technical assistance to the RHD, monitoring the implementation of the organization design and revising and updating the implementation plan. The Project regional advisor supported the elaboration of the final document of the Health Networks bylaw. Other internal organizational documents supported by the Project were a) functions distribution by occupational positions for HMN, and b) a model of Organization and Functions Manual for HMN. Additionally, the Project supported the organization of an evaluation workshop of RHD reorganization implementation in November, identifying progress and challenges.

In March, 2011 the technical assistance of the Project was reinitiated with a workshop to define a new organizational implementation plan for the middle and short term, with the attendance of RG, RHD and Health Networks officers. The workshop objectives were to: a) Propose expected results for the short and middle term linked to the health regional priorities; b) Identify prioritized processes and sub-processes; and c) Recognize organizational requirements.

The Project has been providing technical assistance in the formulation of RHD Personnel Assignment Cadre and its correspondent Labor Position Index. Additionally, in the last quarter, the project has supported to the RHD in the final preparation of the documents of

the Health Networks bylaw and its justification report, which were sent to the RG for its approval; it was approved in September. .

In other regions, the Project organized technical meetings with Regional Governments and RHD officers, in order to develop work plans to address the organizational design of the RHD or the Health Networks (HN) and Micro networks (HMN):

In Apurimac, the Project presented to the RG authorities the scope of an organizational process for the health networks, and elaborated with the RHD a work plan for the re-delimitation of Health Networks and Micro Networks. There were four workshops with the purpose of capturing, processing and analyzing key information (villages, access road, distances and population) required for health micro network delimitation, all of which was presented in a technical report. The new regional government officials of Abancay RHD approved this delimitation.

In Cusco, the project provided technical assistance to the RHD in the formulation of a new organizational redesign; for this purpose, the RG launched an executive resolution constituting a special commission in charge of designing the RHD. The project assisted this commission and facilitated several workshops to: a) define the RHD organizational roles (RHD, regional hospitals and Health Networks); b) define the health functions distribution amongst regional instances (RG Executive, RHD and Health Services Management Units); c) design the RHD organizational structure for its second hierarchical level and functions distribution; and d) the design of RHD organizational structure for its third hierarchical level. The RHD organizational design was completed in December 2010, identifying specific functions for RHD units of its third hierarchical level. At the same time, the Project facilitated the fourth workshop on RHD organizational redesign, aimed at formulating a proposal of organizational design of Health Networks, a) definition of Health Networks organizational structures and roles; b) health functions distribution between Health Networks and Micro Networks.

As a consequence of the governmental change in January 2011, a new commission was set up to review the proposal of RHD reorganization. The Project continued working with this commission in order to define the distribution of health functions amongst Health Network's proposed units, completing Health Networks design, and to confirm the constitution of Health Micro Networks.

In Huánuco, a workshop was held in August, 2010 aimed at making a rapid assessment of HN and HMN functioning, in which the RG and RHD officers concluded that these units have limitations in their institutional performance, and requested for technical assistance in delimitation and organizational design. The second workshop was held in September to identify and generate reliable information about the HN and HMN delimitation (villages, access road, distances and population). Recently, the new RHD officers have asked the Project for technical advice in the organization of the RHD and its Health Networks.

In La Libertad, the Project provided the RHD management team the technical inputs for the revising and documenting the new RHD organizational structure (By-laws and support report) in order to answer to the RG queries to the documents that were sent for approval. In May 2011, the RG approved the proposal, and now it is beginning to be implemented.

The technical assistance to the MOH DO was focused in the validation of the health functions matrix for local governments, developing a methodology for its validation. For this purpose, three workshops were held in the regions of Cajamarca, Lambayeque San Martin, aimed at presenting the health functions matrix to regional and local government officers, with the purpose to receive suggestions for the adjustment of the matrix. The MOH DO organized meetings with different MOH units to revise these suggestions. This process was systematized in a report on local health functions matrix, which has been completed.

The project also supported the MOH DO in the second regional application of the monitoring and evaluation tool on health decentralization (MED) in all the country. The project provided technical advice in the planning of this second application, training of facilitators and in the methodological design for the formulation of regional plans for institutional capacities building, on the basis of the results of the MED application. The project assisted the MOH DO in the validation of the methodology for prioritizing management processes in Madre de Dios.

2.1.6 The MOF and MOH have validated an incentive program to foster results in prioritized health programs through coordination between health services and local governments

In January 2010, the MOF launched the Municipal Incentive Program, established in the Budget Law. This program allocated S/. 350 million to LG by March and a similar amount conditioned to the accomplishment of goals, by September. During 2011, the indicators and goals will be associated to the Result Based Budget Articulated Nutrition Program (PAN), and for rural local governments will refer to Child Growth Control, Affiliation of children less than 5 years age to SIS, budgeting in the PAN budget lines, etc. According to the MOF, the purpose of the program was to engage the LG in the fight against malnutrition by providing incentives to the municipalities to: (i) implement community activities that organize and foster the demand for health services of the families, and (ii) coordinate with the local health services the provision of priority health services aimed at preventing malnutrition. Although the actual mechanisms and processes were not clearly determined, this program opened an important opportunity to strengthen the local health decentralization process due to the availability of significant resources which had been absent in the past.

The project elaborated a joint programming strategy to foster RG along with LG to coordinate, for a particular area, goals, strategies and financial resources for a health priority linked to infant chronic malnutrition. This strategy included technical meetings with key stakeholders to inform scope of the PI, workshop with RG and local authorities to reach political agreements regarding the implementation of the PI, joint programming workshops with RG and local authorities and monitoring. This strategy was applied in 5 regions with the aim to plan the 2011-Regional Health Budget linked to child nutrition activities, involving 53 LG in Ayacucho, 21 LG in Huanuco, 6 LG in San Martin and 40 LG in Cusco. It was expected that local governments' resources would address health promotion, in the budget product "Healthy families, communities, schools and municipalities" which already is part of PAN. However, the definition of the activities linked to health promotion at the local level were not defined, hence the Project, in articulation with MOF and other agencies, promoted its definition by MOH-Health Promotion General Directorate.

Pressed by MOF deadlines to complete 2011 budgets, the RHD did not finish the discussion of these budgets with the local governments, as originally planned. On August, when the final budgets were consolidated by MOF, the Project promoted the coordination between these actors, plus the conditioned cash transference program (JUNTOS), the civil registration organization (RENIEC) and health insurance regional offices, to discuss the different roles and responsibilities related with the accomplishment of the goals set up by the PI.

In October, the MEF published the information of the districts that accomplished the first semester goals, one of which measured a minimum percentage of budget execution in the expenditure lines of Health and Sanitation. In the regions where the Project promoted this discussion and joint programming, Ayacucho, Cusco, Huánuco and San Martín the percentage of districts that accomplished the budgetary goals was 79%, 78%, 74% and 86%, respectively. These districts accomplishing the budget execution goal received the incentives money, in a total amount of S/.63 millions.

During October and November, the Project organized new workshops in these four regions, with the regional and local authorities, with the participation of JUNTOS and RENIEC. Recently elected municipal authorities participated in these workshops and were aware of the MOF program, and the need to accomplish malnutrition reduction goals. Thru November 30, 45% of the incentives money allocated to the municipal governments was already spent, and 11% of these expenses were assigned to Health and 38% to Sanitation.

Starting 2011, the Project designed a new plan for the year, to promote an inter-governmental agreement between the regional and the local governments to address the reduction of chronic malnutrition within the framework of the PI. The initial enthusiasm of the regional authorities of San Martín and Ucayali to sign these agreements diminished because the MOF decided to postpone the allocation of the incentives to the local governments within the framework of an emergency decree that had the aim of reducing public expenses during the second quarter of the year 2011. Nevertheless, this decision was changed by the end of June, and the MOF published the list of districts that accomplished the required goals that conditioned the incentives allocation.

In the next table, there is the number of local governments in each of the six project regions that will receive the incentives. Huánuco and San Martín are the regions with the greater percentage of municipalities receiving this conditional incentive.

Table 5: Percentage of Local Governments by Incentive Received

	Complete Incentive	Partial Incentive	No Incentive	Total	Total
Apurímac	63%	4%	34%	100%	80
Ayacucho	76%	6%	18%	100%	111
Cusco	70%	6%	23%	100%	108
Huánuco	80%	5%	14%	100%	76
San Martín	82%	0%	18%	100%	77
Ucayali	67%	13%	20%	100%	15
Total	74%	5%	21%	100%	467

2.1.7 One Regional Health Directorate has approved a health sector anticorruption plan

This activity was initiated in Huánuco, with the support of previous Social Development Directorate (GDS), and continued at a slowest pace during the new government. The Project presented the methodology to conduct the diagnosis of the main areas of the regional health system that were sensitive to corruption. In July, 2010 there was a technical meeting with a special committee appointed by the RG to complete this task- where the participants adjusted the diagnosis tools, and organized the field work to gather the information. The committee elaborated the diagnostic report, and discussed it with the Regional Health Council and the Regional Health Director.

The main risks of corruption were identified pertaining to three management processes shown in table below. The HRD technical team established 3 work groups to propose indicators and targets, and anti-corruption strategies to increase transparency, accountability, participation and control in these areas.

Table 6: Priority Risks of Corruption per Managing Process

Managing process	Priority risks of corruption
Human resources management	Lack of transparency mechanism to select managers of the RHD
	Selection and recruitment.
	Breach of health services working hours
Procurement management	Overvaluation of goods and services.
Health care management.	Diverting patients to private care.
	Improper and illegal payments

2.2 Health Sector Financing and Insurance

Improve health coverage of poor and vulnerable populations

2.2.1 The MOH has revised the clinical content and standard costing of the Health insurance essential plan (PEAS), so as to ensure gradual increase in health coverage ensuring appropriate coverage of MCH, FP/RH, HIV/AIDS and TB related health services

Upon request of the MOH's DGSP, the Project updated the tools previously developed for costing the Health insurance Essential Plan (PEAS) according to the final list of health conditions and medical procedures included in the legal norm that approved PEAS

(Supreme Decree N° 016-2009-SA). The adjusted costs are required to set tariffs and fees for (a) payment to health public providers by SIS and (b) selling/purchasing health services mainly to/from the Social Security Institute (EsSalud). To this end, a Project carried out the following activities:

- a) Technical meetings with DGSP staff to identify alternatives of clinical management schemes for each health condition included in PEAS.
- b) Technical meetings with clinical experts to validate the alternatives of clinical management schemes.
- c) Technical meetings with clinical experts to identify drugs requirements for each alternative of clinical management schemes.

There were a total of 140 PEAS conditions reviewed and edited. This work included the comparison of PEAS with the national essential drugs list to identify new medical's procedures and new drugs that required to be incorporated in the essential list. This effort has allowed the DGSP's team to revise PEAS, with the participation of an ample amount of health specialists in several working sessions; in fact, this team has gained an advanced knowledge of the technical content of PEAS, which is a key element for the institutionalization process.

The clinical variants of the PEAS which were validated and revised sum 1377 medical variants for 140 conditions of the PEAS.

2.2.2 New health authorities and officials receive key information and policy advice regarding strategic action to strengthen and expand the health insurance reform

During April 2011, the component organized two workshops with new health authorities in Ayacucho and Cusco, to provide key information regarding strategic actions to strengthen the health insurance reform and the implementation of PEAS in these regions. In these workshops the Project presented and delivered executive summaries to new health officials regarding universal health insurance.

During August 2011, at the request of the Office of Insurance Management of Ayacucho RHD, the project organized a workshop to develop with the health networks' teams the operational contents of PEAS using case studies.

The Project has recommended the RHD of Ayacucho and Cusco to contact newly appointed MOH authorities for further advice about the national policy regarding the implementation of PEAS, and will resume technical assistance in this topic taking into account the agreement between MOH and the RHD.

2.2.3 The MOH has designed a health financing reform to ensure financing of the health sector

To ensure the sustainability of the health sector reform, it is important to establish stable financial rules to ensure sufficient resources for its implementation. To this end, the MOH undertook the formulation of a law of health financing and advocated for its approval. The

aim of this law was to improve equity and efficiency in the allocation of resources by clarifying formal rules regarding the main health financing functions: revenue mobilization, pooling and strategic purchasing.

By May 2010, in the second extraordinary meeting of the CIGS, the assembly agreed to elaborate a proposal of a health financial law and the MOH delegated the responsibility of elaborating a draft to OGPP which needed to include: (a) an explicit gradually growth rate of public health expenditures to fulfill the financial requirement for the implementation of PEAS and a prioritized high-cost intervention, (b) the programming rules of financial resources for public health insurance based on actuarial risk criteria, (c) a government-funded reinsurance to pay high-cost medical claims, (d) a definition of explicit payment mechanism for outpatient and inpatient health services, among others.

In this setting, starting July through September, the Project team facilitated the following activities:

- a) Technical meetings with the MOH task force to discuss the scope of the health financing reform in order to identify critical issues to be included in the proposal of health financial law;
- b) Organization of technical meetings with key actors to identify main health financing problems;
- c) Elaboration of a white paper regarding financing health reform as an input for the formulation of the Health Financial Law.

By the end of the year, the Project concluded the chapter regarding Fiscal Space for the Peruvian Health Sector. This study aims to assess if there exists availability of fiscal resources to cover in a gradual and sustained manner the public financing gap for health, mainly for universal health insurance, which amounts 0.6% of GDP (NS/ 3 billion). The main findings of this study reveal budgetary room during the coming 3 years to finance health reform without jeopardizing national fiscal position. The existence of fiscal space for the Peruvian health sector is based on the positive macroeconomic environment, the prospective removal of several tax expenditures and government policies to foster improvement in the efficiency of the tax administration and the public health expenditures. In this context, the challenge of the MOH is to negotiate these resources with the MEF as well as to remove the supply constraints (physical infrastructure, equipment and human resources) to absorb the higher level of resource inflows for spending in the sector, allowing the scaling up of the health reform implementation. The main results of this study were presented in November in an International Health Financing Seminar in Lima, held by the MOH.

Starting 2011, the Project team continued the elaboration of the second chapter of the health financing study, which analyzed the Performance of Health Financing in Peru from 2000 to 2009, including alternatives and recommendations for the convergence and sustainability of the health insurance policy, as well as to improve efficiency in the allocation of resources and revenue mobilization. This report and the study of fiscal space were disseminated and discussed with specialists and public officials in different meetings, and valuable information was extracted to support the MOH proposal of a Health Financial Law. Although the discussion of financial issues related to health has to continue, the MOH

finished with the elaboration of the law proposal, and finally presented it to the Congress, being approved as Law No. 29344 by July 16th

Finally, the project concluded with the third chapter about the absorption capacity of public health resources, noting that the problem depends not only in the amount of budget but in how this resource is allocated. The evidence shows that in recent years the allocation has been skewed to investment in infrastructure and this alone does not contribute to expanding the supply of services that the country demands.

2.2.4 Implementation of the Universal Health Insurance policy (AUS)

With the aim of elaborating a logical framework for the implementation of the AUS policy, the MOH formed by July a technical team with participation of DGSP, OGPP, the Public Health Insurance (SIS) and the Superintendence of Health Providers (SEPS, with assistance from the Program of Support for Health Reform (PARSALUD) and the Project. The group defined the results, activities and indicators of AUS, as well as the guidelines for the elaboration of the baseline. This work concluded in a document "Monitoring and Evaluation Plan of Universal Insurance" which was presented to the MOH and World Bank reviewers. PARSALUD presented the document to the National Committee for Health Insurance Implementation (CTIN).

Regions such as Apurimac, Ayacucho and Cusco decided to move forward the implementation of prioritized key processes/ activities included in their AUS implementation plans. In this context, the Project provided technical support to these regions for:

- a) Definition of health networks and micro networks (see Health Sector Governance),
- b) Definition of human resources competencies profiles for managerial positions (see Health Workforce),
- c) Improvement of drugs programming and planning methodology (see Medical Products, Vaccines and Technologies) and
- d) Formulation of the multi-year health investment plan.

In Cusco, the Project technical assistance focused in the elaboration of a regional plan for the implementation of health insurance. The four years implementation period of this plan was divided in two stages: the first stage (2011-2012) for the implementation of health insurance in the valley of the Apurimac and Ene Rivers (VRAE), and the second stage, starting 2013, in the northern network of Cusco. This plan develops 11 strategies for the next four years of implementation and a plan of action for the first two years.

In May 2011, the Project continued its technical assistance through dissemination meetings in the districts of Kimbiri, Pichari and Convencion. In these meetings, authorities from local health networks signed commitments for the implementation of four strategies during the first six months (a) the optimization process of affiliation, (b) the strengthening of Health Services Production Units (UPSS) with available resources, (c) improving the processes of drug supply management, and (d) improving the information system for affiliation.

Ensure efficiency and equity in health resource allocation

2.2.5 MOH has designed a new Budgetary Program in the framework of the implementation of performance budgeting

Starting 2011, the OGPP promoted the development of new budgetary programs, whose guidelines were presented by Executive Resolution 002-2011-EF/50.01 and 002-2011-EF/76.01 of March and June respectively. The emphasis of this budgetary mechanism is to improve accountability. During May and June, the Project provided technical assistance to the MOH in designing the budgetary program Extension of Health Protection. The health sector decided that the specific outcome, for which the program is designed, includes a set of individual health interventions (PEAS conditions) that have not been covered by other budgetary programs, but have a significant impact on social protection to vulnerable groups. The formulation of the program is part of promoting individual health access to families living in poverty and extreme poverty. In this sense, the health sector approach seeks to move from vertical programs towards comprehensive health care.

Technical assistance has consisted in developing the conceptual framework of social protection and social risk management as well as developing a model that relates the negative effects of disease on poverty. The project also assisted the MOH in the development of health products based on health conditions, defining 11 products which include 54 activities to facilitate budget management by the Regional Budget Units. The budgetary program is under evaluation by the MEF- General Directorate of Budget.

An important fact to note is that while the program is being evaluated by the MEF, the Ministry of Health has included in the 2012 public budget formulation, the budget chains of the 11 health products that guarantee the extension of social protection in health.

2.2.6 Regional plan for improved management of health financial flows has been approved and is being implemented in one region

This process is part of the request for technical assistance from the RG of San Martin to improve the organization of the RHD, and specifically in this case, to develop and improve the financial flows of the health budget units. The precedent is the approval, in December 2009, of the Administrative Directive No. 001-2009-DEA-RHD/SM "Budget Execution Process", whose objective was to organize and simplify the process of budget management, seeking to avoid the disconnection between the health priorities and spending decisions.

During the last months of 2010, the Project conducted a field visit to gather information in order to diagnose the current administrative processes and positions of different stakeholders. Based on this data, the Project elaborated a preliminary proposal for funding flows, which was presented and discussed with the RHD authorities and health networks. After collecting the feedback gathered at the workshop, the Project developed the final scheme of financial flows, to be submitted to the RHD for validation. The validation was conducted in a workshop in June, and an implementation strategy of the proposed budget flows was discussed. A new administrative directive was agreed upon to replace the current one, as well as the design of a manual of procedures that shall allow the operation of these flows. This validation conducted in June also helped to clarify that a real improvement in the

budgetary management requires improving budget system interaction with other administrative systems.

2.2.7 RHD in one priority region has formulated multiyear health investment plan

Upon request of the MOH Planning and Budgeting General Office (OGPP), the project provided technical assistance to the Investment Office in the critical review of the methodological framework for the formulation of a multi-year health investment plan (PMI) at the regional level.

In a first stage, the Project participated in several technical meetings with OGPP Investment Office to adjust the methodological framework in the following aspects:

- Inclusion of a analytic framework regarding the public investment management process with the aim to identify critical issues that undermine the formulation of investment projects and lead to misallocation of resources. The team identified 4 main problems, such as (a) low-specific investment projects, (b) lack of articulation among regional and local governments, (c) lack of investment projects to enhance capacity of health providers and (d) imbalances between capital expenditures and recurrent expenditures.

To tackle these problems, the team has included in the methodological framework rules and recommendations oriented to (a) align the investment process to regional and local priorities, (b) improve equity on the resource allocation, (c) diminish risk of duplicity or overlapping on investment decisions and (d) to improve financial sustainability.

- Clarification of the scope of the multi-year investment plan:
 - a) Focus on public investment at the regional and local levels
 - b) Focus on investment project to enhance resolute capacity of the primary health care level
 - c) Time horizon: 4-5 year investment plan
 - d) Investment unit plan: health network
- Clarification of the multi-stage formulation process and identification of the main parameters to be defined by the MOH, such as health networks and micro networks delimitations, categorization of health facilities, health services and procedures, among others.

The elaboration of the methodological framework for the estimation of the physical gap (infrastructure and equipment) was completed by December 2010. Main methodological features were the following:

- The estimation of the gap implies changes in the current population parameters being used by MOH (real demand instead of potential demand)
- The gap is estimated after a first planning exercise of the health services facilities based in the delimitation of networks and micro-networks proposed by the regional health authority.
- The planning of health services facilities is done based in the new MOH technical norm for the categorization of health facilities.

All of these features were presented to the MOF Planning General Directorate (DGPM), who supported this initiative, and participated in the validation of the guidelines in order to identify the normative gaps that need to be modified for the implementation of these guidelines.

Starting 2011, the Project continued its technical assistance focused in the methodology and tools for estimating and prioritizing investment ideas, also reflected in a technical guide. The features of this methodology were the following:

- a) The sizing of investments is based on the gap of physical resources associated with the Health Service Production Unit (UPSS), as a minimum unit decision.
- b) The evaluation of investment ideas requires clarity of UPSS costs for each level of complexity.
- c) The classification of investment projects ideas facilitates the negotiation that occurs when prioritizing.
- d) It is important that regional governments propose their own criteria for prioritization.

The focus and main ideas of the methodology of multi-annual investment planning was socialized to regional government officials and RHD in three macro regional meetings organized the MOH with the project. Moreover, the Project collaborated with the MOH General Directorate of Infrastructure and Equipment Maintenance (DGIEM) to develop the infrastructure and equipment parameters for five levels of complexity of the health system (I-1, I-2, I-3, I-4 and II-1).

In May 2011, the PMI formulation methodology was validated in San Juan de Lurigancho health network, and as consequence, the contents of Step "UPSS Planning" were adjusted by introducing two variables to the methodology "Strategies for organization of UPSS" and "Options purchase of services", useful for investment planning in metropolitan areas. In June, the OGPP began the process of approval of the Technical Guidelines, obtaining the approval of both the DGSP and DIGIEM. The results of the validation were also presented to the RG of San Martin for the purpose of identifying the political value of information resulting from the exercise and identify next steps for the formulation of the PMI for the entire region.

2.3 Health Information

The capacity of public health facilities providers to collect, analyze, and use data has been strengthened in six regions

2.3.1 National data quality standards are established and improved

The MOH has focused its institutional efforts to implement national data standards, and out of the six official data standards, the one used to register the medical procedures is considered to be pivotal for the correct use of the remaining standards, since it is directly associated to the reimbursement of health services rendered by public facilities. The other data standards that will have to be implemented are those directed to the systematic registration of: 1) pharmaceuticals, 2) users identification, 3) health facilities, 4) health operative units, 5) medical episode, 6) health staff, and 7) health financing agency/source.

Starting May 2010, the MOH (through the OGEI and DGSP) launched the technical validation process for the medical procedures standard. This standard, based on the American CPT (Current Procedural Terminology) 2008, is to replace the previous MOH catalogue for medical procedures, based on CPT 2004, and is envisaged to endure for at least 5 years. The MOH requested the Project for technical assistance for the systematization of suggestions gathered during the validation period, as well as to provide its inputs in order to ensure the internal and external validity of the standard.

For this purpose, a technical committee was formed with the participation of DGSP and OGEI representatives. The MOH also invited EsSalud, whose representation has been assumed by its Corporate Planning Office. Meetings were held regularly and served to gain first hand information on the experience that EsSalud has regarding the operation of the medical procedures standard. EsSalud has been using CPT 2007 as the basis of its medical registering routine; however, EsSalud advocates for the use of CPT 2010 for the reporting of specialized cardiologic procedures, based on the technological advance that has occurred in the past years. EsSalud also proposed that a permanent commission be established in order to update and adapt further versions of the catalogue.

Box 1

1. The Assessment and Evaluation section of the catalogue can be based on the MOH's proposal. However, the Project recommends that the medical procedures list be supplemented with a list of medical-associated professions procedures, e.g. the NIC classification of nursing procedures
2. The anesthesiology section of the catalogue should be based on the original CPT 2008 document
3. The Project recommends that the surgery section of the catalogue be based on the MOH proposal, but adding specific modifications
4. The radiology section of the catalogue should be based on the original CPT 2008 document
5. The laboratory section of the catalogue should be based on the MOH's modification of CPT 2008. However, the Project recommends that additional fields may be included (short descriptions and synonyms) in order to facilitate the implementation process
6. The medicine section of the catalogue should be based on the MOH's modification of CPT 2008, but adding specific modifications

In accordance to a DGSP request, the Project prepared a report with a detailed analysis of the proposal delivered by the MOH. Main recommendations are presented in box 1:

In October 2010, the MOH continued with the revision of the proposal of the catalogue of medical procedures. Its level of advance was 80% at the moment and part of the delay was generated on the change of EsSalud authorities. To facilitate the work the Project prepared a document comparing the changes that have been taken in CPT2010 as compared with CPT2008. This piece of information was relevant for a quick update of the MOH's proposal in selected sub-sections of the catalogue (i.e. cardiologic procedures). The numbers that reflect changes introduced are presented in Table 7.

Table 7: Number of Changes in CPT 2010 compared to CPT 2008

Chapter	Added	Modified	Eliminated
Evaluation and Management	017	028	015
Anesthesiology	002	002	001
Surgery	116	150	032
Radiology	018	004	018
Laboratory	022	034	003
Medicine	077	030	051
Total	252	248	120

Starting 2011, the MOH identified that the minimal technical advance that had to be reached in the coming months was the confirmation and updating of the medical procedures related to a set of approximately 600 tracer medical procedures. The MOH asked the Project to provide a technical proposal, based on the larger set of medical procedures so as to have an internal discussion and to proceed to the approval and official launching.

In June, the MOH requested the project to prepare a proposal providing auxiliary information for the catalogue, based on the description of medical procedures, so as to better understand the nature of the medical act to be financed. The project finished this piece of work and delivered it to the MOH. In addition to the request, the project also prepared an application rules section, so as to facilitate the improvement of the registering process at the provider level.

An additional topic in the agenda was the identification of a new demand in the development of standards. It concerns the development of interoperability standards for health data. These standards are at the core of information exchange between providers, financing agencies and supervising institutions, since they establish not only the “vocabulary” to be used in the transactions (i.e. already approved health data standards) but also the “grammar” to be used to exchange these data. It seems from the meetings held with the OGEI, that HL7 (Health Level 7) interoperability standards and XML format may be the basis of the development of the standards.

The relevance of the development of interoperability standards was also been identified by PARSALUD project which is making an exploratory analysis on the requirements for data transmission from health providers to the National Intendance of Health (SUNASA). The first interoperability standards to be discussed will be the ones related to the transmission of the identification of patients and financing agencies. The Project maintained technical synergies with PARSALUD in order to align this specific effort with the general approach taken for the development of the rest of interoperability standards.

During 2010, the MOH started a consultancy to prepare a technical agenda oriented towards the development of interoperability standards, based on HL7. The Project provided a very close technical cooperation with the MOH's consultant, through the exchange of technical information on the topic and the organization of technical meetings with EsSalud (Corporate Planning Office), the Society of Medical Informatics and Cayetano Heredia University (UPCH). It is important to mention that the implementation of the HL7 standard requires that a non-governmental non-for-profit organization be in charge of the technical process.

By the end of 2010, the MOH had advanced in the start-up of a technical committee in charge of the planning and development of standards based on HL7, and UPCH had shown strong interest in being part of the core institutions responsible for launching the HL7 group – Peruvian Chapter. UPCH is using HL7 standard for the experimental electronic transmission of clinical information related to malnutrition and pregnancy within wireless networks and applications in Callao. HL7 management will also be a part of the regular topics to be discussed along the master studies in health informatics the UPCH has launched.

Additional meetings were held with SUNASA, SIS and EsSalud in order to get their institutional approaches for advancing the technical agenda. In general terms, there is an acceptance that, in parallel to the formal definition of the technical committee in charge of the official agenda, there is need to advance the technical discussion of the design and implementation of some key interoperability standards that are implicitly mandated by law. The most important one is the interoperability standard for the affiliation process. SUNASA has two milestones, one set for 2011 and the other set for 2012, in which the on-line transfer of affiliation data has to be advanced and finished, respectively, across financing and provision agencies.

Regarding the design of interoperability standards, in July 2011, OGEI has already approved a regulation that states the requirements that need to be fulfilled in order to design an electronic health record. In this regard, the use of HL7 is now official as the interoperability standard to be used in the health sector.

2.3.2 Regional plans for improved collection, analysis, dissemination and use of information by health micro networks have been approved and implemented in three regions

For year 1 of the Project, three regions were identified as priority areas for the modernization of health information systems: San Martin, Cusco, and Ayacucho. In each region, the Project identified technical counterparts and an agenda for updating regional Health Information action plans. In San Martin an IT investment proposal was formulated by the RHD and it is expected that this proposal is prioritized among all investment projects that San Martin RG has for year 2011.

In April 2010, the Project started to promote the formulation of Regional Health Information action plans in San Martin, Ayacucho and Huánuco. These processes were lead by the RHD and its statistics and informatics unit and the scope of the activities to be executed involved years 2010 and 2011. After the plans were finished in August 2010, the Project has

maintained coordination with the technical teams in charge of their implementation in each region and has followed its execution, proposing its evaluation for the last quarter of 2011.

The contents of regional action plans involve the activities related to the identification of strategic health indicators (regional and local), primary data sources needed to be used, data retrieval, electronic processing and the associated information analysis for decision making. An important participation of health micro-network and hospital managers was observed during the planning period in San Martin, Ayacucho and Huánuco. In general terms, there seems to be a very positive attitude towards the modernization of health information systems across public health facilities. This attitude seems to be associated with the recognition of the direct link between the quality of health provision data and the corresponding financing of the health facilities. In fact, this recognition has prompted several facilities to identify as a need the development and implementation of modern health information systems both at the primary and the hospital level. Under this scenario, the presentation of GalenHos as an integrated health information application was welcomed and generated high expectancies in the aforementioned regions.

Starting the project activities, there was an intense coordination with Ayacucho Regional Hospital (ARH) in order to identify improvement opportunities in the application of GalenHos. The hospital requested additional developments to the software in order to enhance its role as management tool. During 2010, the Project continued its technical assistance in Ayacucho RH in order to improve the structure of billing reports and introduce modifications to the existing modules. In early October, an advanced training program was executed towards the analysis of GalenHos database to allow the generation of new managerial reports.

Starting 2011, new regional health authorities were appointed in Ayacucho, and they spent some time identifying their priorities. Although there was an initial interest in implementing GalenHos for Primary Care, no technical agenda was developed at that time. At the Ayacucho Regional Hospital, the new administration assessed during several months the role of having a commercial Hospital Information System instead of GalenHos, although the software continue working according to the local expectations, and requests for further maintenance have been significantly reduced. Prior menaces to the sustainability of GalenHos in this hospital vanished in the short term due to the fact that officials defending the implementation of commercial solutions in this hospital have not found significant technical faults in GalenHos. Another contributing factor is the current demolition of part of the hospital's infrastructure, situation that makes impractical to attempt an IT change, since there will be a need to incur in software reinstallation costs with the new infrastructure. Reinstallation costs for GalenHos are significantly lower as compared with commercial systems, since there is local staff than can assume directly this task, with zero marginal costs for this task. On the contrary, commercial reinstallation would duplicate the cost required for the implementation of this IT option. By August 2011, GalenHos is fully operational at Ayacucho Regional Hospital.

GalenHos was also presented in other regions, such as San Martín, Huánuco, La Libertad, Cusco, and Cajamarca starting the second quarter of 2010. During the third quarter, the Project had meetings with representatives of Tumbes Regional Hospital and Lima Health Directorate for implementing GalenHos in the following three hospitals: 1) JAMO Hospital in Tumbes, 2) Cañete Hospital and 3) Matucana Hospital. The implementation of GalenHos in Lima Health Directorate did not have further advances due to the health authorities' changes associated with the regional elections in 2010. In the rest of the hospitals, the implementation process involved the critical appraisal and optimization of current patient processes of care, for instance in the patient admission, outpatient visit programming, patient clinical files management, among others.

Box 2

1. Preparation of a cross-walk between the current local list medical procedures and the MOH's official catalogue of medical procedures
2. Identification of public and private financing sources that will be introduced into GalenHos
3. Update and/or confirmation of prices to be allocated to medical procedures performed at the hospital
4. Introduction of medical and non-medical staff information into GalenHos database (profession, function, ID, department)
5. Medical time-programming, at least one month in advance, for every service, department
6. Comprehensive listing of services that exist in the hospital
7. Update of pharmaceuticals stocks present in the pharmacy and the main hospital warehouse (including quantity, price, SISMED code, lot, manufacturer)
8. Customization of users' profiles for GalenHos access and use
9. Comprehensive listing of hospital beds organized by medical services and departments, and operational status

Implementation of GalenHos-Hospital started in the following hospitals: Cajamarca Regional Hospital, Tarapoto Hospital, Moyobamba Hospital, Sicuani Hospital, Quillabamba Hospital, and Tumbes Hospital. In each case, a time schedule depicting the technical activities that had to be executed locally was provided to the local implementation teams and was executed without any interference. Accordingly, these hospitals financed all the travel expenses for their IT staff in order to receive the first half of an in-depth training in GalenHos, at the Project office. This training program was structured in two weeks on a full-time dedication basis. Trained IT staff made the standardization of information within their hospitals and reported to their executive directors the actions that have to be taken in non-IT areas in order to have a successful implementation of GalenHos. Samples of key activities that had to be executed are shown in Box 2.

Although coordination with Cajamarca Regional Hospital started in 2010, the start of the implementation of GalenHos was delayed until the second quarter of 2011, after new authorities assumed the RG. Activities restarted and the new director confirmed the decision to implement GalenHos in the new Regional Hospital. Adaptation of health standards (e.g. operative units, medical procedures, and medical drugs, among others) began, and is currently under way. Migration of previous clinical information is under way, and is expected to take the rest of the year, due to the duplication and inconsistencies found on the previous databases. The hospital revealed interest in developing an Operating Room-Surgery module to the current version of GalenHos. The specific agreement was signed.

In San Martin, the implementation of GalenHos started in 2011, in Moyobamba and Tarapoto Hospitals, with the corresponding training sessions. Starting January through August, the local work addressed the migration and/or adoption of data health standards to be managed by GalenHos. This work showed to be more difficult than expected, due to the coexistence of many manual registration routines with semi-automatic data entry. In particular, the adoption of the current medical procedures standard revealed difficult to face, since there was more technical detail to be taken into account as compared to previous lists of services that were neither comprehensive nor consistent. This was particularly evident when the assignment of prices to procedures started, when several inconsistencies were identified between pricing lists. Another explanation of the extended period of migration is based on the insufficient level of compromise shown by medical staff on the preparation of the cross-walks between their previous lists and the new medical procedure list provided in GalenHos. These situations will extend the implementation of GalenHos over the last quarter of 2011.

GalenHos in its basic modules was installed in Tarapoto and Moyobamba hospitals in May. This solution involved the following modules: medical archives, admission, scheduling, outpatient care and a reporting system that links GalenHos database with SIMED. It is not envisaged to implement the pharmacy module at this stage, since it would oblige the implementation of the billing module, for which there seem to be difficulties, in particular, for the definition of the procedural charter and its pricing policy.

Regarding Huánuco, new health authorities have confirmed their interest in advancing the agenda for modernizing their hospital information system. Two hospitals have confirmed their interest in this initiative, i.e. Huánuco and Tingo María. In 2010 Tingo Maria hospital received technical assistance in order to develop an IT investment project, which has been already presented, approved and executed. Tingo Maria Hospital has recently signed the agreement with the project and the implementation process is expected to start in the last quarter of 2011.

In Cusco, training activities for the implementation of GalenHos with the IT staff of Sicuani Hospital were held during the first and second quarter of 2011. The institutional agreement between Sicuani hospital and the project was signed and on-line training activities for the implementation of GalenHos have continued with the IT staff of this hospital. As expected, this hospital will be developing a blood bank module within GalenHos. The project has recently signed an agreement the Quillabamba hospital, for the implementation of GalenHos in the last quarter of 2011.

In La Libertad, Belen Hospital signed the institutional agreement to complete the implementation of GalenHos. After the signature of the institutional agreement, this Hospital began the preparation of an investment project for the further strengthening of its IT infrastructure. The hospital has requested the project to provide technical feedback on the best infrastructure to be implemented (to be followed by the update of GalenHos).

An agreement was also signed with JAMO Hospital at Tumbes, to make official GalenHos as their Hospital information system. Moreover, this hospital has signed in the aforementioned agreement the commitment to develop an outpatient module for detailed clinical data registry. This development represents a significant advance in the design of an

electronic health record. Besides, this application will contribute to lower patient waiting times for the outpatient care. During 2011, training activities were performed by the project with the attendance of key staff of this hospital, and implementation activities were executed as planned. A new module for the design and development of an outpatient clinical registration module was developed, but changes in the top managerial team of the hospital prevented the conclusion of the implementation process on a timely basis. However, activities have been maintained and it is expected that with the new authorities, GalenHos will be fully operative by the end of 2011.

The first year of the Project was intensive in the identification of improvement opportunities regarding GalenHos – Hospital version, related with the modules of pharmaceuticals management, and human resources management. Regarding the first one, a set of key indicators were discussed and identified in order to implement a pharmacy balanced scorecard. This scorecard will be focused on the integrated management of pharmaceuticals in the facility and will go beyond the storage management monitoring. Regarding human resources, time programming of human resources was standardized according MOH guidelines. This allows the development of specific reports on the distribution, production and productivity of human resources at the health facility.

Within July and September, the identification of improvement opportunities of GalenHos – Hospital version continued and an extensive revision involved the following modules: general tables, clinical archives, medical-time programming, outpatient care programming, and laboratory. For each module, improvements were annotated so as to introduce them when the migration of GalenHos-Hospital to PostGreSQL takes place. For instance, three new reports were generated to improve the performance of the clinical files unit:

- a) Report that identifies records with high probability of duplication. Usefulness: A continuous process of depuration of redundant clinical records will lead to less archiving space and to the generation of consistent patient clinical files,
- b) Report that automatically identifies clinical files that have not been used in the past five years. Usefulness: The volume of clinical files in the active segment of the archives will remain under control and will not generate storing risks to the hospital,
- c) Report that locates the physical location of clinical files inside the archiving rooms. Usefulness: Shortening of location time which in turn, will contribute to shorten waiting times for patients.

Moreover, local improvements made to GalenHos modules (at Ayacucho Regional Hospital) have been subject to an expert IT development audit.

During 2011, maintenance activities continued, and some of the most important changes were:

- Logical reconfiguration (division) of the pharmacy warehouse into three separate warehouses: regular warehouse, national strategies warehouse and donations warehouse. This improvement goes beyond the current SISMED regulations, and allows the specialized management of each warehouse with its own business policies, and with the generation of its own operational indicators and aides (e.g.

- alerts when pharmaceuticals of any of these warehouses are close to the expiration date).
- Introduction of the prototype of the outpatient electronic registry module into GalenHos. Assessment period will extend during a quarter, and according to the results, this module will be added to the standard GalenHos version. The assessment will be executed within JAMO Hospital, in Tumbes.
 - Introduction of the HIS export routine. This routine allows the direct generation of MOH's HIS database based on GalenHos registration modules. The routine was put into operation by Ayacucho Regional Hospital.
 - Design of the data enter screen for the exchange of information between the healthcare provider and SUNASA. This development aligns GalenHos with the sector milestones expected to be met in order to implement the universal health insurance reform. However, there is need to complement this advance with the development of the corresponding interoperability standards. This work may take several months before a final solution is designed and implemented.
 - Revision of the SIS new forms in order to verify its full compatibility with GalenHos database.

Regarding GalenHos – Primary Care, the design process started in April 2010, gathering the information needs of the MOH, SIS, RHD, health networks and micro-networks from Ayacucho and San Martin and Lima providers, as well as from MOH national strategies, OGEI and SIS.

Information needs from MOH's national strategies, and SIS data requirements have been analyzed and introduced into GalenHos design. Main characteristics of GalenHos-Primary Care are: 1) It will be developed using PostGreSQL as database manager; 2) it will be a web service oriented (programming language: C#); 3) data entry units are located at health centers; 4) registration of information is patient-based, rather than program-based; 5) data to be entered has at least two primary origins: individual, and family. Some relevant technical characteristics of GalenHos database are shown in table below.

Table 8: Main characteristics of GalenHos Database between database managers

	PostGreSQL
Objective	To be a more solid database manager, comparable to Oracle, Sybase or Interbase
Licensing	Berkeley Software Distribution (Open Source)
Advantages	Its strength is its scalability. Capable to be adjusted to diverse numbers of CPUs, memory, making it possible to provide support to simultaneous operations requests It has a better support for triggers and procedures resident at the server level Allows the verification of the reference integrity, and the storing of procedures within the database
Disadvantages	High resource consumption

The design process finished the first quarter of 2011, and included the definition of data registration requirements to be incorporated, as well as the logic structure of the database. The platform database to be used is PostGreSQL and the programming language C#. This combination allows the development of GalenHos for multiple web applications: MS Internet Explorer, Mozilla Firefox, Google Chrome, etc. This pilot implementation of GalenHos Primary Care started on April in Kimbiri health network, at Cusco. A prototype of a minimal set of GalenHos modules were developed and installed. This set of modules involves clinical archives (individual and familial), admission, and outpatient registering. Local operators have been trained and it seems that the application fulfills their necessities regarding these components of the health information system.

During the second quarter of 2011 GalenHos Primary Care has been implemented in its basic version in three primary care facilities in Ayacucho: Santa Elena, Las Nazarenas and San Juan Bautista. Modules implemented are: clinical archives, appointment management, and outpatient care. The implementation of GalenHos has served to start local initiatives to improve clinical files processes. One example has been the elimination process of duplicated files, a process that has been started and is expected to continue during 2011 and 2012. Another improvement has been the linking between family registers and individual clinical files.

GalenHos Primary Care includes an optimized data entry based on the individual rather than on national health strategies and programmes, making it feasible the follow-up of the patients regarding specific priorities. For instance, in San Martin, GalenHos will serve for controlling the effectiveness of the interventions aimed at diminishing the current rates of pediatric chronic malnutrition. The integrated data entry screen is presented below.

As shown, the clinical data for an individual patient are integrated and simplified in one screen, allowing the registration of:

- Growth and development control
- Nutritional control
- Vaccinations
- Pharmaceutical prescription
- Current morbidity
- Medical procedures administered.

Modificar Admisión de Consulta Externa HC: 492850 Allcca HUAYLLA LUANA (Estado: Registrado) (Edad: 2 A = Años)

Paciente (F10) Cita (F11) Atención (F12)

Triage Presión 100/80 Sist/Diast Temp 38 ° C Peso 43 Kg. Talla 110 cm. Pulso 0 0-250 Frec.Respiratoria 0 0-70

3.1 Anam/Ex.Físico 3.2 Info.Atención 3.3 Indicaciones 3.4 Tratamiento 3.5 Destino Atención

3.2.1 Consulta Regular

Immunizaciones (multiple items selected)

Procedimiento

- Administración de DPT
- Administración de vacuna contra fiebre amarilla
- Administración de vacuna contra sarampión, paperas y rubéola

Otros Procedimientos (multiple items selected)

Procedimiento

- Consejería integral
- Hematocrito

Diagnósticos - Desarrollo

Diagnóstico

Diagnósticos-Morbilidad (multiple items selected)

Diagnóstico

- Absceso periamigdalino
- Amigdalitis aguda, no especificada

3.2.2 Información morbilidad

Control del Crecimiento y desarrollo

2° año 1 2 3 4

Año 01 02 03 04 05 06 07 08 09 10 11 12

>28d<-1año X X X X X X X X X X X X

Estimulación temprana

Lactancia materna complementaria

Percentil

Edad (años)

Tratamiento Recibido

Selección Medicamento

- ALBENDAZOL 200 mg TAB
- ALBENDAZOL 20 mL 100 mg/5 mL SUS
- FERROSO SULFATO HEPTAHIDRATO 300 mg TAB
- FERROSO SULFATO HEPTAHIDRATO 180 mL 15 mg/8

Filiación Cuenta Imp.Atención Aceptar (F2) Cancelar Imp.Ficha SIS Históricos

2.4 Health Workforce

Support the design and implementation of a broad-based system for planning and managing the health workforce to ensure competency of workers in the health sector.

2.4.1 Dialogue between experts and policy makers to design civil service policies in the health sector

In 2010, the MOH installed the Intergovernmental Health Commission (CIGS) in order to harmonize the implementation of national and regional policies in the framework of current legislation and to evaluate the performance of the shared conduction of health processes at both levels of government. In this setting, the CIGS defined a work plan for 2010. One of the issues prioritized was “the improvement of the labor law to make it unique, fair and equitable”. A working group composed of the MOH General Direction of Human Resources (DGRH) and the RHD of Huánuco, Junín, Huancavelica, Moquegua, Madre de Dios, Cajamarca, Lambayeque y Arequipa was conformed in order to define a Health Care Path (HCP) proposal. To this end, the MOH defined a team to whom the Project provided technical assistance in the design of a roadmap, later approved by the CIGS.

In addition, the Project facilitated the relationship between SERVIR and the MOH team through two meetings. At the first meeting, the official responsible for public careers in SERVIR issued some recommendations regarding the scope of the HCP; SERVIR reported that they will develop the administrative career of public servants and that the MOH would need to define the care path of health workers. In the second meeting, all the managers of SERVIR were involved and agreed that SERVIR would participate in the activities regarding health care path definition.

In June, the MOH formed a work group responsible for preparing a report containing specific proposals for a comprehensive reform of the public HCP; this group included representatives of the organic units of the MOH and Professional Associations, and was chaired by one of the advisors to Minister's Office. Most significant agreements of this group were:

- Principles of health care path: merit; progression; irreversibility; integral; adequacy; sustainability; presumption of legitimacy.
- The proposal should include health professionals, technicians and auxiliary, but, should exclude administrative personnel.
- The proposal should consider career path for managerial positions.

In September, the Project completed the roadmap for the development of the proposal of HCP, prepared a comparative analysis of health career experiences in Latin American countries, and prepared an initial proposal of Health Care Path to be discussed with technical experts in labor law and public health.

In October, the Pan American Health Organization (PAHO) organized an International Forum "Advances and Trends in Health Care Path developed in Latin America Region". The Project worked with MOH team to prepare the conceptual framework and a basic proposal of HCP. In order to obtain an informed participation in the exchange of experiences, the Project designed a comparative chart about characteristics and advances in HCP in each country, in the framework of a health human resources management system. The country presentations focused in:

- Conditions of work management at the national level (terms of engagement; negotiation and conflict; workers health)
- The process of design and negotiation of the proposal of Health Care Path.
- The main issues addressed in the proposal of health care path and staff involved.
- Funding for the implementation of the health care path
- The organization, structure and functions for the management of the health care path.

In November, the MOH organized a virtual discussion session with the members of the CIGS working group involved in the design of the proposal of HCP. In order to obtain contributions and opinions of regional teams about the proposal, during November and December, the MOH organized virtual forums through PAHO Public Health Virtual Campus. All the teams were invited to participate in 5 forums: Definition and Scope of work of a HCP, Principles of the HCP, HCP and duties, HCP and rights, HCP and pending agenda. In December, PAHO financed a study tour to Chile for the MOH team, to exchange information and experiences about HCP. Representatives of San Martin, Apurimac and La Libertad

Regions accompanied the national team during this visit.

In January 2011, the Project and the MOH-DGRH team evaluated the progress made in the definition of a HCP, and one of the agreements was to provide technical support to the MOH in the publication of the analysis and opinions obtained in the national and international meetings, focused on the comparative analysis among selected LAC countries in the development of a health career path. The project elaborated reports about the process and products obtained in each of the meetings, which were taken into account in the redaction of the chapters of the MOH publication.

During May through June 2011, the project participated as a member of the Committee for the organization of the "Fifth meeting of managers in health human resources" held in Lima in August 2011. One of the three central topics selected for this meeting was related to HCP. The project participated as moderator in the Roundtable about HCP and was part of the gallery banner of institutions that have contributed to the MOH in the design and implementation of strategies to improve the management of health human resources.

2.4.2 Design and validation of a broad based system for planning health workforce has taken place in one region

Due to the importance of supporting the regions in the definition of the gap in health human resources (HHR), the project prioritized technical assistance to regions to determine the needs of HHR at the micro network level. According to the agreement with the MOH-DGRH, the Project will jointly develop and validate a methodology in one region and this experience will be scaled up to the national level. In this sense, the following activities were developed during March 2010.

- Bibliographic review of the methods to identify HHR needs, based on epidemiological patterns, availability and productivity of HR, etc.
- Obtain regional information about the operation of the "Software for the centralized register of payrolls and data of public sector human resources" managed by MOF. Some findings were that the regions covered by the project keep updated information and this software register all kind of HHR except staff recruited for the CLAS facilities. However the data is not being analyzed by the RHD. With this information, the project held a technical meeting with the MOF regarding the functioning of the software. The MOF requested the project's technical support to train health management teams for the analysis and use of the information produced by the software
- Start the design of the methodology for defining the HHR gap.

During April through June 2010, the Project defined a technical proposal for the estimation of HHR gap. This proposal will allow, in a simple and feasible way, to achieve a fairly accurate estimation of human resources gap for the implementation of the health insurance policy in primary healthcare, focusing on the micro-network as the unit of analysis. a proposal to gather and analyze information for its validation in the field was also developed. Technical and participatory design of this methodology was discussed within a MOH task group.

During July through September 2010, the project met with the MOH DGRH to exchange ideas about the estimation of human resources requirements for primary health care. The decision was to use the needs-base approach, which converts projected service needs to personnel requirements using productivity norms and professional judgment. This approach can respond to the health needs and services and to address the health needs of the population using a mix of HHR.

To calculate the numerator, the Project used ASEGURA software, which contains a list of health services and the length of time for each category of personnel dedicated to each service at each level of care. In order to apply it at the regional and network level, the project and the MOH organized a workshop with Callao Region and Lima Ciudad Health Directorates to identify main adjustments to the software. During January through March 2011, the Project revised the set of services provided in the primary health care sector and determined the type of specialist involved, specially pediatrics, gynecologist and family doctors. This was to specify the requirements for the workload of these specialists in health centers.

ASEGURA was arranged to be flexible to: i) consider local incidence of priorities diseases; ii) determine the work which is actually undertaken by health staff by networks according to PEAS services and the actual operating capacity of health facilities iii) consider regional and local population structure.

To calculate the denominator, the Project used as a technical reference the WISN method (Workload Indicators of Staffing Need), which is based on actual work that health workers do and is useful for calculations of both current and future HHR requirements. It is based on working time, components of work and activity standards. To apply this method, it was necessary to define the length of time really available to provide only clinical services. For this purpose, the MOH financed and developed a research with the Project technical assistance. This research was carried out in Ayacucho, applying more than 100 surveys to both professional and technical staff. The content of the survey was focused on the distribution of time for the implementation of different activities or tasks in a full workday. To calculate the actual time available to provide clinical services by health staff category (standard workload), it was considered the total hours under a contract and deducted the time health workers are legitimately not available to deliver clinical services at their normal place of work throughout the whole year (vacations, sickness absence, holydays, training, local travel, administrative burden, etc.). The results of this study are shown in the table below.

Table 9: Ayacucho, Available Working Time per Year by Selected Staff Category

	Physician	Dentist	Nurse	Obstetric Nurse	Technician
Available working time to provide CS	1,226.4	1,152.4	1,204.4	1,188.8	1,314.0
% of time to provide CS	68.1%	64.0%	66.9%	66.0%	73.0%
% of time to provide non CS	3.6%	3.1%	2.9%	4.3%	0.9%
% of time, non provision	28.2%	32.9%	30.2%	29.6%	26.1%

CS: Clinical services

Another piece of information required was an index that shall adjust the calculations of the human resource gap, especially in rural areas, because of the different levels of population density, because performance is different in rural and urban settings. In this sense, the Project promoted a study with the MOH in San Martin in order to calculate what was named as "index of rurality", based in the average physician productivity in all health facilities under each category of district. The consultant hired by the MOH defined the rurality index for all the districts of San Martin, using a set of indicators per district. The project provided feedback and maintained close coordination with the MOH to monitor this consultancy. Currently, the MOH is using the results of this report to allocate new health professionals to rural areas.

The RHD of San Martin was committed to determine the needs of human resources for the first level of care (10 health networks, 39 micro networks and 358 health facilities), to include it in the 2012 budget formulation process. As a result, a roadmap was agreed among MOH, RHD team and the project, including the organization and collection of the required information, the identification of tasks with the respective responsible, and the timetable.

The activities developed during April through September 2011 were:

a) ASEGURA adjustments: With the support of an IT expert, adjustments were made to allow:

- Calculations based on network population
- Consider regional prevalence of priorities diseases
- Consider the portfolio of procedures performed in health facilities and could potentially be done in the short term
- Select health conditions and procedures according to the needs of network programming
- Include available working time per year to provide PEAS conditions.
- Include rurality index by districts and the respective productivity index adjustment.

A first workshop was held in Moyobamba, to test the adjusted ASEGURA. Working groups were assembled by network, in order to do the calculation of the gap for each network. During validation some network information was not accurate and there was a discussion about the type of information to use for the number of health workers. In this sense, the agreements of this workshop were: a) The project will review the functioning of the software; b) RHD will organize groups by network to improve quality of data; c) Each group will install ASEGURA again; d) RHD will define criteria to establish the number of health workers by network, in order to be used in gap calculations; e) RHD will define criteria to determine the available working time per year by occupational group.

There was a second validation with the support of an IT specialist to be able to resolve the likely problems that may arise and to establish the needed adjustments.

To date we have software to be used at a network level. Calculations have been made with the information obtained with the SM team

b) Available working time per year: In a workshop developed with all the heads of networks, San Martin RHD decided to calculate its own "standard workload" conducting a self-

administered survey to all workers in all networks, instead of making a sample survey of health facilities such as that in Ayacucho. In this sense, the project developed the following tasks:

- Design a new instrument to collect information, taking into account the lessons learned from the study in Ayacucho, in the sense of being more precise in the questions and their alternatives.
- Validate the instrument and the methodology in Lima Centro Network, with all the staff of the network, although only 54.3% responded to the survey. Then, meetings were held with respondents to collect feedback to improve the instrument.
- A final version of the instrument was revised with RHD San Martín and finally approved. A timetable to distribute the instrument was designed. Unfortunately, a prolonged strike of workers did not allowed to conduct self-administered survey.

In order to have the required information, groups of experts were organized by occupational groups to fill out the survey. Results were analyzed and we found cases in which more than 80% of staff time was spent on activities not related to the provision of healthcare (in some cases were more than 100%). Given these results, the RHD technical team decided to estimate the expected distribution of physician time, by expert opinion.

c) **Rurality index:** Using data of the study developed by MOH for all the districts in San Martín, the project made calculations of the rurality index by network and then established the adjustment index by productivity. Performance ratios varied from 0.68 in El Dorado Network thru 0.91 in San Martín and Rioja Networks. This information was included in ASEGURA software.

d) **Current staffing:** In order to calculate the gap, besides to determine the required staffing, it is necessary to determine the current staffing by network. Some of the difficulties were the staff turnover; the positions budgeted but not covered. So, the RHD had to determine current staffing to calculate human resources gap. There are a total of 2,075 Health workers at the first level of service provision in the region, 9.9% are physicians, 14.8% are obstetric nurses, 11.5% nurses and 54% are technicians.

e) **Regional prevalence of priorities diseases:** ASEGURA software considers national prevalence of main diseases. In order to adjust ASEGURA to network calculations, the project provide technical assistance to establish regional prevalence to main diseases. Dengue, Malaria and Leishmania have incidence rates in the Region two to four times higher compared with national rates; diarrhea and acute respiratory diseases are higher at the national level.

One of the conclusions of this work is the need to define “Activity standard”: How much time on average a case should take each staff category which is involved in it, working to acceptable professional standards and standards related to distribution of health providers’ time. It is not acceptable that health workers, who are hired to provide health care, spend a majority of their time in other activities. If this continues without properly organizing and controlling the distribution of these times, there will always be human resource gaps to fill.

2.4.3 Design and validation of regional human resources management system has taken place in one region

At the national level, during the first half of 2010, the Project held technical meetings with the MOH and SERVIR in order to discuss the framework used by SERVIR in the definition of the management processes involved in the public system. Within this framework, the health sector had to define the specific processes related to health. The project initiated a conceptual discussion with the MOH in order to share a vision of an institutional HHR management system based on competencies. Under the decentralization process, the MOH was aware that the regions will define their own systems; for this, the MOH organized workshops to discuss with the regions and define together, processes and sub-processes that should be considered in the system and that will provide the framework for regional work. SERVIR participated in these discussions.

One of the agreements with MOH was the definition of the processes involved in the system, and the Process Mapping which defines it. This system consists of 8 macro-processes: (a) Planning, (b) Job design and work organization, (c) Labor Management, (d) Performance Management (e) Capacity Building, (f) Compensation Management; (g) Management of Relationships, and (h) Management of the Human Resources System. Within these 8 macro-processes, there are considered 30 processes and 46 products identified for these processes.

The inputs of the system are: health policies; health strategies; health care model; management model; health services organization model; health care portfolio; health services portfolio. Some of the outputs of the system are: HHR requirements; competencies profile; post profiles; health workers selected by competencies; performance gaps; training programs based on performance gaps; incentives policies; etc. The outcome of the system is: suitable health workers with relevant competencies are in the right place doing the right thing. The HHR management system is supported among others by an information system and a financing system; and constitutes an input by the drug supply system and quality management system. According to this framework, the Project defined a proposal of contents of each process, which will be revised by an extended team of the DGRH and RHD.

This design was shared with local technical teams of the RHDs of San Martin, Ayacucho and Huánuco, where the authorities have shown their interest and commitment to become experiences of validation and implementation of part of the system. For a viable implementation of the system, it has been agreed with the regions to establish criteria for prioritizing the process which would be first analyze and implement. The proposal is to conduct a bottom-up work, starting with the identification and prioritization of the existing problems of human resources in health facilities, then identify and develop the processes involved in this problem; and for those processes selected, perform the analysis of the interrelationships with other processes and identify those responsible for the different products, both in the facility, as in the network, micro network, and RHD setting.

Starting 2011, the Project and the management team of the MOH DGRH monitored progress in the design of the architecture of the HR Management System and defined the next steps, especially considering the government change. In this sense, the MOH DGRH

decided to publish the progress made to date and the Project supported the MOH team in the definition of the structure and contents of the document, and in drafting the publication Health Human Resources Decentralized Management System, based on competencies. This document was distributed in the “Fifth meeting of managers in health human resources” held in June 2011.

At the regional level, San Martin RHD demonstrated to have technical and political conditions to develop all the project activities in an articulated way. So, initial steps of the design and the implementation of the system were worked in this region. Because of changes in the management team in San Martin RHD, especially in the office in charge of leading the design of the system, it was necessary to make a balance of progress achieved with the new team. The agreements of this meeting were:

- a) Based on the architecture defined at the national and regional level, the processes of the system will be designed in a bottom-up approach.
- b) To design a process, a micro network will be selected, and a workshop to identify and prioritize a health service problem will be held.
- c) The process or processes related to the problem prioritized will be identified.
- d) For the process selected, the flow of decisions from bottom to up will be defined, as well as the sub-processes with their inputs and outputs, to resolve the problem identified in the micro network.
- e) After evaluation and validation of the implementation of new flows or the improvement of the existing process, an operational manual will be drafted.

The RG has asked the Project for technical assistance to develop selection processes based on merit according to competencies profile. The project provided support in the design of the scope of work of a consultant to design the performance standards and evaluation tools to develop selection process for: 3 key posts in RHD, Directors of 2 Hospitals; Chiefs of 4 networks which are Budget Execution Units. The Regional Government approved the pending ROF and CAP, and designed the procedures for the selection process, with the technical assistance of the Project.

In Huanuco RHD, one of the requirements was the design of managerial competencies. In order to help the RHD team to more clearly define their needs for technical assistance in this area, especially to determine how it will be used these competencies, we agreed to conduct a workshop on "Human Resource Management competency-based". Participants in the workshop were workers of RHD, networks, micro networks and hospitals. This workshop has enabled the team of RHD to know and understand the processes involved in the system and can determine in which processes they will apply the competencies.

Ayacucho RHD asked for technical assistance to determine a “salary scale”. One of the main problems in the region is the large number of projects being implemented, many of which employ staff with different salaries to develop the same activities. This is generating discomfort and loss of staff motivation. A first activity was to developed a technical meeting with RHD managers; in this meeting the project presented the salary scale as an instrument

of the Compensation process and the inter relationship of this process with the other processes of the HHR management system. One of the conclusions of this meeting was the need to build capacities in human resources management in all managers in RHD, networks, micro networks and hospitals. In this sense, the project developed a training course of Human Resources management system based on competencies in three workshops, to 47 participants.

2.4.4 Development of job competencies profiles for health managers and systems for evaluation of competencies and supervision designed and validated in one region.

This result is related to the implementation of the HHR management system based on competencies. The project implemented some processes of the system related to ensure competency of health workers. These processes were: selection, performance evaluation and incentives. The first step to implement the system was the definition of competencies, including performance standards and evaluation tools for each competency. In general terms, competencies could be divided in three types: a) organizational competencies (common for all the workers in the organization and are related to vision, culture, strategies and values); b) transversal competencies (Common for a unit in the organization, related to group goals); c) functional competencies (Individual competencies that must have all those performing a specific function or position within the organization; more specialized.) Within functional competencies in health, we can define: technical competencies (related to health provision) and managerial competencies (related to management). The project worked in the definition of managerial competencies, as a specific and functional competency.

During the first half of 2010, the Project reviewed the matrix of functions transferred in the decentralization process related to HHR management system, met with USAID/Calidad en Salud project so that they can be involved in the definition of technical competencies (clinical), and met with PARSALUD to learn about their Management Training Program (PREG). To strengthen coordination with these partners, the Project team reviewed the competencies and the content of the modules of Government, Information, Drugs, Insurance, and provide comments and suggestions for improvement the PREG, and worked in the definition of performance standards for these competencies and their assessment tools.

The MOH included in the 2010 work plan of the DGRH, the design of guidelines to be considered by regional levels to develop managerial competencies. In this sense, based on the experience and lessons learned in the development of clinical competencies for the first level of care in 3 regions (Huánuco, Pasco and Junín), the MOH designed two technical norms: 1) Competencies, Performance standards and Evaluation tools for 8 selected clinical competencies; 2) Guidelines to design competencies, standards and evaluation tools, using functional analysis. The project participated in the validation of these norms. The definition of managerial competencies needs to be discussed further because clinical competencies can be evaluated through observation, but decision making process needs other tools.

On the other hand, SERVIR is responsible for the definition of competencies profiles of eleven "type posts" defined in the Law N°29158, one of which is HR Management. For this purpose, SERVIR is using the behavioral approach. According to the International Labor

Organization (ILO), there are two approaches regarding competencies: 1) Behavioral: It emphasizes the characteristics and personal attributes. 2) Functional: Focuses on performance outcomes and defines minimum capabilities required to fulfill the functions of the organization. In the case of specific managerial competencies, ILO suggests the functional approach.

The project developed periodical technical meetings with the MOH and SERVIR in order to share conceptual frameworks regarding types of competencies and methodologies. The project prepared conceptual frameworks to help the MOH to analyze them and define a methodology to begin the validation at the regional level. The MOH worked with Callao and Lima discussing and validating tools and methodologies in order to define a technical norm for the national level. While the project worked in USAID prioritized regions to define, validate, and systematize lessons learned in the definition of managerial competencies, to be taken into account by the MOH. During the whole Project period, the Project developed periodical technical meetings with the MOH in order to share experiences developed at the regional level in the implementation of a methodology for the definition of managerial competencies.

At the regional level, the project conducted various workshops in San Martin in order to train a regional technical team in the methodology to define competencies, starting with the Institutional Development and Quality Office (DCDI) and its respective posts. Taking into account all the competencies in the profile based on key functions, the personnel of this Office defined their own competencies, considering the functions defined in the RHD Organization and Functions Rules (ROF) and the Office MOF. The competencies were defined for each post with their respective level of performance. They also defined critical competencies for each post. A result of this activity was the elaboration of a Technical Guide to define competencies based on the "Labor competencies map" previously designed with technical assistance from a USAID Project. With this new profile, the Project worked on the list of competencies of the DCDI, considering its functions, the main processes under their responsibility and the sub processes involved in each process; then proceeded to define the competency profile for each of the posts of this organizational unit. Similarly, defined the level of performance for each competency (Basic, Intermediate and Advanced) depending on the level of job responsibility to perform certain function, prioritizing no more than 2 competencies for each position.

The project adapted the functional methodology and presented this experience during the Second Meeting of the Latin American Network of Human Resources Management by Competencies and Sustainable Organizations, held in Santiago de Chile, on November 2011. International experts agreed with the simplification made to the methodology, the same that reduces design time and improves communication because it avoids the use of highly technical terminology.

During 2011, the same methodology was developed for all organizational units of the RHD, to define competency profiles each of the posts, determine performance levels for each competency, and prioritize competencies for each post. The next steps are to establish performance standards for each of the priority issues and design competency assessment tools. With the competencies profile, the RHD can develop recruitment processes for their

vacancies and completing the design of their job profiles. Performance standards will allow RHD to design their training programs, and the competency assessment tools will allow RHD evaluate managers' performance to identify the performance gap for supervision and monitoring processes, and make the selection process based on competencies. San Martin finished by March 2011 the definition of competencies profiles to each of their units. All the work and the results were written in a document called Dictionary of Competencies that will be published to be used by other regions.

At the national level, the MOH asked about the possibility of using the competency profile defined by San Martin, in order to identify competencies for the functions transferred under decentralization. In that sense, the project developed a matrix which correlated competencies with each of the functions transferred. This matrix showed the need to explore some functions which require the participation of experts, and organize technical meetings with the MOH Directorates and Offices to review and complete the competencies that may be lacking in the matrix

At the regional level, the project held a workshop in Huánuco, with the participation of all the RHD managers, the University Dean, Professional Associations and the RG Chief of Human Resources. The objective of this workshop was the presentation of a conceptual framework of managerial competencies and the validation of a proposal to prioritize the definition of such competencies in specific areas. The Regional team expressed the need to define competencies within the decentralization framework in order to strengthen capacities to manage their new functions. For this reason, the proposal was to work with the 16 Functions and 125 Faculties transferred from the national level to the regional level. Since the 16 functions are very broad, it was decided to work based in the 125 faculties. Using criteria such as: a) Frequency, b) Importance; c) Difficulty, and d) Results of MED, the Regional team defined two areas to begin the definition of managerial competencies: a) Develop and implement strategic planning (administration and development) of HHR, in the context of sector policies and legislation; b) Managing and ensuring actions for comprehensive health care in their geographical area and in regard to the primary care level, in coordination with local governments.

In Huánuco and Ayacucho, the project provided technical assistance to define the Architecture of competence which is a preliminary document which embodies the agreements related to the design of competencies, especially the type of competencies that will be designed, for whom and in which process will be used. Since the RG has approved a new definition of networks and micro networks, on the basis of provinces and districts, the need to define the responsibilities of these managers is a priority, so they can cover these new staff positions with competent workers. For this purpose, they must define the functions to be assumed by networks and micro networks.

2.5 Medical Products, Vaccines and Technologies

Improve capacities and policies at the national and regional levels to ensure that medical products, vaccines, contraceptives and supplies are procured, stored, transported and in stock at facilities according to established logistics

The project approach in the process of enhancing regional capacities to manage the supply of medicines and supplies is focused on optimizing forecast needs, purchasing management and develop efficient distribution systems that promote adequate availability in health facilities. During 2010, the Project started with the review of current norms and procedures and having meetings with officials in the regions, responsible for the acquisition of pharmaceuticals, for a joint evaluation of alternatives that can enhance transparency to procurement processes.

During the assessments conducted in the regions during the first half of 2010, the existence of several indicators were noted regarding the lack of transparency in the transactions concerning the purchase and handling of medicines and medical supplies. While higher-value purchases are made at the national level through reverse auction mode, there are several purchasing processes of medicines, supplies and equipment which are implemented at the regional level that need more supervision and control.

Initial actions to improve and control procurement processes were promoted in Chanka RHD (Apurimac Region). The Medicines Directorate appointed a person to work on their behalf in the area of logistics (responsible for purchases). The main function was to control the operation and transparency of the various procurement processes. Additionally, a procurement contracts management system was structured so they can run on the scheduled time, following the due process.

In San Martin, an analysis of the drugs supply process was carried out and specification were defined for the areas in charge of procurement and its control. A complete manual of revised processes and procedures was elaborated.

During the third quarter of 2011 an assessment of the drug supply situation in the region of Ucayali was completed. In a subsequent meeting with the Regional Health Director and top officials of the RHD, the need for technical assistance of the Project was identified in the estimation of needed medicines and supplies and in managing the procurement process. A work plan was agreed to be implemented during the final three months of the year.

2.5.1 Design and validation of the methodology to plan and forecast needs for pharmaceuticals and supplies in one region

The first step in the process of pharmaceutical supply is the quantification of needs in the region. Starting 2010, the Project developed a methodology to assess how the regions have been developing this function. The evaluation highlighted the need to improve the process of estimating and projecting the requirements of pharmaceutical products and medical supplies. On one hand, those responsible for carrying out the calculations show a number of shortcomings that prevent the process to be improved. There are limitations in the statistical methodology used, inadequate demand model, low quality of information available, poor coordination between all areas involved and lack of a service portfolio at the micro networks

levels. On the other hand, there are obvious signs that indicate problems in the projection of needs, such as inventory inconsistency, low quality of products available at the health facilities, physical inventory management problems and the perception of having low budgets for their purchases.

The Project proposal was to design a new system to project the needs based on a holistic approach considering all health performance based processes, including the following operations:

- A portfolio of services defined at the health facility, their operational capacity and the epidemiological characteristics of the target population.
- Linking treatments or conditions with required drugs and supplies, determine a list of essential medicines and medical supplies required at the micro network level.
- And, before developing a model to estimate the demand for medicines and supplies, it is necessary to improve the quality, timeliness and consistency of the information on consumption and inventory. Without this step, it is very difficult to obtain reliable and accurate results for any estimation model.

Then, and in a coordinated way with other areas of the RHD, the scheduling of the physical needs of materials should be properly reflected in the budget programming according to the availability of financial resources. The required medicines and medical supplies projections should be a joint effort of the micro networks, the areas of logistics, planning and economics.

By the second half of 2010, the Project began developing a new proposal to establish a scheduling procedure, allowing a better rationale for purchase, intended to optimize the use and availability of financial resources with the physical needs of medicines and supplies. On the other hand, it was necessary to generate a managerial capacity of quick reaction without affecting the quality of purchases.

The proposed system is structured on the basis of five sub processes: forecast drug use, purchasing planning, delivery schedules, financial budgets and budget formulation. The methodology is based on drug needs based in health services' planning process. The approach was made on the basis of systematize successful experiences of some RHD in the management of drug procurement programs. The aim is to develop a methodology for estimating needs for medical supplies and medical devices:

- Aligned with the sanitary objectives of the region
- According to the epidemiological profile of target population
- On the basis of the programmed services and the production capacity of the Networks / Micro Networks, and articulated with the programming and budget availability.

The agreed methodology is as follows:

- a) Collection and analysis of information for estimating and scheduling pharmaceutical and medical supplies.

- b) Defining criteria for RHD programming.
- c) Validation of medical cases and drugs and supplies estimated by the micro-network.
- d) Validation and consolidation of information from the micro-networks by health networks.
- e) Consolidation of reported cases and of the estimation and scheduling of medicines and supplies by operational networks.
- f) Consolidation of information and assessment of medicines and supplies programmed in the region.

The implementation of the forecasting methodology started in 2011 in San Martin. In this Region, the Project conducted 5 workshops, in which it has been established the methodology and procedures to implement. The results were validated for each of the 10 health networks of San Martin and were presented and discussed with the regional drug committee members; priority was given to related drugs with the regional goals (mainly malnutrition) and agreed on final parameters for the estimation of drugs.

The main findings identified with the participation of the RHD team were:

- The estimation of drug needs in the RHD of San Martin has been carried out centrally, without consultation and with little participation of other execution units, networks and micro networks.
- The statistical method used is the historical consumption, trying to adjust deviations from the averages, fill in missing information in some cases and project trends. They believe that due to the use of an inappropriate statistical methodology, the results of the estimation of drugs have fallen short of expectations.
- They have used for the first care level 436 items (drugs and their various presentations).
- Show a heterogeneous level of inventories. There are 19 items with the equivalent of 10 or more years of use, 31 items 3 to 7 years of use, 27 with about 2 years consumption (in total 136 items in inventory are sufficient to cover the one to more years of consumption) and on the other hand there are 38 items in inventory equivalent to 3 months or less consumption, with risk of shortages.
- The inventories and consumption patterns of certain products (overuse of antibiotics, ant parasitic, anti-inflammatory, antihistamines) are signs that the region have budgetary resources.
- Prescribers drive consumption to the drugs they know are available, marking patterns according to their availability.
- The system self adjusts to face shortages of production factors deteriorating the quality of the service: no respect level resolution or referral systems (only works in extremes). They cater on demand, without prioritization. Use staff without

- appropriate skills for prescribing: psychologist, nutritionist, nurse, nursing technician and medical technologist (in addition to doctors and obstetricians), Substitute for optimal treatment alternatives; not have the tools for proper diagnosis, and so on.
- Begin to make prescribing patterns and consumption that are a reflection of the deterioration of the supply capacity of health services.
 - Patients and users have not incorporated the concept of comprehensive treatment. Many do not return for monthly treatment or collect for drugs. The opportunity cost of going to health facilities is higher than the expected benefit. This is most evident in lower income populations.
 - They have no tracking system to complete treatment, do not know how to buy and deliver to their estimated cases.
 - Consider that several diseases are not funded by the SIS (eg epilepsy, diabetes) and are not receiving full treatment (in some cases bought at private pharmacies and drugstores).
 - There is no uniformity in prescribing practices, using different alternatives for each variant according to regional characteristics.
 - No control of prescription drugs for resolution levels.
 - Hospitals of all networks (with the exception of Tarapoto) are health centers I-4. This creates confusion when deciding which actually corresponds to the first level.

After an initial estimate of projected consumption by 2012, it was decided to prioritize the calculation of those products that were associated with regional priority in reducing malnutrition. First, emphasis was placed on the analysis of those conditions included or causing the problems of malnutrition. Its incidence was projected for 2012. Second, and according to expected cases, we estimated the drugs and supplies that should be used in treatments and determined the gap between the ideal consumption and actual consumption. Finally, design a transition plan to gradually close the gap. It is remarkable that the RHD is determined, as a result of the programming for 2012, to take action to close the gap in relation to consumption of drugs aimed at reducing malnutrition, as a regional priority.

On the other hand, at the request of Regional Directorate of Medicines, technical assistance was provided for the projection of needed medicines and their participation in the national corporate purchase in 2012 of the Apurimac I. Calculations were made by those responsible for supplying drugs of each micro-networks in the region and responsible for health strategies. The estimates were endorsed by the managers of each micro-network and validated by the Regional Directorate.

2.5.2 Regional plan to improve drug logistics system to ensure the quality and availability of pharmaceuticals has been approved and is being implemented in one region

Regional plans to improve drug logistics system, started with a quick assessment of the pharmaceutical supply systems in selected regions. The Project developed a tool that aims to evaluate the whole process of supply in the regions, including the way they are financing and managing the system. Based on the findings, the Project began to design work plans and proposals that could have a positive impact on improving the availability of medicines and supplies at the health facilities. As a working method, both the assessments of the processes as well as the plans or improvement actions were analyzed and drafted in conjunction with the RG teams, involving both regional health authorities, such as Social Development Managers and RHD, as well as line staff, managers and operators. The initiatives have to start from the regions, because they will be responsible for implementing them.

By June 2010, the assessments of the medical products supply systems were finished in the regions of Apurimac, Ayacucho, Cusco, Huánuco and San Martín. To design the action plans, the first step was to perform an assessment, in conjunction with regional health officials, of the way they have been operating the drugs and supplies delivery system in their regions. Parallel meetings were held with designated counterparts in each region in order to know their perception of the problems and discuss what their expectations were. As a second step, when the preliminary reports were prepared, further meetings were held with all staff and workforce involved in the process. The objective at this time was to validate the findings, which should clearly define the purpose of the whole supply process and clearly identify which were the factors that were barriers to achieve these results. The final report, validated by officials and employees of the RHD, was delivered to the counterpart in the region and discussed with the project advisor in the region. The third step was to develop workshops in order to identify the causes, not only on a first level, but also to explain the underlying roots at a primary or most fundamental level, of what had been considered inadequate management of drug supply. On this basis, having identified the underlying root, the Project conducted workshops in order to define the action plans.

By August 2010, the regions of Apurimac, Cusco and San Martín finished the elaboration of their improvement plans. These improvement plans were presented to the RHD Directors for approval and thus have their political support. The three regions decided to focus their efforts on developing a distribution system for medicines and supplies, trying to decentralize this function from the central warehouse in DIRESA to networks and/or micro networks. All regions stressed the importance and need to improve their processes to generate information as a basis for appropriate management. The region of San Martín prioritized the need for a thorough analysis of all logistics processes in order to find a more efficient procedure, according to their organizational characteristics, to manage the supply of medicines and supplies. An important factor in the development of improvement plans has been the cooperation from other projects, especially from USAID/Calidad en Salud and PARSALUD.

In the RHD Chanka from Apurimac Region, there were important advances in the implementation of a distribution network - called Distribution Center of Drugs and Supplies (CDMI). The objective was to decentralize the distribution of drugs from the central location of the RHD to the micro networks. During November two directorial resolutions were approved which facilitated the implementation of the CDMI and its operating policies. In December five CDMI were inaugurated and came into operation. The new authorities appointed in 2011, agreed to continue the work plan developed the previous year, continuing the implementation of the CDMI once defined the new regional structure of micro networks. They also decided to begin the systematization of the entire management system to ensure the quality and availability of drugs and medical devices, and reinforce the relationship with the administrative areas (planning, logistics, SIS) in order to make procurement processes more fluids. The methodology is based on including in the management criteria:

- a) Replacement cycle management based on the pull system (the process starts from the health facilities and is pulled, with integrality logic.).
- b) Cash Flow Management (management of scarcity to maximize results in line with the mandate of the Region).
- c) Purchasing Management (coordinated with the budget cycle).
- d) Risk Management (incorporating the danger of stop the cycle of supply, as a priority).

In the Apurimac I, at the request of the new administration, the Project provided technical assistance to develop the action plan for the Medicines Directorate, on the basis of improving the whole process of supply of medical products, ensuring availability in health facilities. The Project was requested for further assistance to develop processes manual, roles and create indicators to optimize the management of drug supply in their region. At the request of the Director of the RHD, we worked in the layout and standardization of local procurement processes. The objective was to optimize this process, reducing wasted times.

In Ayacucho the RHD decided to prioritize the development of regional list of essential drugs by level of care. Technical assistance was provided, also to develop a handbook as a way to systematize the work. In late September, driven the RHD approved the regulation of drug committees and subsequently the regional list of essential drugs.

With the new administration, the quick assessment made during the 2010 was updated and defined technical support lines, which were prioritized: procurement processes, both in participation in the national corporate purchase and regional purchase. In July 2010, the Project conducted an analysis of the whole process of acquisition in the region and developed a proposal to reorganize these processes. Under the new ROF of the RHD, the executing units are responsible for operating and executing acquisitions. The Drugs Directorate is responsible for lead and regulation roles. The proposal, which is subject to discussion, embodies this perspective.

San Martin RHD prioritized the design and layout of its drug supply processes. In January 2011 a final meeting was held to validate what was developed during the last months of the

previous year. The product was a Processes Manual (MAPRO) for the RHD, networks and micro networks for medicines supply management.

Cusco RHD decided to work with the generation of information, strengthen its distribution system and improve its programming and needs projection of medicines and supplies. The Project conducted its first workshop in January 2011 where the RHD defined areas for improvement in their processes of information generation and distribution. Later in March, these strategies were included in the implementation plan of the AUS, developed by the RHD Cusco. It has been decided to initiate technical assistance in AUS prioritized networks (Kimbiri-Pichari, North Cusco, and La Convencion). The Medicines Directorate was actively involved in this process. They have also decided to improve the quality of information generated in the region in relation to inventory and consumption of drugs.

During May 2011, the Project began the intervention of the component in Ucayali region, through the development of a quick assessment of drug supply, to identify major constraints and areas of intervention.

In conclusion, the project has been working different processes related to the entire system of drug supply in each region. The experience of a region has been enriched by extending it into other areas, with the purpose to adapt what has worked well to different situations.

The experience of Apurimac I that emphasized the process of budgeting and execution is implemented in Ayacucho, with additional technical assistance to redesign its procurement processes. The lessons learned from the experience in Apurimac II (DISUR Chanka) which strengthened the management of distribution on the basis of pull system and giving the leading role to four micro networks was applied in Cusco, assigning the leading role to a health network.

The methodology for developing the regional list of essential drugs developed for the RHD of Ayacucho was applied with better results in Apurimac I, to elaborate a regional list of essential drugs for primary care. The work plan prepared for Ucayali follows the experience of providing technical assistance to Apurimac RHD in order to restore the financial and operational capacity of the Directorate of Medicines.

3. Improvements in Maternal and Child Health and FP/RH in Intervention Regions

Important improvements have occurred in maternal and child health indicators in the last four years as measured by the continuous Demographic Health Survey (DHS). As compared with the national average, maternal and child health indicators in Project regions showed an unfavorable situation, because of higher poverty, higher rurality and poor sanitary conditions. Nevertheless, some of these regions, mainly the Andean regions have improved their indicators above the national averages during 2007-2010, in response to the priority received from the national government and the intervention of different health cooperating agencies, including USAID.

Infant mortality has decreased in 8 points at the national level while the decrease has been higher in three Project Regions: Apurimac, Ayacucho and Huánuco. The percentage of children under 36 months with chronic malnutrition has also decreased in 6 points at the national level, and only Huánuco has gained a greater decrease in this indicator. A process indicator, related with the organization of health services provision, as the percentage of children less than 12 months with complete growth monitoring has improved in 16 points at the national level, and all of Project regions –but Apurimac and Ucayali- have obtained better improvements (Table 11).

Table 10: Child Health Indicators 2007-2010

	Infant Mortality (per 1000 new born)		Infant Chronic Malnutrition (WHO pattern)		Children with complete CRED	
	2007	2010	2007	2010	2007	2010
Country	25	17	29%	23%	24%	40%
Apurimac	35	25	42%	39%	49%	62%
Ayacucho	37	22	42%	39%	20%	52%
Cusco	27	28	37%	35%	21%	51%
Huanuco	31	23	49%	37%	24%	70%
San Martin	35	28	25%	27%	25%	45%
Ucayali	25	30	31%	32%	24%	37%

Source: INEI-MEF (2011): Indicadores de Resultados de los Programas Estratégicos 2010

The percentage of mothers that received professional care during deliver increased in 7 points at the national level, and in 11 points when measured among rural women. In Apurimac, Ayacucho, Cusco and Huánuco, the improvements are higher, both than the national average and the rural average. San Martin and Ucayali showed little or no improvements in these indicators, with a worse situation for rural women (Table 12).

The use of modern FP methods among married women has little improvements both at the national level and in Project Regions. The figures showed that this indicator is even decreasing in Regions as Cusco, San Martin and Ucayali (Table 12).

Table 11: Maternal Health and Family Planning Indicators 2007-2010

	Professional Delivery		Professional Delivery - Rural Women		Use of Modern FP Methods	
	2007	2010	2007	2010	2007	2010
Country	77%	84%	53%	64%	48%	51%
Apurimac	84%	98%	79%	95%	47%	48%
Ayacucho	76%	90%	64%	88%	38%	42%
Cusco	75%	82%	62%	71%	45%	41%
Huanuco	65%	86%	55%	76%	53%	55%
San Martin	70%	73%	61%	57%	54%	48%
Ucayali	71%	69%	32%	28%	50%	48%

Source: INEI-MEF (2011): Indicadores de Resultados de los Programas Estratégicos 2010

3.1 Maternal and Child Health

Project activities focus in strengthening policies and institutional capacities in the areas of governance, financing, human resources, information and medical products, are contributing to the improvement of maternal and child health. Below is a description of how Project activities are related with these country priorities.

During this period, the project has provided technical assistance to improve the management of health services including maternal and child health services. In San Martin and Apurimac services have been organized in micro health networks. This experience is being systematized in a methodological guide for other regions to organize their services.

The project is also implementing a methodology to estimate human resource gaps to provide health services included in the PEAS. This package of benefits include maternal and child services.

The MOH with the assistance of the project has reviewed the medical procedures and drugs of the PEAS, including the clinical conditions of maternal and child health. This review has identified the pharmaceutical products that should be included in the national drug request. The PEAS includes clinical procedures, drugs and supplies for clinical conditions of maternal and child health.

Box 3:

The clinical variants of the Health Insurance Essential Plan are related to the following MCH and FP/RH areas:

- Safe motherhood (2 variants related to antenatal care and delivery), maternal pathology (185 variants), new born pathology (153 variants)
- Family planning (12 variants including VSC)
- Adolescents (1 variant)
- Menopause (4 variants)
- Abortion (12 variants)
- Cancer of women and men reproductive tract (3 variants)
- STD (13 variants) and HIV/AIDS (31 variants)
- Sexual and domestic violence (11 variants)

The Incentives Plan for the Improvement of Municipal Management (PI) is one of two public programs, created by the MEF to align the efforts of the public primary health providers with local governments, in order to reduce infant chronic malnutrition. Particularly, the program seeks to improve the quality of municipal expenditures, through the implementation of results-based budget at the municipality level. In the initial phase of PI implementation, the Project facilitated the coordination between MEF and the MOH, and between these governmental bodies and NGOs to support the program and articulate the interventions. Particularly effective was the involvement of the JUNTOS Program. The project provided direct technical assistance to 59 rural district municipalities in San Martin, Ayacucho and Huanuco, to validate specific coordination mechanism between regional governments – health directorates, networks and micro networks- with local governments, so as to reach agreements regarding child health priorities and goals, and articulate their interventions and resources. The municipalities have defined prioritized effective interventions addressed to reduce infant chronic malnutrition, in coordination with the health services. The Project also provided technical assistance to three RG in achieving inter-governmental agreements with the municipalities to accomplish the targets related with infant malnutrition.

San Martin RG authorities requested technical assistance from the Project to develop a program based on effective interventions to reduce infant malnutrition. The Project and the technical staff and authorities of the RG identified 21 effective interventions based on evidence and determined the baseline coverage of these interventions. The interventions were divided into: a) strategies to improve intake of nutrients and micronutrients (nutritional counseling and delivery of food and micronutrients), b) strategies for disease prevention (installation of water and sanitation systems, promotion of hand washing with soap, safe disposal of infant feces, vaccination, family planning, institutional delivery, postpartum care), c) strategies for disease management (quality care in health services, therapeutic feeding for children with severe acute malnutrition, treatment of diarrhea with zinc, treatment of pneumonia with antibiotics, treatment of dysentery with antibiotics, calorie and protein supplement for malnourished pregnant women).

After setting goals for coverage of effective interventions, using the SPECTRUM software, the Project estimated that the prevalence of child stunting could be reduced by 10 points by the end of 2014. Also, it was estimated that the rate of infant mortality and maternal mortality ratio would be reduced by over 20 points over the same period. To implement these effective interventions, the Project assisted the regional authorities in the design of operations.

3.2 Family Planning and Reproductive Health

The financing component of the Project focused on providing technical assistance to the MOH to implement the Universal Health Insurance (AUS). One activity was the installation of the Cooperation Agencies and Donors Committee in support of this reform (World Bank, IDB and several cooperation agencies such as the Belgium, Spanish, Italian, among other.)

The project also provided technical assistance to the MOH to update the PEAS covered by universal health insurance. To this end, a technical team of medical specialists revised health conditions and procedures for diagnosis, treatment and preventive activities of the

PEAS. The revision included the preparation of clinical management guidelines for each condition. Regarding the reproductive health and family planning, the developed guidelines are 14 which address adolescents and young adults, and 38 which address adults. The updated plan will increase access of lower-income population to reproductive health and family planning services, though the public health insurer.

The Project is also providing technical assistance to the MOH and regional governments for planning multi-year investments. The multi-year planning methodology allows the estimation of requirements for physical resources (infrastructure and equipment) for the comprehensive care of children at risk of malnutrition or malnourished child and family planning services (clinics, laboratories, and family and community health.).

The project has provided technical assistance to the regions of Ayacucho and Apurimac to improve logistics systems of medicines and medical supplies, including modern contraceptive methods. To this end these two regions have designed their regional essential drug lists by level of attention for levels I thru II-2. In the past, these regions used the national list for planning their needs which did not correspond to the epidemiological situation or with the level of complexity of health services. This regional request was established by consensus between the RHD and representatives of health networks and micro-networks. Also to improve access to medical products and contraceptive methods, the Project has estimated the budgetary requirements that the Apurimac RHD has used to obtain additional resources for the purchase of pharmaceutical products.

In San Martin, the project is providing technical assistance to the GR and DIRESA to improve access to contraceptive methods and improve the quality of prenatal care and institutional delivery as part of plan to reduce child malnutrition.

4. Proposed Benchmarks and strategies 2012 – year 2

The new Government of Peru has declared the following priorities in the health sector, as set forth by the Minister of Health, Dr. Alberto Tejada:

Purposes

1. To promote health and to prevent illness, through community empowerment, through new lifestyles and behavior change in the framework of respect to culture and identity.
2. To improve access and quality of health care articulating the three levels of government, strengthening human resources, in number, competence and attitude.

Strategic priorities

1. Reduction of preventable and evitable health problems
 - Healthy environments in the framework of health determinants
2. Guarantee access to integrated and quality health care with a emphasis on vulnerable population
 - Extend health protection, financing of the health benefits, infrastructure, equipment and human resources.
3. Strengthening of health sector stewardship
 - Design, conduct, supervise and regulate the National Health System.

Actions

1. Develop actions of health promotion and prevention with multi-sector articulation
 - To achieve healthy lifestyles in the person, families and healthy environments in the communities that contribute to control the infectious illnesses and chronic illnesses.
 - To strengthen networks of healthy municipalities to develop creative proposals and initiatives aimed at achieving social welfare.
2. Guarantee access and financing to a package of health services established in the SIS, according to quality standards of quality and applicable to all service providers in the health system.
 - Health care of degenerative and chronic illnesses will be included progressively, from detection to treatment. It will be initiated with five high cost cancer illnesses
 - Articulation of health services through strategic alliances among health service providers with the purpose of complementing services.
 - Establishment of conditions and mechanisms for the habilitation and a accreditation of public and private health facilities according to quality standards.
 - Strengthening of the SUNASA, responsible for the defense of the health services users.

3. Strengthening of health services supply in the poorest regions of the country: Huancavelica, Apurímac, Ayacucho, Huánuco, Amazon, Cajamarca, Cusco, Puno, Loreto and Ucayali
 - Improvement of the development of competences and capacities of the personnel of health with orientation in the primary attention of health.
 - Presence of medical specialists at national level will be increased, through a politics of recognition and incentives.
 - Distance technical support and use of the telemedicine.

4. Access to quality generic pharmaceuticals
 - Free access to the essential medicines in the 100% of the primary health care facilities
 - 100% of the generic medicines will be provided by national or foreign certified laboratories regarding Good Manufacture Practices and under quality control.
 - Increased generic medicines sale units at national level.

5. Implementation of the Service of Mobile Attention of Urgencies
 - Design and organization of the Rural and Urban SAMU
 - Start of operations in North Lima and in the regions of Huancavelica, Ayacucho and Apurímac.

At the current moment, the new MOH authorities have not yet spelled out the specific strategies and activities related to these stated policies and USAID is in the process of contacting the new authorities to define a collaboration agenda in health. In this setting, it is premature to put forth defined benchmarks and strategies. Nevertheless, in this section **preliminary areas of collaboration** are identified, subject to further orientation by USAID.

To this end, the table below shows possible complementarities between the MOH's stated priorities and the Project statement of work. As can be seen, the purpose of the project as specified in the Revised Statement of Work (January 2011) is consistent with declared purpose 2 of the MOH.

Regarding the MOH's Strategic Priorities 2 and 3, there is a direct relationship with OUTCOME 1 Health Governance, OUTCOME 2: Health Financing and OUTCOME 4: Health Workforce.

Regarding the MOH's prioritized actions 2, 3 and 4 are closely related to OUTCOME 1: Health Governance, OUTCOME 2: Health Financing, OUTCOME 3: Health Information, OUTCOME 4: Health Workforce and OUTCOME 5: Medical Products and Vaccines.

Table 12: Policy Priorities of MOH and the Project Statement of Work

	Minister of Health	Revised Statement of Work
Purpose	2. To improve access and quality of health care articulating the three levels of government, strengthening human resources, in number, competence and attitude.	By promoting improved policies and capacities to strengthen Peru's health system, the Project will contribute to improve the quality and coverage of health services for all Peruvians, and particularly for poor and rural populations. Under this award, national and regional level public entities will be strengthened to respond to challenges and opportunities created by a changing health sector, while focusing on equitable access for all.
Strategic priorities	<p>2. Guarantee access to integrated and quality health care with a emphasis on vulnerable population</p> <ul style="list-style-type: none"> Extend health protection, financing of the health benefits, infrastructure, equipment and human resources. <p>3. Strengthening of health sector stewardship</p> <ul style="list-style-type: none"> Design, conduct, supervise and regulate the National Health System. 	<p>OUTCOME 2: Health Financing. Peru has increased its public spending on health to achieve its health care coverage goals, and is funding health services to ensure efficiency and equity in the public health system.</p> <p>OUTCOME 4: Health Workforce. Policies for improved human resources management in the public health sector are implemented.</p> <p>OUTCOME 1: Health Governance. The MOH, regional and local authorities are operating in coordination under the decentralized health system by developing, implementing, and enforcing sound policies and regulations that are effectively implemented.</p>
Actions	<p>2. Guarantee access and financing to a package of health services established in the SIS, according to quality standards of quality and applicable to all service providers in the health system.</p> <ul style="list-style-type: none"> Health care of degenerative and chronic illnesses will be 	<p>OUTCOME 2: Health Financing</p> <ul style="list-style-type: none"> Technical assistance to MOH/SIS/

	<p>included progressively, from detection to treatment. It will be initiated with five high cost cancer illnesses</p> <ul style="list-style-type: none"> • Articulation of health services through strategic alliances among health service providers with the purpose of complementing services. <p>3. Strengthening of health services supply in the poorest regions of the country: Huancavelica, Apurímac, Ayacucho, Huánuco, Amazon, Cajamarca, Cusco, Puno, Loreto and Ucayali</p> <ul style="list-style-type: none"> • Improvement of the development of competences and capacities of the personnel of health with orientation in primary health care. <p>4. Access to quality generic pharmaceuticals</p> <ul style="list-style-type: none"> • Free access to the essential medicines in the 100% of the primary health care facilities 	<p>Essalud/RG: Costing of selected high cost cancer illnesses</p> <p>OUTCOME 2: Health Financing</p> <ul style="list-style-type: none"> • Technical assistance to MOH/SIS/ Essalud/RG: Costs and tariffs for complementing services among health service providers <p>OUTCOME 3: Health Information. The MOH, regions, and local health networks are generating and using accurate and timely information to manage the health system.</p> <ul style="list-style-type: none"> • Technical assistance to MOH to establish and implement data standards • Technical assistance to SIS/RG: Implementation of GalenHos <p>OUTCOME 1: Health Governance</p> <ul style="list-style-type: none"> • Technical assistance to regional governments to develop and validate organization and service provision standards for primary health care <p>OUTCOME 4: Health Workforce:</p> <ul style="list-style-type: none"> • Technical assistance to regional governments: Health workforce management with emphasis on health planning, selection, recruitment and evaluation based on competencies. <p>OUTCOME 5: Medical Products and Vaccines. The Peruvian health system appropriately procures and manages the pharmaceuticals and supplies needed for all public health services and programs.</p> <ul style="list-style-type: none"> • Technical assistance to regional governments: pharmaceuticals and supplies logistic management with emphasis on forecasting, procurement and distribution.
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Table 13: Suggested Benchmarks and strategies for year 2 (2012)

Outcome (according to Revised Statement of Work)	Benchmark	Activity	Strategy
<p>OUTCOME 1: Health Governance. The MOH, regional and local authorities are operating in coordination under the decentralized health system by developing, implementing, and enforcing sound policies and regulations that are effectively implemented.</p>	<ul style="list-style-type: none"> Draft of the Health Decentralization Plan 2012-2016 elaborated and approved by the Decentralization Secretariat Prime Minister's Office 	<ul style="list-style-type: none"> Technical assistance to the Decentralization Secretariat Prime Minister's Office to develop the Health Decentralization Plan 2012-2016 Technical assistance to regional governments to develop and validate organization and service provision standards for primary health care Technical assistance in the implementation of the program against chronic malnutrition in San Martin 	<ul style="list-style-type: none"> Constitution of a Consulting Group integrated by respected experts that can provide technical input and political support. Identification and validation of the charter of health services which constitutes the first contact with the health system. Prioritization in rural areas
<p>OUTCOME 2: Health Financing. Peru has increased its public spending on health to achieve its health care coverage goals, and is funding health services to ensure efficiency and equity in the public health system.</p>	<ul style="list-style-type: none"> Draft of costs estimates charter of health services which constitutes the first contact with the health system 	<ul style="list-style-type: none"> Technical assistance to MOH/SIS/RG: Costing of charter of health services which constitutes the first contact with the health system Technical assistance to MOH/SIS/ Essalud/RG: Costing of selected high cost cancer illnesses Technical assistance to MOH/SIS/ Essalud/RG: Costs and tariffs for complementing services among health service providers 	<ul style="list-style-type: none"> Develop agreements with SIS and EsSalud regarding these activities

Outcome (according to Revised Statement of Work)	Benchmark	Activity	Strategy
<p>OUTCOME 3: Health Information. The MOH, regions, and local health networks are generating and using accurate and timely information to manage the health system.</p>	<ul style="list-style-type: none"> Approval of medical procedures data standard GalenHos for primary care fully operational in San Martin 	<ul style="list-style-type: none"> Technical assistance to MOH/EsSalud to establish and implement data standards Technical assistance to SIS/RG: Implementation of GalenHos (hospital and primary care) 	<ul style="list-style-type: none"> Develop agreement with EsSalud/SIS regarding these activities
<p>OUTCOME 4: Health Workforce. Policies for improved human resources management in the public health sector are implemented.</p>	<ul style="list-style-type: none"> Approval of guidelines for human resources planning Study regarding salary and incentive structure for rural staffing elaborated 	<ul style="list-style-type: none"> Technical assistance to regional governments: Health workforce management with emphasis on health planning, selection, recruitment and evaluation based on competencies. Study of regarding salary and incentive structure for rural staffing and retention 	<ul style="list-style-type: none"> Promote technical relationship between MOH/RG and SERVIR
<p>OUTCOME 5: Medical Products and Vaccines. The Peruvian health system appropriately procures and manages the pharmaceuticals and supplies needed for all public health services and programs.</p>	<ul style="list-style-type: none"> Approval of guideline for pharmaceuticals and supplies forecasting Systematization of forecasting, procurement and distribution improvement experiences in regions 	<ul style="list-style-type: none"> Technical assistance to regional governments: pharmaceuticals and supplies logistic management with emphasis on forecasting, procurement and distribution. 	<ul style="list-style-type: none"> Promote partnership between RG and MOF

Annex 1: Deliverables for year 1

	Deliverables
D1.	Overall report on activities under the five Outcomes of the task order during the period, addressing their effect on the improvement of maternal-perinatal, child health and FP/RH and proposing benchmarks and strategies for future interventions
D 1.1.	Report on the results of dialogues with political parties regarding the health agenda
D 1.2	Report on the process of health decentralization, including activities undertaken, and recommendations for future strategic action to strengthen and expand decentralization of the health sector
D 1.3	Report containing the decentralized management model for selected national health priority, including activities undertaken, and recommendations for implementation
D 1.4	Report on the progress made regarding reorganization and revised functioning of the RHD
D 1.5	Report containing the assessment of the Municipal Incentive Program in three regions, including activities undertaken, and recommendations for improvement
D 2.1	Report on policies and regulations taken by the national health authority regarding health financing and insurance
D 2.2	Report on the process of health insurance, including activities undertaken, and recommendations for future strategic action to strengthen and expand the health insurance reform
D 2.3	Technical report on health financing reform and strategy to ensure health financing reform developed with broad participation and gain wide public support
D 2.4	Report on policies, regulations, and programmatic actions taken by regional governments regarding health financing
D 2.5	Technical report on validated methodology to formulate and implement a Multi Year Health Investment Plan at the regional level
D 3.1.	A report of policies, regulations and programmatic actions taken by national and regional governments regarding registry, use and dissemination of reliable data for decision making related to integrated health and to MCH, FP/RH, HIV/AIDS and TB.
D 4.1.	Report of policies, regulations, and programmatic actions taken by regional and national governments and health authorities regarding human resources for health.
D 5.1.	Report on policies, regulations, and programmatic actions taken by regional and national governments and health authorities regarding pharmaceutical and supply chain management systems.

