



**USAID**  
DEL PUEBLO DE LOS ESTADOS  
UNIDOS DE AMERICA

**PERU**

**POLITICAS  
EN SALUD**

**Technical report  
evaluating the  
organization of the  
RHDs**

**USAID/Peru/Políticas en Salud**

**Contract No. GHS-I-10-07-00003-00**

January 30th, 2013

*Prepared for:*

**Luis Seminario, COTR**  
USAID/Peru Health Office  
Av. Encalada s.n.  
Lima - Perú

*Submitted by:*

**Abt Associates Inc.**  
Av. La Floresta 497 Ofic. 101  
San Borja  
Lima - Perú

**In Partnership with:**

Futures Group International

This document has been elaborated by Carlos Bendezú, Rocío Mosqueira, Jéssica Cavalcanti and Alberto Gonzales, USAID|PERU|Políticas en Salud Project, financed by the United States Agency for International Development (USAID) under contract No. GHS-I-10-07-00003-00.

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

Technical Monitor: Alfredo Sobrevilla.

## Tabla de Contenidos

<b>1. ACRONYMS</b> .....	<b>iii</b>
<b>Executive Summary</b> .....	<b>v</b>
<b>2. General Considerations regarding the process of decentralization</b> .....	<b>7</b>
2.1 Relevant aspects of the political process and the development of regulatory power linked to decentralization .....	7
2.1.1 The process of decentralization in Peru .....	7
2.1.2 Recentralization of authority: the Government of President Fujimori.....	8
2.1.3 A new outlook on the regions: President Toledo’s Administration.....	8
2.1.4 Decentralization shock: President García’s Administration.....	11
2.2 Relevant aspects in the implementation of Decentralization.....	16
2.2.1 Regulatory Phase in the transfer of Functions, Programs and Projects.....	16
2.2.2 Executive phase of transfer of Functions, Programs and Projects .....	17
<b>3. Decentralization in health</b> .....	<b>19</b>
3.1 Background in decentralization in health .....	19
3.2 Objectives of decentralization in health .....	22
3.3 Decentralization in health: The path followed .....	22
3.3.1 Phase I, 2003-2005: Initial phase of the process of transfer.....	22
3.3.2 Phase II 2006-2007: Accelerated transfer .....	25
3.3.3 Phase III 2008-2012: the process of re-sizing in the organization and functions of the RHDs.....	25
<b>4. Process of reorganization of RHDs</b> .....	<b>28</b>
4.1 Adaptation and institutional strengthening of the Health Sector in the Regional Governments.....	28
4.2 USAID technical assistance in the organizational redesigning of the RHDs .....	29
4.2.1 Underlying Conceptual Elements in the Proposal of Organizational Redesign	29
4.2.2 Proposal of organizational redesign.....	31

---

4.2.3	Proposal for institutional capacity strengthening.....	33
4.3	Organizational redesign of La Libertad RHD.....	35
4.3.1	Reorganization process at La Libertad RHD.....	35
4.3.2	Development of Institutional Capacities.....	48
4.3.3	Factors conditioning the process.....	49
4.3.4	Balance of the reorganization process of the RHD within the framework of the decentralization and the exercise of transferred functions.....	50
4.4	Organizational redesign of the RHD of San Martín.....	54
4.4.1	Reorganization Process at San Martín RHD.....	54
4.4.2	Development of Institutional Capacities.....	69
4.4.3	Factors conditioning the process.....	70
4.4.4	Balance of the process of reorganization of the RHD.....	71
4.5	The organizational redesign of the DIRES Cajamarca.....	75
4.5.1	Reorganization Process at Cajamarca RHD.....	75
4.5.2	Development of institutional capacities.....	81
4.5.3	Factors determining the process.....	81
4.5.4	Balance of the process of reorganization of the RHD of Cajamarca.....	82
<b>5.</b>	<b>Lessons Learned.....</b>	<b>86</b>
<b>6.</b>	<b>Methodological Annex.....</b>	<b>88</b>
<b>7.</b>	<b>References.....</b>	<b>91</b>

## 1. ACRONYMS

<b>ASB</b>	Analytical Staff Budget
<b>BIC</b>	Body of Institutional Control
<b>BHAP</b>	Basic Health for All Program
<b>CSP</b>	Center of Strategic Planning
<b>CCM</b>	Concerted Capabilities Map
<b>HD</b>	Health Directorate
<b>HDMS</b>	Health Decentralization Monitoring System
<b>HIC</b>	Health Intergovernmental Commission
<b>HRM</b>	Health Regional Management
<b>IGCH</b>	Inter-Governmental Commission in Health
<b>ICPCNI</b>	Integrated Care Program for Child Nutrition Improvement
<b>LCHA</b>	Local Committee of Health Administration
<b>LOF</b>	Law on Organization and Functions
<b>MA</b>	Ministry of Agriculture
<b>MRDSI</b>	Management of Regional Development and Social Inclusion
<b>MDM</b>	Model of Decentralized Management
<b>MOF</b>	Manual of Organization and Functions
<b>MoH</b>	Ministry of Health
<b>MR</b>	Ministerial Resolution
<b>NARG</b>	National Assembly of Regional Governments
<b>NCC</b>	National Coca Company
<b>NID</b>	National Institute of Development
<b>NIFW</b>	National Institute of Family Welfare
<b>NFCSD</b>	National Fund for Compensation and Social Development
<b>NCD</b>	National Council of Decentralization
<b>NPC</b>	National Planning Center
<b>NRICS</b>	National Register of Identity and Civil Status
<b>NSPI</b>	National System of Public Investment
<b>ODPTS</b>	Office Data Processing, Telecommunications and Statics
<b>OLEP</b>	Organic Law of the Executive Power
<b>OLGR</b>	Organic Law of Regional Government
<b>PCM</b>	Presidency of the Council of Ministers

<b>PCBSC</b>	Primary Care and Basic Sanitation, Cajamarca.
<b>PM</b>	Procedures Manual
<b>RG</b>	Regional Government
<b>RHA</b>	Regional Health Authority
<b>RHD</b>	Regional Health Directorate
<b>RO</b>	Regional Ordinance
<b>ROF</b>	Rules of Organization and Functions
<b>SAP</b>	Shared Administration Program
<b>SD</b>	Supreme Decree
<b>SPI</b>	Sport Peruvian Institute
<b>ST</b>	Staffing Table
<b>TCRA</b>	Transitory Committee of Regional Administration
<b>OLRG</b>	Organic Law of Regional Government
<b>USAID</b>	United States Agency for International Development
<b>USAID HPR</b>	United States Agency for International Development / Health Policy Reform Project

## Executive Summary

Decentralization in the country began with the modification of the 1993 Constitution –during President Toledo’s Administration- regarding the XIV Chapter on *Decentralization, the Regions and the Municipalities*. This modification dealt with the concept of decentralization, the political organization of the State and the organization of the Regions. Its objective was to recover and strengthen the various elements of political democracy that were weakened in the 90’s and to accomplish an integral, equitable and sustainable development of the country. The constitutional modification and its legal development document define in a better way the concept of decentralization. This legal framework defines that the national territory is organized in regions, departments, provinces and districts. It also establishes the nature of the regional governments, their organic structure and their competences. Finally, it defines the municipal model, identifying its competences and functions.

Decentralization was expected to be accomplished through phases, according to criteria that facilitate the allocation of competences and transfer of resources from the national government to the regional and local governments. On this basis the following laws were enacted: Law of Fundamentals of Decentralization, Organic Law of Regional Governments; Organic Law of Municipal Governments, and the Law of the System of Accreditation of the Regional and Local Governments. Under this legislation, regional governments began to operate, starting the process of transfer of functions and competences from the national government to the regional and local governments.

During President García’s Administration, the process of transfer of competences and functions toward the regional governments was accelerated and finalized. Additional regulations were developed, completing the normative framework for decentralization in Peru. Among these norms there are: the Law of the Executive Power, the Decree that creates the Authority of the National Civil Service, the Law that creates the National Center of Strategic Planning; the Law of Reform of the National System of Public Investment, the Law of the System of Acquisitions and Contracting of the State, and the Regulation of the Budget System.

Under these legal developments the framework of public management is substantially modified, and it was deemed necessary to perform the organizational redesign of regional governments as well as their corresponding sectoral offices.

This report analyzes the organizational redesign that was performed by Regional Health Directorates (RHD) of Cajamarca, La Libertad and San Martín with the aim for adapting themselves to the transfer of competences and functions within the decentralization framework. These three regions are distinct regarding geographical, cultural, social and economical considerations. Each one has had a different response to the decentralization process, with different degrees of acceptance of the technical assistance provided.

In La Libertad, the Regional Health Authority (RHA) is the highest ranked office of the Regional Government in health issues and is located in the peruvian coast. This authority is more developed on organizational grounds in comparison to the other regions. This is reflected on the presence of new regulatory instances, and on a functional perspective a change from a strictly sectoral approach to an integrated multi-sectoral territorial approach for solving regional health priorities –based on the

reengineering of the Promotion Office at the RHA. This positive organizational outcome has been associated to three factors, a) the stability in the position of the officials of the Regional Health Authority for more than 4 years, thus, having continuity in their administration; b) the existence of a group of experienced and technically competent professionals, c) the emergence of alliances with local governments through the *Territorial Health Agreements*.

San Martín RHD is located in the jungle zone. Its organizational changes began in 2005, and have been extended to 2009 (in the case of its networks to 2011). The first phase of the organizational redesign corresponded to the adaptation of its structure to the main technical processes it had to perform on a regular duty, complementing this piece of work with the necessary definition of incentives and policies regarding human resources management. Organizational redesign in San Martín has also been linked to the implementation of regional health policies based on analogous regional health priorities, i.e. the reduction of child-chronic malnutrition. This alignment is boosting the RHD's reconfiguration of its networks its micro-networks region-wide.

Cajamarca RHD is located in the Andes of Peru, and its advances in organizational redesign have been limited. Its organization dates back to 2006, and resembles a deconcentrated unit of the MoH. The principal problem that Cajamarca RHD is facing for more than 15 years, is the coexistence in the same region, of four offices exercising the same functions and administrating their own budgetary resources. This arrangement, instead of reflecting an advance on decentralization or deconcentration matters, shows a degree of organizational anarchy that severely affects the exercise of a unified regional health authority.

According to the observations made for this report, it is important that the MoH issues a new law of organization and functions, according to the process of decentralization. Regarding decentralization, this regulation should define (1) the MoH's role as national health authority, (2) its articulation and coordination mechanisms with regional and local governments, and (3) the definition of inter-governmental coordination mechanisms, regarding national health policy issues and the monitoring of the decentralization process.

It is of the greatest relevance to start a capacity building program for health staff at all levels of the system. This should be based on the definition of required profiles and competences as requested by the adequate exercise of the health functions transferred to regional governments.

Finally, it is important to highlight that besides a new organizational design it is relevant to design the organizational change strategy, and accordingly, formulate its plan of implementation. In practice, this represents an institutional development program, i.e. to manage the transition from the current organization into a new one with clear indications on what its performance should be, based on quality, coverage, and efficiency criteria.

## 2. General Considerations regarding the process of decentralization

Decentralization is a process regarding the reform of the State characterized by the transfer of political, economic and administrative power from the national government toward its regional and local components. It comprises the political, and administrative and fiscal aspects which are fundamental to its conception. It also constitutes a system of administration of the State whereby management of regional or local interests are entrusted to independent bodies which possess legal autonomy, which is legally recognized by the State.

The decentralization of the State permits to bring the ordinary citizen closer to the State, so as the regional and local governmental entities can promote a balanced territorial development and generate capacities for distributing the benefits of economic growth. As such, decentralization is based, essentially, on the following reasons:

- Political: It is permitted, within a model of a unitary State, the creation and strengthening of governmental entities, a fact that makes possible the incorporation of new actors within the national political scene.
- Economic: Permits to assign greater resources to less favored areas. In turn, this can be used to improve equity in the distribution of the State's resources. On the other hand, it also permits to improve the process of allocation of public resources to sub-national entities.
- Social: Social participation is increased, which in its turn can be of value in the struggle against poverty and cultural and socio-economic inequalities. In this way, decentralization favors social inclusion.

### 2.1 Relevant aspects of the political process and the development of regulatory power linked to decentralization

#### 2.1.1 The process of decentralization in Peru

In Peru, the beginning of the XXI century has brought democratic continuity, economic stability and the re-launching of the process of political, economic and social decentralization. This process of decentralization adds on the one initiated under the Political Constitution of Peru of the year 1979, wherein the process of decentralization had two well-defined governmental entities: the municipal government and the regional government(1). Within this context, municipalities were granted a large number of well-defined competences and regions were conceived as geo-economic units.

The constitutional norm did not specify the nature of these competences and it has been created a Regional Assembly in each region. This Assembly was composed of members of parliament who elected the President of the region.

During the first government of President García, the Law of Foundations of the Decentralization Process was enacted. This law defines the nature, objectives, functions, and composition of the entities of the regional government as well as its regulatory mechanisms(2).

Within this legal framework, 11 regions were created and representatives to a similar number of Regional Assemblies were elected, allowing the creation of Regional Councils and the election of Regional Presidents. These governments operated from 1989 until 1992, when they ceased to function under Alberto Fujimori's mandate. During this short period regional governments were immersed in the deep economic crisis that Peru was suffering; a fact which severely hampered the exercise of their functions(3).

### **2.1.2 Recentralization of authority: the Government of President Fujimori**

The initial advances gained in the decentralization process were halted and retreated with the coup d'état carried out by Fujimori in April 5th 1992, who dissolved the regions and established in as a replacement place 25 Transitory Committees of Regional Administration (TCRA), under direct dependence of the Executive Power(4).

Subsequently, President Fujimori summoned a new Democratic Constitutional Congress, to write a new Constitution, approved and enacted in 1993, and currently valid. The 1993 Constitution maintained the municipalities as local governmental entities and also included the regions but without specifying their authorities, their competences, their managerial bodies and their resources(5). Far from it, through the Ministry of the Presidency, a slow albeit effective process of re-centralization was started, leading to settlement of administrative bodies within the regions to be directly dependant of the Executive Power. This period is marked by a great step back in the decentralization of the State.

### **2.1.3 A new outlook on the regions: President Toledo's Administration**

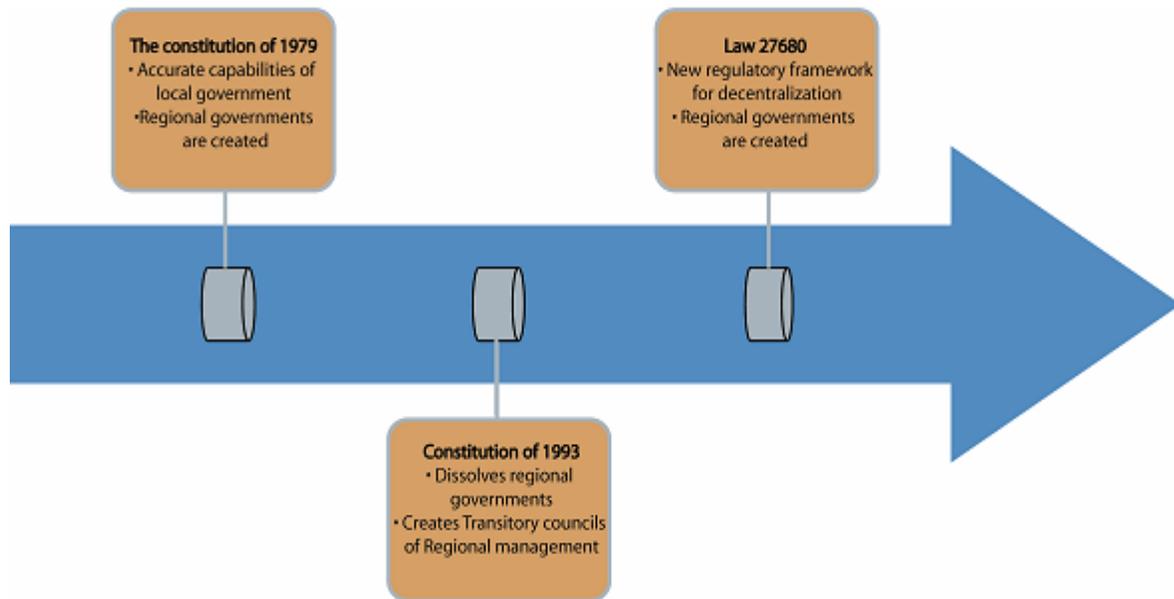
After President Fujimori handed down his resignation in November of the year 2000, and a short transition period, President Toledo was elected for the period 2001-2006. He proposed to advance the decentralization process through the creation of regions(6). President Toledo's administration considered necessary to reactivate decentralization on the basis of the following principles:

- Acknowledgement of diversity. A country having such a variety of cultural, historic, geographic and economic conditions as Peru, cannot continue to be governed under such rigid criteria that do not adjust to the needs of its inhabitants.
- Clarity in assignment of responsibilities. If each level of government has well defined roles for the provision of goods and services to the population, overlapping of responsibilities and conflicts of jurisdiction will be avoided.
- Participation of citizens. Participation makes possible for the people to express their needs and provide information to guide the actions of the regional authorities. It also makes possible the exercise of social control over elected authorities.
- Strengthening of capacities. Related with the development of staff capacities in exercising their new assumed competences.
- Adapting of the National Government. The modification of the structure and functioning of the National Government must be consistent with the process of decentralization by carrying out a series of reforms within its administrative systems. These changes will influence positively in the stability of reforms introduced.

To advance the decentralization, the Constitution was modified, establishing decentralization as a permanent policy of the State having as its main objective the integral development of the country(7). Decentralization is to be carried out by phases in a progressive and orderly way under criteria that allows the allocation of competences and transfer of resources from the national government toward regional and local governments.

Also, it establishes that the nation's territory is to be organized in regions, departments, provinces and districts. It specifies that regions are to be created on the basis of adjacent areas which are integrated historically, culturally, administratively and economically, thus, forming sustainable geo-economic units. Regionalization is to be initiated by electing governments in the current departments(7). Also, it established the nature of the regional governments, its organic structure and competences. Finally it specifies the functions and competences for the local governments.

**Figure 1. Evolution of the decentralization constitutional definition according to three key administrations**



Source: USAID|Perú|Health Policy Reform

### **Normative development on decentralization**

In 2002 several legal norms were approved related with decentralization (Table 1). These norms were directly linked to Law 27680.

**Table 1. Legal norms on decentralization**

Legal norm	Main specifications
Law on the Foundations of Decentralization(8)	<ul style="list-style-type: none"> <li>• Establishes competences for the 3 levels of government, defines their functions and their economic-administrative regime (regional and local governments)</li> <li>• Defines 3 types of competences: exclusive, shared and amenable of delegation.</li> <li>• Regulates intertwined government’s relationships.</li> <li>• Establishes public health as a shared competence among the three levels of government.</li> <li>• Defines four phases for the effective transfer of competences and functions from the Ministries to the regional governments.</li> </ul>
Organic Law of Regional Governments(9)	<ul style="list-style-type: none"> <li>• Establishes the objective, role, structure, organization, competences and functions of regional governments, identifying general and specific (sectoral) functions</li> <li>• Specifies the leading principles for regional policy-making and management.</li> <li>• Regulates the transfer process of competences, functions, powers, resources and budget to the Regional Government, through an accreditation based transfer</li> <li>• Public health is defined as a shared competence, and establishes the specific functions regarding health matters</li> </ul>
Modification of the Organic Law of Regional Governments(10)	<ul style="list-style-type: none"> <li>• Mandates alingment of policies and functions of regional governments with the sectoral policies.</li> <li>• Assigns diverse sectoral functions to the following offices: Economic Development, Social Development, Planning, Budgeting, Territorial Planning, Infrastructure, Natural Resources and Environmental Management.</li> <li>• Assings responsibility to sectoral Regional Directorates for the implementation of national and regional policies. Regional Directorates are responsible to render account of their management performance before the Sector’s Authority and the Regional Management Office.</li> <li>• Establishes selection of sector’s regional directors through a public selection process coordinated by the regional governments and the National Government.</li> <li>• Specifies January 2004, the date for starting the health sector functions transferring</li> </ul>

Source: USAID|Perú|Health Policy Reform

The Policy of the National Agreement<sup>1</sup>, on the Political, Economic and Administrative Decentralization, establishes the commitment to build a Decentralized State Model through the

---

<sup>1</sup> An important contribution of President Toledo’s administration is to have established a solid ground for democracy in Peru and the collective building of national policies for the setting up and functioning of the National Agreement. At this level the State’s policies are designed, prepared and approved on the basis of

progressive transference of competences and resources from the national government to regional and local governments. Correspondingly, it is the responsibility of the Peruvian State to establish the institutional framework for citizens' participation for decision making on political, economic and administrative issues(11).

Other relevant norms to consider are: Framework Law to Modernize the Management of the State (12) and the Organic Law of Municipalities(13).

The Framework Law of the Modernization of the Management of the State is aimed to obtain higher levels of efficiency within the State apparatus in order align them to needs of citizens. As objectives this law proposes a State:

- a) Committed to the service of its citizens
- b) With effective channels for citizens' participation
- c) Decentralized and de-concentrated
- d) Transparent in its management
- e) Staffed with qualified and adequately-paid public servants
- f) Fiscally balanced

The Organic Law of Municipalities stipulates that “local governments are basic entities of the territorial organization of the State and immediate channels for local citizens' participation in those public affairs which contribute to the institutional framework and the autonomous management of the interests of the corresponding communities, being essential elements of the local government, the territory, the population and the organization”(13).

These two laws, once approved and enacted, formed the basic legislative framework for the election and installation of the regional and municipal governments. This process was finished as of January 2003. However, this implementation phase of the reform –and the corresponding transfer of functions from the central level toward regional governments- was halted in 2005. One of the main reasons that explain this situation is the electoral defeat of the government in the referendum that proposed the creation of macro-regions.

#### **2.1.4 Decentralization shock: President García's Administration**

Alan García turned decentralization into the central issue of his second term in office. During quarter 4 2006, the National Council on Decentralization (NCD)- carried out an assessment on the advancement of decentralization and put forward a proposal to re-launch and to intensify its implementation process(14).

---

dialogue and consensus with the aim of defining a guide for the country's sustainable development and to strengthen the country's democratic form of government.

The proposal indicated, for the period 2004 – 2006, only 30% of the transferable functions had been readily transferred to the regional governments. Within the country's budget, participation of decentralized governments increased from 16,8% in 2002 up to 23,3% in 2005(14).

Also, this document mentions that the process of decentralization began to decline in the year 2005, as a result of three important facts: the discouragement generated by the failure in the forming of the macro-regions by referendum, the lack of leadership on the part of several regional presidents due to the fact that the majority of them were elected with less than 25% of the votes, and the weakening of the political will of the National Executive to decentralize. Additionally the active resistance of several National Government bodies led to the delay and postponement of the process of transfer and decentralization(14).

This deceleration was further accentuated by the lack of important public policy instruments, such as the Organic Law of the Executive Power (OLEP), the Law of Public Employment, the law that classifies the assets and companies of the State by levels of government, and by the delay on the activation of the Center of Strategic Planning (CSP)[12]. Decentralization was also affected by the lack of tools, such as the National System of Public Investment (NSPI), the System of Acquisitions and Engagements of the State, and the Budgeting System among others(14).

The proposal put forward by the NCD to re-launch and intensify decentralization led to the announcement of President García of 20 specific measures, to favour it (later known as the Decentralization Shock) approved by several laws(15-19) (Table 2).

**Table 2. Specific measures of the Garcia’s administration to intensify decentralization**

Announcement 1	Transfer to Regional Governments of 185 sector’s functions established by the Organic Law of Regional Governments, with their human, budgetary and material resources.
Announcement 2	Regional Governments directly and freely designate their sector regional directors.
Announcement 3	Transfer to Local Governments of the FONCODES Infrastructure Projects. Finishing of the first phase of transfer of the Programs of INABIF, Wawa Wasi and the National Program Against Family and Sexual Violence.
Announcement 4	Transfer to the Regional Governments of the shares of the Electric Power-Distribution Companies at the regional scope: Sociedad Eléctrica del Sur Oeste S.A. to the Regional Government of Arequipa, Electro Ucayali S.A. to the Regional Government of Ucayali and Electro Puno S.A. to the Regional Government of Puno.
Announcement 5	Transfer to the Regional Government of Cusco of the shares of the Coca National Company - ENACO.
Announcement 6	Transfer of the sport infrastructure of the IPD-Instituto Peruano del Deporte (Peruvian Institute of Sports) to the Regional and Local Governments.
Announcement 7	Transfer of management of primary health attention, through Pilot Programs, to the Provincial and District Municipalities.
Announcement 8	Transfer of management of primary education centers and programs, through Pilot Programs, to the Provincial and District Municipalities.
Announcement 9	Transfer to RG the Execution of the Program of Department Roads, and the Decentralized Rural Transportation Program from the Ministry of Transportation and Communications
Announcement 10	Connection to Internet of 4154 rural localities, to facilitate access to the Information Technologies.
Announcement 11	Transfer, to the Regional Governments of forty-seven (47) non industrial fishermen’s wharfs and aquiculture centers; and to the Local Governments commercialization modules of hydro biological species.
Announcement 12	Exoneration of General Sales Tax for sanitation works, pavement of streets and sidewalks and electrification works executed by district municipalities.
Announcement 13	Exoneration of Income Tax Payment for industrial companies in the Andean Highlands located at and above 3200 meters above sea level.
Announcement 14	Assignment to the Regional Governments of the Special Projects in charge of the INADE not having a bi-national character.
Announcement 15	Design of a new national decentralization plan, towards its full implementation in at least one pilot region
Announcement 16	Democratization of Committees of Inter-Regional Coordination.
Announcement 17	Tax Reform for strengthening tax collection and appropriation of the higher IGV revenues.
Announcement 18	Execution of a Plan for Strengthening of Capacities and Evaluation of Resources by PCM.
Announcement 19	Transfer of heavy machinery from MINAG to Regional Governments and the initiation of the process of decentralization of several State entities.
Announcement 20	Creation of the Andean Export Program to incorporate the Andean Zone into the national export activity.

Source: USAID|Perú|Health Policy Reform

To implement the Decentralization Shock several laws were enacted, among which stand out the following ones:

- Supreme Decree N° 068-2006-PCM, establishes provisions relative to the culmination of those transfers programmed for the Regional Governments.
- Supreme Decree N° 076-2006-PCM, modifies “Annual Plan of Transfers of Sectoral Competences to Regional and Local Governments for year 2006”, approved by Supreme Decree N° 021-2006-PCM.
- Supreme Decree N° 077-2006-PCM, establishes provisions relative to the process of transferring of Management of Primary Health Attention to the Provincial and District Municipalities.
- Supreme Decree N° 078-2006-PCM, authorizes the Ministry of Education, with participation of Municipalities, to carry out a Pilot Plan for the Municipal Management of Education at the initial and primary levels.
- Ministerial Resolution N° 664-2006-EF/10, establishes the identification and quantification of budgetary resources associated with the transfer of functions.

In 2007, attention was centered on the implementation of 20 decentralization measures, and the improvement of administration systems, especially the National System of Public Investment, which became decentralized in nature(20).

Beginning 2007, NCD was dissolved and its functions were assumed by the Decentralization Secretariat at the PCM(21). On the other hand, the implementation of the Budget by Results was started(22). In May, laws promoting the merger of district municipalities and their association in commonwealths, and establishing the separation of powers between the Executive of Regional Government and its Council were approved by the Congress(23).

Also, in the same year, the new OLEP was approved re-defining the Executive’s exclusive and shared functions and specifying the relationship between the National and Regional levels of government(24). Mandatory national policies for the National Governmental entities were considered, with a special focus on decentralization(25). Among these policies stand out the following ones:

1. Ensure the timely and adequate transfer of competences, functions and resources to Regional and Local Governments, taking into consideration principles of subordination, graduality, complementariness and neutrality among the national, regional and local levels.
2. Clarify the functions, competences and the coordination mechanisms among governmental levels, so as to define administrative and functional responsibilities in services provision.
3. Generate capacities in Regional and Local Governments in sectoral management issues.

Year 2008 was characterized by the efforts of the Executive Power for the implementation of the new OLEP. Among the stipulations of the OLEP are the following ones:

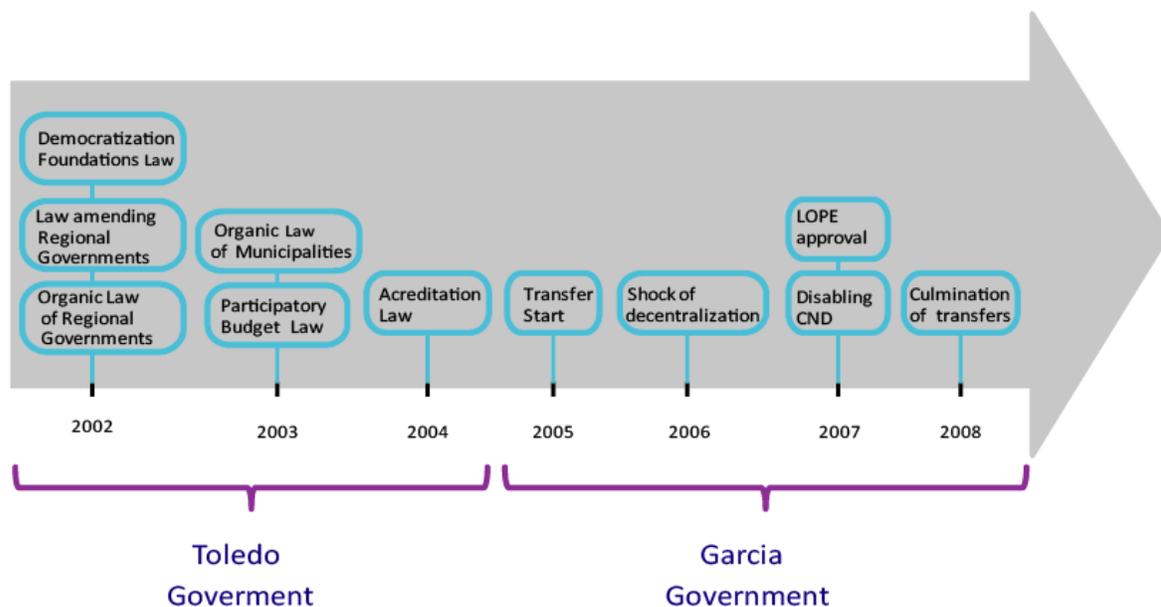
**Table 3. Stipulations included within the OLEP(24)**

Stipulations for exercising shared competences among the National, Regional and Local Governments.
Creation of the Inter-governmental Coordination Council under the authority of the President of the Council of Ministers. This Council was aimed to strengthen decentralization and provide follow-up for the State's Policies,
Mandate to specify the exclusive and shared competences of the Executive Power with the Regional Governments and the Local Governments within the new Laws of Organization and Functions of the different Ministries to be generated.
The execution on the part of the Executive Power, through its dependencies, of those competences of the sectors that still have not been transferred to the Regional and Local Governments according to the Organic Law of Regional Governments, the Organic Law of Municipalities and other pertinent laws.

Source: USAID|Perú|Health Policy Reform

Other relevant laws were approved that have an important impact on decentralization. The first of them, is the norm to reform the civil service, in order to strengthen managerial capacities of the regional and local governments(26). Also, the law of institutional modernization of regional and local governments permits to improve services provided to citizens and the development of their functions(27). Finally, the establishment of a National System of Strategic Planning integrates within its framework the regional and local governments(28).

**Figure 2. Important milestones in the decentralization reform under Toledo's and Garcias's administrations**



Source: USAID|Perú|Health Policy Reform

## **2.2 Relevant aspects in the implementation of Decentralization**

### **2.2.1 Regulatory Phase in the transfer of Functions, Programs and Projects**

The transfer of functions, programs and projects was initiated in the year 2003 with the transfer of social programs. In order to effectively attain the transfer, regional and local governments had to comply with standardized performance indicators to certify that they had the capacity to transfer functions, programs and projects.

In 2004 the Law and Regulation of the System of Accreditation was approved and within its framework began the transfer of sectoral functions to the regional governments(29). Despite the creation of the System of Accreditation, the previous verification mechanisms were still used to transfer programs and projects, and the System of Accreditation was limited to the transfer of functions.

In 2005 the transfer continued according to the Annual Plan under the scheme previously described(30). In the first half of year 2006, transfer was virtually suspended, mainly due to the impending change of administration.

At the start of President Garcia's administration, transfers were carried out within a flexible interpretation of the Law of the System of Accreditation. In this manner, in 2007 the Annual Plan of Transfer of Sector Competences to the Regional and Local Governments(31) was issued as well as other norms oriented to accelerate transfers. The following measures stand out:

1. The phase of request of transfer of competences and signing of agreements were omitted.
2. Compliance with the general requisites for transfer of competences ceased to be a part of the phase of certification, and was replaced by a commitment of regional government to comply with them.
3. The certification phase was drastically modified; becoming a self-evaluation of the regional governments and their sectoral compliance with the requisites for transfer of competences.
4. Inter-governmental master agreements were signed among sectors and regional governments to carry out actions of collaboration, coordination and cooperation, as were the case.

**Figure3. Simplified Comparison of the Transfer Process**

PREVIOUS WAY (2005-2006)							
	1	2	3	4	5	6	7
Preparation of sectoral plans and Annual Plan of Transfer	Requests of transfers of RRGG and LLGG	Signing of agreements of cooperation and technical assistance	Execution of activities and technical training	Certification of requisites of accreditation	Accreditation of RRGG and LLGG as certified	Resolution of controversies before the CND	Effective action of transfer of functions and resources
CURRENT WAY (2007 to the present date)							
	1			2	3		4
Preparation of sectoral Plans and Annual Plan of Transfer	Commitment of compliance with general requisites			Certification of requisites of accreditation	Accreditation of RRGG and LLGG as certified		Effective action of transfer of functions and resources
	Inter-Governmental Master Agreements				Resolution of controversies		

Source: Secretariat of Decentralization(32)

Besides the norms included important measures that responded to demands submitted by various actors during previous years:

- National Government Sectors are obliged to define their budgetary, human, and logistic resources together with documentary needs linked to the exercise of functions to be transferred(33).
- Two types of requisites for accreditation are: i) teaching and training of human resources; and ii) technical documents on management regulations. Logistics and equipment were not required(34).
- Framework agreements were signed on management, collaboration, cooperation and coordination matters to support the strengthening of regional governments capacities(35).
- Design of indicators for the follow-up and evaluation of transfers(36).

In theory, the transfer of sectoral functions and of the infrastructure projects should have been finished by the end of 2007. However, this could not be accomplished and for this reason the deadline was extended to March 31, 2008 in the first place(37) and then to December 31, 2008(38).

### 2.2.2 Executive phase of transfer of Functions, Programs and Projects

Despite to regulatory development described before, regions complained that transfer of functions was only administrative in nature, since this process was not accompanied by financial and human resources. This fact was confirmed by the Peruvian Ombudsman, who in 2006 pointed out “(...) the process of effective transfer of competences (...) has been limited to the signing of Sustaining Act of Delivery and Acceptance, as well as to the delivery, in some cases, of the documentation (...)” and recommended that “National Government Sectors should be aware that transfer of sectoral competences must be accompanied by budgetary, material and human resources linked to each one of the functions to be transferred, in accordance to the criterion of regulated provision contained in letter c) of item 14.2) of article 14° of the Law on the Foundations of Decentralization”(39).

The 2006 Secretariat of Decentralization of the Presidency of the Council of Ministries to the Congress, pointed out that “(...) sectors claim that they do not have more resources to transfer to the regional governments in view that the transferred functions correspond to those functions that were being exercised by RG in a de-concentrated manner as a TCRA due to the fact that they were transferred with the associated (...)”(40).

To provide a solution for this deadlock, in 2007 the Executive issued guidelines for the identification and quantification of resources associated with the transfer of functions(33). These guidelines mentioned that Sectors must determine resources to be transferred to Regional Governments. For this, sectors had to consider the minimum conditions set for the transfer of functions. In practice, there was a general request to national sectors and regional governments to identify the amount of resources corresponding to the execution of the transferred functions.

In general the evaluation of the results of decentralization during the period 2006-2010, positive and negative aspects can be considered (Table 4)

**Table 4. Pros and Cons of the decentralization process during the period 2006-2010**

Pros	Cons
Formal delimitation of competences and functions between national and regional level.	Accreditation System and its verification mechanisms centered in fulfilling formal aspects: preparation of plans, creation of organic units, etc.
Approval of the majority of laws for the organization of Ministries.	Annual plans had short deadlines, limiting the possibilities of a real articulation, resembling mainly, the reflection of the sectoral offer.
Increase the transfer of financial resources, in particular, for infrastructure budget.	Infrastructure budget is defined by Central Government. The stewardship is lost by the public budget regulation.
Health Sector leads the decentralization through transfers to local levels (41, 42)	Although Decree DL- N° 1026 established types of transfers of human resources, its regulation is pending.
It is carry out the first evaluation of decentralization MED	Implementation of a System of Monitoring and Evaluation of Decentralization is still pending
Training and technical assistance carried out by national sectors.	It was irregular and not aligned to the transferred functions.

Source: USAID|Perú|Health Policy Reform

### 3. Decentralization in health

#### 3.1 Background in decentralization in health

Regarding the health sector, the situation in 2002 was that of an institutional recentralization. As mentioned before, with the self-inflicted coup-d'état of 1992, came the creation of the TCRA and Regional Health Directorates (RHD) within it, all of them under the dependence of the Ministry of the Presidency. In this manner, the RHDs turned into de-concentrated bodies of the national level depending on MoH on their specific functions and on TCRA for their administration.

At this point it is worth to specify that in the 90's the country began a process of reforms in order to tackle the most severe social, political and economic crisis in its history. President Fujimori's administration organized an important program of investments for the expansion and rehabilitation of the public installations, the associated provision of human resources (personnel), equipment and furniture and the promotion of alternative models of training and supervision. Within this context, in 1993 the Program of Focalization of Basic Social Expenditure in Health was started (in 1995 changed to Basic Health for All Program (BHAP)(43).

With the influx of fresh resources from BHAP, advances were accomplished in providing health care at the first level of care. This fact is reflected by the extension of coverage in health centers and health posts, equipment and strengthening of national programs, especially in the area of mother-child care and in the area of communicable diseases(44).

**Table 5. Public health facilities: 1990-1999**

Facilities MoH	1990	1992	1996	1999
Health Posts	2,958	2,958	4,762	4,958
Health Centers	826	826	1,026	1,114
Hospitals	148	148	136	148
<b>Total</b>	<b>3,932</b>	<b>3,932</b>	<b>5,926</b>	<b>6,220</b>

Source: General Office of Planning and Budgeting. MoH 2000

These important efforts to transform the health care continued until the beginning of the present decade. Within this context interventions were carried out such as:

1. Implementation of the Shared Administration Program (SAP)(45). In 1994, created Local Committees in Health Administration (LCHA) - within BHAP. LCHA shares management responsibilities of the health facility between the State and the organized community. Health activities are executed according to a local health plan, which is based on local health census information(46). Direct participation of the community in the management of the health service proved to be an efficient way to gain productivity and a more responsive health service(47). This form of operation gave SAP its particular character: local decentralization with flexibility in management.

In 2007, the Supreme Decree that made possible the functioning of the PAC was replaced by a law that “established the general framework of joint management and citizens’ participation for health installations of the first level of attention of the MoH and the regions”(48).

2. Regional Projects: UNI (in Trujillo, financed by the Kellogg Foundation), APRISABAC (Multilateral Agreement Peru-the Netherlands-Switzerland with RHD-Cajamarca), PACD 2001-2003 (in Tacna and Ayacucho) which provided comprehensive health care, developing in particular the component of attention to the community. Also, San Martín RHD implemented in Tarapoto a model of Comprehensive health care for Children.
3. Project 2000 (USAID) and the Project of Health and Basic Nutrition (World Bank) which made an important contribution for the guidance and development of changes in the Model of Attention toward a more comprehensive health care, thus, setting the first ideas on a decentralized organization providing primary care services(49, 50).

In 2002, when the Organic Law of Regional Governments and its amendment were published(9, 10) with the sectoral specific functions in health matters (Table 6).

**Table N° 6. Specific Functions in Health Matters**

1. Formulate, approve, execute, evaluate, direct, control and manage the region's health policies according to the national policies and sectoral plans.
2. Formulate and execute the concerted Regional Plan in Health.
3. Coordinate integral health activities within the regional scope.
4. Participate in the Coordinated and Decentralized National Health System.
5. Promote and execute, prioritarily, activities of health promotion and ill-health prevention.
6. Organize the levels of care in public health facilities in coordination with local governments.
7. Organize, implement and maintain health facilities for ill-health prevention, protection, recovery and rehabilitation in coordination with local governments.
8. Supervise and inspect public and private health facilities.
9. Carry out and execute, in coordination with the competent bodies, prevention and control of risks and emergency damages in disasters.
10. Supervise and control production, commercialization, distribution and consumption of pharmaceuticals and related products.
11. Promote and preserve the region's environmental health.
12. Plan, finance and execute projects of health infrastructure and equipment, promoting health technological development within the regional scope.
13. Make available for the population, information on the sectoral management, as well as the offer of health infrastructure and services.
14. Promote education, training and development of human resources and articulate health services with teaching, research and community based activities.
15. Evaluate periodical and systematically the goals accomplished in health matters.
16. Execute, in coordination with local governments, effective actions that contribute to improve population's nutritional status.
17. In matters of sanitation: <ul style="list-style-type: none"> <li>• Formulate, approve and evaluate regional plans and policies in matters of sanitation, according to local governments and according to national and sectoral policies and plans.</li> <li>• Execute the promotion, technical assistance, training and scientific and technological research in matters of sanitation.</li> <li>• Support technically and financially the local governments in providing sanitation services.</li> <li>• Assume the execution of programs of sanitation at the request of local governments.</li> </ul>

## 3.2 Objectives of decentralization in health

In its most ambitious dimension, health decentralization constitutes a tool which reaches a complete state of psychological, physical and social wellbeing of the person, the family and the community. Decentralization has five well-defined purposes by MoH(51).

1. Improve the supply of health services, making them timely, with quality and adequate for the population's local and regional needs, previously neglected. Decentralization allows the design of plans, strategies and services which promote equity of access. Also, decentralization facilitates the cultural adaptation of health provision through an that inter-cultural approach that recognizes of diversity and respect for different customs and traditions(52).
2. Provide a more effective framework under which health services are provided. Goods and services provided must be secure and healthy, and decentralization should also contribute to make those services responsive to people needs.
3. Contribute to the development of each locality or region by making decisions on the best use of available resources, and calling for new investments in health. Decentralization makes possible the identification of the most vulnerable territories of the region or the local government making possible to define interventions on health determinants. In the same way, decentralization permits the incorporation of the population into the health priorities (53-57).
4. Make possible that not all decisions had to be made in Lima. Decentralization allows the adoption of timely decisions by local decision makers. These authorities have the advantage of being closer to the needs of the population.
5. Promote citizens' participation. Decentralization facilitates citizens' empowerment, accompanied by a higher degree of monitoring of the functioning of the health services. No less important is the fact that decentralization makes possible participatory mechanisms for the selection of health priorities and policies with a mandatory character for the regional level of government (53-57).

## 3.3 Decentralization in health: The path followed

### 3.3.1 Phase I, 2003-2005: Initial phase of the process of transfer

The plans for transfer of health functions were based on the Law of the System of Accreditation of the Regional Governments and its Regulation(29, 58). The Annual Plan had as its principle, graduality in the implementation which was prepared on the basis of the articulation of the sectoral plans, and contained the following:

1. Sectoral functions, personnel, documents, budgetary resources and goods to be transferred;
2. General and specific requirements, and management indicators for each sectoral function to be transferred so as to justify the corresponding accreditation, and;
3. Detailed schedule of the transfer process from sectors to the regional and local governments.

### Concerted Map of Competences in Health

During the first semester of 2002, President Toledo’s administration declared that health decentralization would not be executed until the last phase of decentralization (8). Nevertheless, health authorities of the regions of: Lambayeque, La Libertad, San Martín and Ucayali with support of USAID|Perú|PHRplus initiated the work to design a matrix of de-aggregation of competences by levels of government. This document was called the “Concerted Map of Competences in Health”. The initiative was joined by all regions of the north macro-region including Tumbes, Piura, Cajamarca, Amazonas and Loreto(59).

The design of the matrix was based in the Organic Law of Regional Governments, since RHD competences are to ...” formulate, approve, execute, evaluate and manage the regional policies and plans in health, as well as to promote, regulate, support and supervise the public services in health”(9). Also, another input was the document on the essential functions in public health (among them, supervision, financing, health insurance, purchasing and provision of services)(60, 61). To this documents must be added: the Methodological Guide of the Concerted Map of Competences in Health prepared by PRAES/USAID(62), which identifies 14 functioning health areas:

1. Policy making	8. Human resources management
2. Strategic planning	9. Pharmaceuticals and supplies management
3. Operational planning	10. Health investments management
4. Regulation	11. Health information management
5. Health services organization and management	12. Health research
6. Financial management	13. Civil participation promotion
7. Health insurance management	14. Physical resource management

Within the 14 functioning areas, 18 processes or competences were identified, due to the fact that in the functional area of regulation 3 different processes were identified (health of persons, environmental health and pharmaceuticals and supplies); and in the functional area of services organization and management two different processes were identified (health of persons and environmental health)(59).

Besides, within the 18 processes, 142 sub-processes or specific functions were identified. Each one of them can still be de-aggregated into more specific tasks(59).

The Concerted Map of Competences in Health in short and medium term were taken by the regions of the “macro-norte” and submitted to the MoH to be considered within the III National Meeting MoH-Regional Governments in 2004(63). Subsequently, in a National Workshop the Plan of Transfer for the medium-term was approved. In this workshop 22 Delegation Agreements between the MoH and Regional Governments were signed. The focus of these agreements was centered in the organization of health services and environmental health (64).

The proposal of the Medium-Term Plan 2005-2009 between MoH and Regional Governments was submitted in February to the NCD by the MoH, as specified in the process of accreditation(63). NCD approved on March the Medium-Term Plan for Transfer of Faculties for all Sectors(30). Within that Plan the NCD incorporated 124 faculties or specific functions to be transferred from the MoH to Regional Governments in the medium term (30). However, NCD altered the number of faculties to be

transferred in 2005, reducing from previously agreed 73 faculties, to only 21. For this reason, it was necessary to carry out further concertations between the MoH and NCD to modify the NCD criterion. The USAID|PHRplus team provided technical assistance to MoH in order to prepare a counter-proposal. Finally, consensus was reached to transfer 37 faculties in 2005. Such faculties corresponded with the strategic functions of health policy formulation; regional planning; processes management; organization for the exercise of regional functions; health regulation; information management and human resources management.

### Transfer of competences and functions

The transfer process was initiated in 2005; and all the 23 regional governments except Lima and Callao requested the transfer of the 37 health faculties. As expected, the process of certification of compliance or not with requisites for accreditation began. This action was carried out between November and December of 2005. In July of 2006 the effective transfer of the certified functions was carried out

The MoH in its Annual Report of 2006, informed the Peruvian Congress on the advances in the transfer of faculties in health to the regional governments.

**Table 7. Advances of decentralization of the Regional Governments regarding the certified faculties, 2006.**

No. Of Regional Governments	No. of Certified Faculties
17 RREGG	Certified 37 Faculties
3 RREGG	Certified 27 Faculties
1 RREGG	Certified 22 Faculties
1 RG	Certified 21 Faculties

Source: Assesment of Sectoral Plan of Transfers. MoH

Transfer of faculties in health were approved by the respective Regional Governments and then was officially approved by Ministerial Resolutions in the month of July of the year 2006(65, 66). This phase was characterized by the absence of technical assistance from MoH to the regional governments. Within this context, it was important the technical assistance provided by USAID|PRAES to the MoH and the RHDs of the Macro Norte(67). A limitation encountered was that competences, functions and faculties transferred were not associated to new financing for development of capacities.

However, despite its limitations, transfer of functions from MoH to RHD was, in general terms, more fluid and coordinated as compared to other sectors. Intra-institutional relationships between the Regional Government and its RHD were not articulated as desired. For this reason, the organizational culture of the health personnel was more aligned with the institutional framework of MOH than with the Regional Government.

### **3.3.2 Phase II 2006-2007: Accelerated transfer**

The Transference Plan of Sectoral Competences to the Regional Governments in 2006 was approved but was not executed. [62]. Notwithstanding this fact, the new government promoted the process of decentralization by means of the decentralization shock (see section 2.1.4) (15-17).

In this phase, there were two great limitations: first, a great de-alignment between the responsibilities transferred and the existing institutional capacities; and second, the weak relationship between the RHDs and their corresponding regional governments.

### **3.3.3 Phase III 2008-2012: the process of re-sizing in the organization and functions of the RHDs**

The cycle of accreditation regulated by the Secretariat of Decentralization of the PCM established that this cycle would end as of December 31, 2007. However, due to the complexities of the process of effective transfer of competences and especially to the short deadlines for this process, the proposed goal could not be fulfilled and therefore the deadline was extended until December 2009(68).

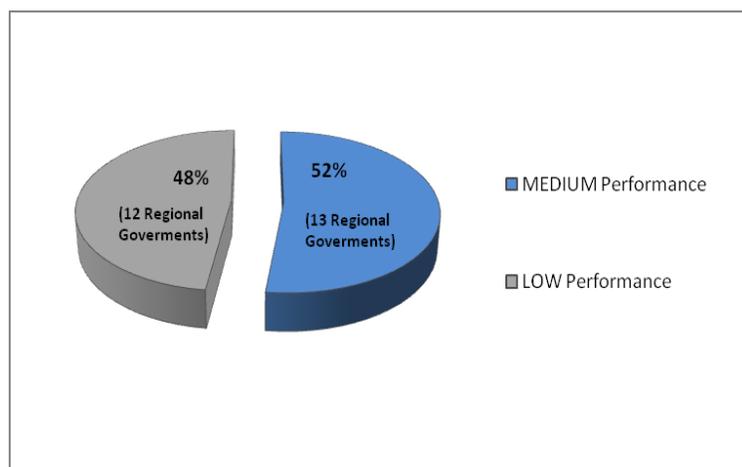
The accreditation norm ordered the generation of a mixed commission (representation from sector plus regional government) for defining actions in order to accomplish the transfer of competences corresponding to year 2007. These actions included (1) the identification of human resources associated to the exercise of such competences and functions and (2) the management indicators for the shared exercise of the aforementioned functions (69).

Another outstanding element of this phase is the creation of the Inter-governmental Commission in health (IGCH) as a permanent entity for the articulation of nationwide policies, plans and programs between the MoH, and the Regional and Local Governments. IGCH represents a concrete and dynamic space for the decentralized management in health, thus, facilitating the transition from a sectoral approach of health management into a territorial one (70).

IGCH was built on the basis of the Macro-Regional meetings which had the technical assistance of the USAID|PRAES project. In these meetings, representatives of the MoH, the Region Health Directors and the representatives of the local government, met to analyze, carry out dialogue and tackle the most important problems in the sectors.

In 2009, the MoH with the technical assistance of USAID|PRAES Project prepared a tool for monitoring the exercise of the functions transferred to the Regional Governments(71). Globally, there were no Regional Government showing a High Level of Exercise; 13 showed “Low Exercise” (52%) and 12 regional governments (48%) showed a Medium Level of Exercise(72).

**Figure 4. Global Exercise of Functions Transferred in the Regional Governments**



Source: MoH. Office of Decentralization. 2010

According to the previous chart, none of the transferred functions was wholly exercised. Those functions that were already being exercised before the process of decentralization are the ones having the highest percentage of ratings in the evaluation. Besides, there exists a common standard of low-grade performance regarding functions of sectoral regulation of environmental health and occupational health, sectoral regulation of persons' health and sectoral regulation of human resources in health.

In synthesis, within 2003-2005, the RHDs had not legally assumed the functions defined in the Organic Law of Regional Governments. By year 2006, the RHDs assumed formally the functions that had been transferred to them; but, without trained personnel for exercising these functions and with a moderate flow of financial resources. In the third phase, the RHDs formally assumed all the functions that had been transferred to them, although with limited capacity to exercise them and with increasing levels of financing.

**Table 8. Evolution of levels of responsibility, capacity and availability of financial resources**

Period	Levels of development In Regional Government with regard to:		
	Formal Responsibility	Capacity	Final Resources
<b>2003-2006</b>	Low	Medium-low	Low
<b>2007-2008</b>	High	Low	Medium
<b>2008-2012</b>	High	Low	High

Source: USAID|Perú|Health Policy Reform

Finally, what we have commented regarding the actions occurred from the initiation of the process of decentralization up to the present date is specified in table 9.

**Table 9. Phases in the health decentralization process**

Phases	Processes	Approach	Results	Limitations
<b>I</b> <b>2003 to 2005</b>	Concertation on distribution of essential health functions at regional level  Mechanisms for selection and follow-up of Regional Health Directors	Approach centered on transfer of functions  Gradual process of standard transfers  Mechanism of accreditation	Medium-term Plan to transfer functions to RG  Initial transfer of functions on the basis of certification of basic conditions	No explicit association of requirements of resources (capacities and financing)  Weak articulation of RHD to RG (Ex TCRA)
<b>II</b> <b>2006 to 2007</b>	Acceleration in transfer of functions  Elimination of processes of selection and follow-up of Regional Directors in Health  Increase of resources	Approach centered on transfer of functions  Accelerated Process of Standard Transfers	Elimination of medium plan and of system of accreditation  All identified health faculties are transferred	De-alignment deepens between responsibilities and capacities of institutions  Weak relation between RHD and RG is maintained
<b>III</b> <b>2008 to 2012</b>	Creation of IGCH within OLEP framework  Continues increase of resources	Approach of Model of Decentralized Management (MDM): Passing from functions to services	Weak exercise of transferred functions  MDM methodology is applied incipiently	Institutional capacities still weak for exercising of regional health authority.  RHDs organizational designs in strengthening process.

Source: USAID|Perú|Health Policy Reform

## 4. Process of reorganization of RHDs

### 4.1 Adaptation and institutional strengthening of the Health Sector in the Regional Governments

In January 2003, the Regional Governments initiated their functions incorporating as governmental entities the Presidency of the Regional Government, the Regional Council, the Regional Managerial Office and the line management offices established by the Organic Law of the Regional Governments(9).

Besides this modification, there was no other substantial advance in the organizational adaptation of the regional governments. The RHDs (previously dependent on the corresponding ministries) after 2006 became fully dependent of the Regional Government, except national health strategies (previous vertical programs). Notwithstanding this fact, the RHDs maintained themselves as compartmented working entities, exclusively within their sectoral scope and without connection with the daily life of the other regional entities.

Other bodies such as: budget execution units, health networks, or special projects were also incorporated within the structure of the regional government and its sectoral directorates. In summary, there was not a clear alignment between the RHD and its corresponding Regional Government, generating the overlapping of functions and a double line of authority with the MoH and RG.

Through years, the initial structure of the regional government turned into a leafy organization both vertically and horizontally. In the vertical way, due to the existence of several organizational levels of authority and in the horizontal way, because of the existence of units with a segmented compartmented form.

Formal transfer of functions without the training of the staff and disregarding the organizational aspects of decentralization resulted in the weakening of the regional governments in their capacity to exercise and articulate the transferred functions. This situation was evident during the first four years of functioning of each regional government. After this period, a second phase began with an organizational content that was better defined and consistent with the passing from a sectoral vision of development to a territorial vision of development.

The change of model implies a process of institutional reorganization which covers: a) the actual organizational redesign; and, b) the preparation and execution of a plan of organizational change. The incorporation of the transferred functions to the daily life of the regional governments imposed on them the challenge to adapt their internal organization and with it, that of their sectoral dependencies. These changes were carried out in the RHDs as well as in the executive body of the Regional Government.

The reorganization of the regional government and of its RHDs needed to carry out an important technical effort with a strong political support. This is due to the fact that reorganization entails drastic and irrevocable modifications of the institutional operation. This can be usually accomplished if certain elementary conditions are satisfied. These conditions are explained in the following lines (73):

- Officials convinced on the fact that change is important and necessary.
- Shared vision of change by all members of the organization.

- Identification and control of barriers, real and potential.
- Strong corporative commitment for change and the strategic steps for its progress
- Leaders directing the change process.
- Organization staff trained to comply with their new functions and to correct the unwanted behavior.
- Evaluation systems put in place to quantify results and carry out feedback.
- Incentives system in place to strengthen the desired behavior.

## 4.2 USAID technical assistance in the organizational redesigning of the RHDs

Within the context above described, the USAID|Perú|PRAES Project was asked to provide technical assistance for the organizational redesign of RHDs so as to adapt them for the transferred competences within the decentralization process and the new territorial approach for the provision of public health services(74, 75).

In this respect, the methodological layout of organizational redesign consists of nine sequential processes. Some of them should be developed with the regional government and others with the RHDs. These processes are:

1. Regional agreements to organizational redesign.
2. Development of the institutional strategy to implement organizational redesign.
3. Definition of the functions of the regional government and the Sectoral functions of the RHD.
4. Design of the structure and functions of the 2° organizational level.
5. Design of the structure and functions of the 3° organizational level.
6. Approval of the organizational redesign by the Regional Government.
7. Design of the institutional system of follow-up and incentives.
8. Design of processes of the Institutional Human Resources Management System.
9. Formulation of management documents for the organization.

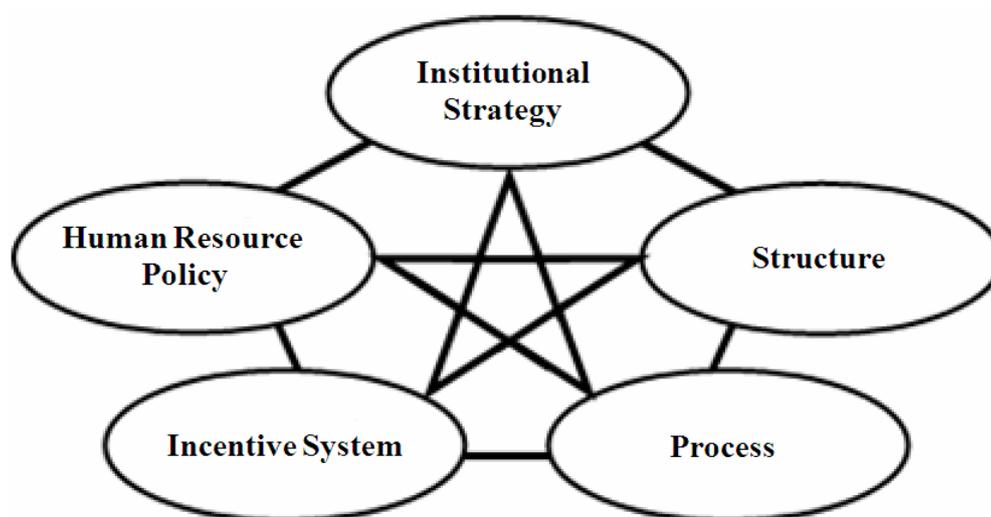
This proposal was submitted, discussed and agreed upon with the regional governments of San Martín, Cajamarca and La Libertad. These regional governments followed these processes and adapted, in different ways, the proposed model of organization, according to regional needs and realities. This process will be detailed in the following section.

### 4.2.1 Underlying Conceptual Elements in the Proposal of Organizational Redesign

The proposal of organizational redesign took into account the *Theory of Organizational Development* of Gallbraith and Mintzberg. From Gallbraith has been taken his Star Model Framework which consists in a “series of design policies that are controllable by management and can influence employee behavior”(76, 77). The Star Model Framework is composed of five elements that interact among themselves with the aim of providing the organization with self-

identity and the possibility to comply with its institutional objectives. These elements are: 1) the strategy, which determines vision, mission and direction, 2) the structure (design of organizational structure), which defines the distribution of power and authority, the roles in the organization establishing the relations of dependence, the mechanisms of coordination, 3) the processes which include the tasks to be carried out and the associated information flows, 4) the incentives to carry out and tackle the objectives of the organization, and 5) human resources policies, which will influence and define the profile of the staff(76, 77).

**Figure 5. Main components of the organizational design (star model)(76)**  
Star Model adapted



Source:Adapted of The Star Model. JR Galbraith

Gallbraith gives great importance to the relationships which may arise among each one of the elements of the Star, having as an assumption the possibility to adapt quickly the organizational design to the context wherein the organization develops. However, this situation is usually observed in the private sector but not so much in the public sector. In order to balance this approach, the technical assistance team also used the conceptual framework made by Mintzberg, who defines the organizational design on the basis of functions regularly exercised by key structural elements(78). These elements are five: the strategic apex, the techno-structure, the support staff, the middle line and the operating core (79).

The strategic apex is the element in charge of making the organization able to fulfill its mission in an effective way; in our case, the mission is defined by the Regional Government.

The middle line secures both, the vertical and horizontal integration. Vertical integration is related to the level of consistency among the activities carried out by the strategic apex and the operating core. In its turn, the horizontal integration is defined by the level of coordination existing among and within the operating units.

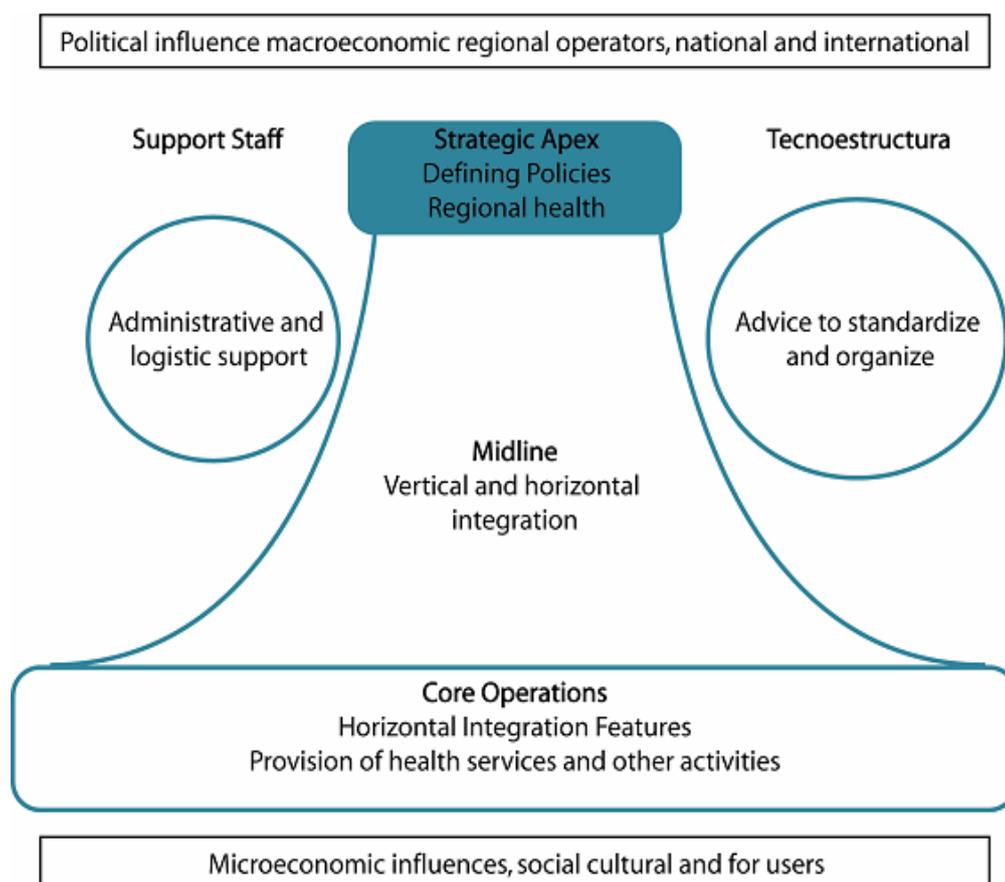
The techno-structure is the component of the organizational structure in charge of carrying out the evaluation tasks. This component provides technical advice with the aim that those decisions are made that shall affect the organization.

The support staff is the specialized component in charge of providing indirect services to the whole organization but its work is located outside the operational work flow.

The operating core is the component that fulfills the institutional mission. In our case, the operating core is the health services providers units.

According to Mintzberg, these structural components inter-relate among themselves through (1) mechanisms of coordination (adaptation or mutual adjustment, direct supervision, standardization of processes, standardization of products, standardization of abilities, standardization of rules), (2) development of the preeminence of one of the parts of the organization above the others, with some type of decentralization (i.e. the dissemination of power in order to make decisions), this produces different types of configuration. On the basis of the above mentioned facts, Figure 6, shows graphically the simplified configuration of a regional system of health on the basis of these five components.

**Figure 6. Design of the organizational structure of a HRD.  
Mintzbergs Model on Organizational Structures  
Adapted**



Source: Mintzbergs Model from Unger et al(80)

#### 4.2.2 Proposal of organizational redesign

The USAID|PRAES Project provided technical assistance to Regional Governments of La Libertad, San Martín and Cajamarca regarding their RHDs' organizational redesign within of the Regional Government institutional adaptation and the decentralization legal framework(81). Taking as reference the Star Model Framework, the sequence of steps followed was, in the first place, the definition of the scope of its redesign, thus, establishing its objectives. The corresponding working commissions had to articulate a process of reorganization with that of

their own regional governments. A second moment corresponded to the definition of the institutional strategy, reformulating its institutional missions and visions and adding the guiding principles and values of its functioning. A third moment corresponded to the managerial analysis of the transferred functions. This step was critical to know what capacities to strengthen when implementing the proposal. Also, this analysis allowed the assignment of the received competences to the regional government. The next step corresponded to the configuration of the organization having as criteria of specialization: regulatory-service rendering, administrative-technical, among others(81).

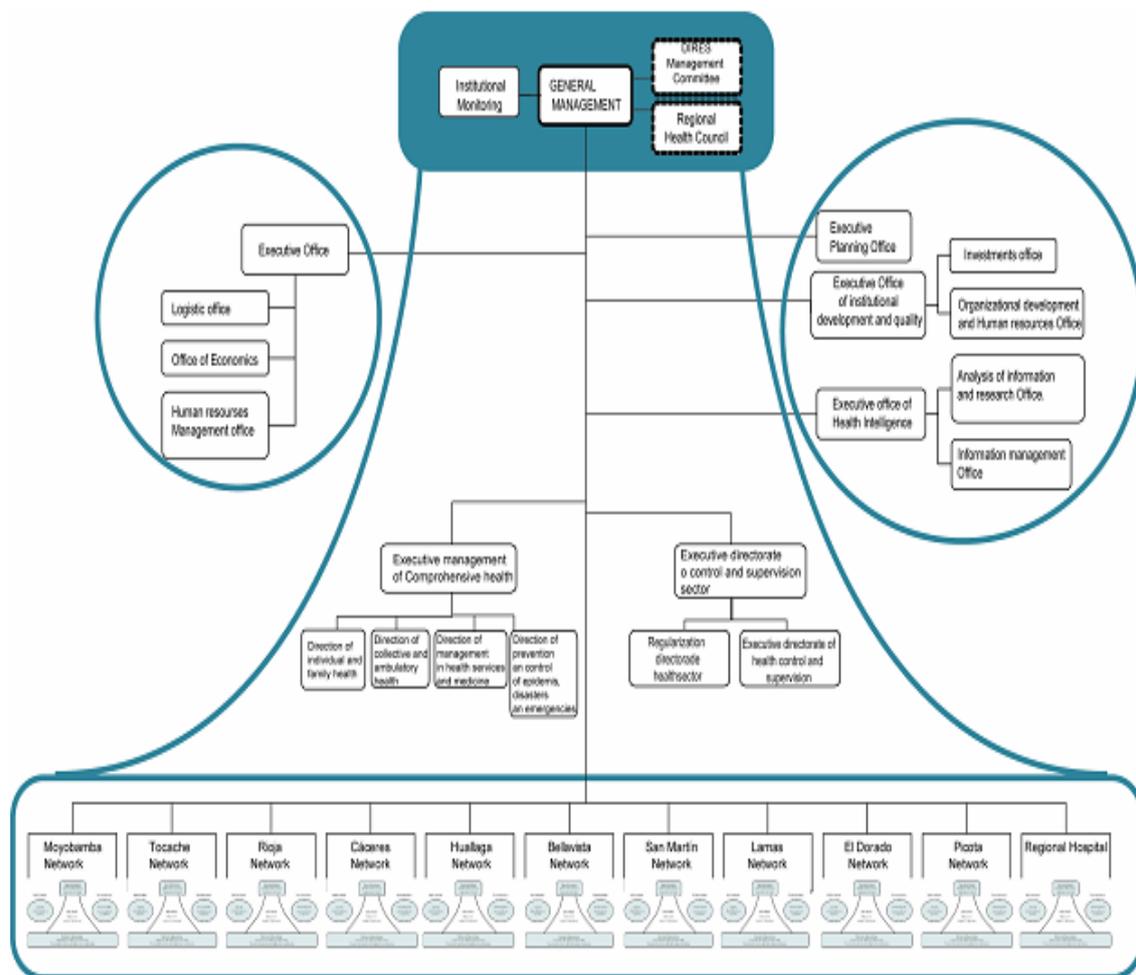
The structural and functional analysis proposed by Mintzberg permitted to place the analyzed organic units within a more explicit organizational design (Table 10 and Chart. 7).

**Table 10. Arrangement of organic units of a RHD according to Mintzberg’s Typology**

Criteria of Specialization	Types of intervention	Organic Units
Strategic Apex	Top Management	General Management Office Body of institutional control Management Board Health Regional council
Middle Line (by function)	Regulation of Health Services	Executive Office of Comprehensive Health Care Executive Office of Sectoral control and supervision
Support Bodies	Management resources Logistics Economy Human resources	Executive Office of Management (Office of Logistics) (Office of Economy) (Human resources Management Office)
Counseling Bodies	Requirements of counseling: Planning Institutional Development HHRR Development Information Analysis	Executive Office of Planning Executive Office of Institutional Development and Quality Executive Office of sanitary intelligence
Operating Bodies	Provision of health services	Health Networks Health Micro networks and its health facilities

Source: USAID (Perú) Health Policy Reform

Figure 7. Typical organizational structure for a Regional Health Directorate



Source: USAID|Perú|Health Policy Reform

### 4.2.3 Proposal for institutional capacity strengthening

The transfer process of health functions began in 2005 and formally ended in 2009. Its institutional capacity building process was aimed at strengthening regional capacities on human resources, to improve the performance of the functions transferred. It had to overcome previous unsuccessful attempts, as summarized in the following table 11:

**Table 11.**

Year	Responsible	Advances	Outcome
2005	Decentralization Office and AMARES Program	Capacity building plan for the decentralized management of health functions	Not formally approved or implemented.
2005	Decentralization Office	Design of a Diploma in Decentralization of Health.	Unfinished design, not implemented
2006-2007	MoH units	Training on performance improvement in areas defined by the MoH,	Too short, not articulated on the central-decentralized balances between MoH and RHDs
2008	Decentralization Office and USAID PRAES	Diploma on decentralized management at the local level.	Not executed due to budgetary restrictions
2008	MoH (Intergovernmental Coordination Committee for Capacity Building)	Annual Training Program linked to annual transfer plans.	Not articulated to regional processes, and not financed.

Source: USAID|Perú|Health Policy Reform

In 2009, USAID|PRAES presented a building capacity proposal for the decentralized management of health functions within RHDs(82). The proposal entailed two perspectives: the institutional and the personal. The institutional component contemplated the structure, and processes in which the RHD staff would regularly perform its duties. On the personal component, the proposal considered the competencies needed to obtain a satisfactory individual performance that would also have an impact on the institutional performance of the RHD.

The proposal was the core of the Performance Improvement Plan of the RHD, and was to be articulated to the Institutional Strategic Plan. It had an intervention plan developed in three components:

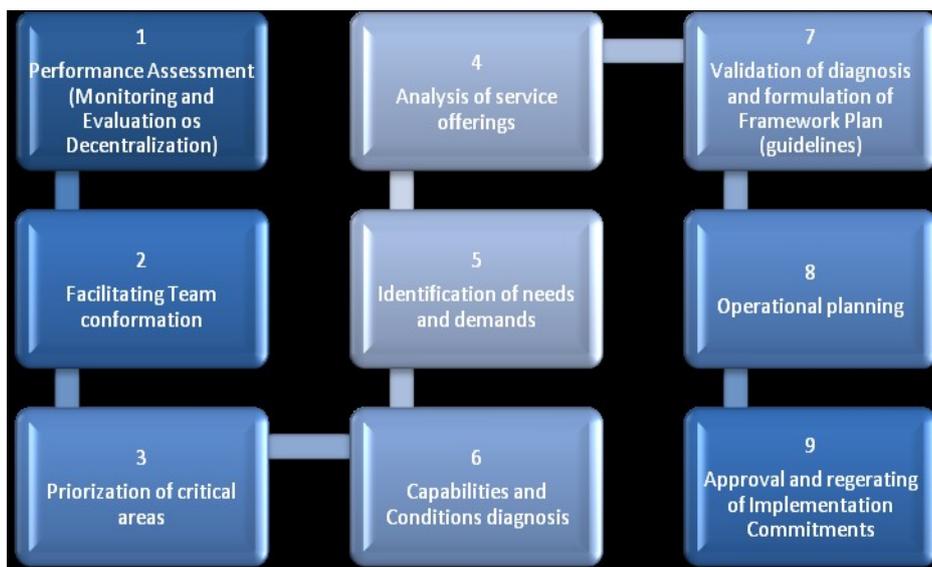
- Capacity building on staff linked to critical management areas.
- Technical assistance to prioritized functional areas
- Creation of physical conditions necessary for the proper performance of functions transferred.

The Plan required for its execution the following aspects:

- Feedback with the monitoring of the deployment of decentralized health functions and the organizational redesign process(71).
- Involvement of the RHD human resources teams.
- A short-term plan and a medium-term plan, both of them approved by the RHD.

Methodologically the plan was developed according to the steps shown in figure XX. The approach was socialized with each region, and each RHD associated the execution of these strategic plans and annual capacity building plans with its organizational redesign.

**Figure 8. Capacity strengthening process**



Source: USAID|Perú|PRAES

### 4.3 Organizational redesign of La Libertad RHD

#### 4.3.1 Reorganization process at La Libertad RHD

##### 5.3.1.1 Phases of the process of organizational redesign

This section describes the transition of La Libertad Regional Health Authority (RHA) as a MoH's de-concentrated body into a RG decentralized body. (See: Table N° AA). This transition establishes also the administrative dependence of the RHAs with regard to the RG and the technical-regulatory dependence with regard to the MoH.

**Table 12. Norms and Regulations of the transition of RHD as de-concentrated body into a decentralized body of the MoH**

Period	Topic	Norm	Content
November 2002	Establishes and regulates the structure, organization, competences and functions of RGs.	Organic Law of RGs (9)	Regulates the structure, organization, competences and functions of RGs.
December 2002	The Regional Health Directors are under the authority of MoH and the RG	Law modifying Organic Law of RGs (10)	Regional Health Directors are responsible for the implementation and execution of national and regional policies at the sectoral level within the regional territory. They are under the authority of MoH and the respective Regional Directorate of the RG, to whom they are accountable.
December, 2006	The RHA, depends of the corresponding Regional Directorate of the RG	Law regulating the Transitional Structure of the RHDs (83)	"The RHDs are bodies depending of the corresponding Regional Directorate. They are in charge of the specific sectoral functions in the scope of the RG".

Source: USAID|Perú|Health Policy Reform

In La Libertad RG, the process of organizational redesign of RHD was initiated formally in 2008. That year, the process of transfer of functions in health from the national to the RG in La Libertad RG finalized (84). Within this context, the RG asked for technical assistance to USAID/PRAES in order to build a proposal of organizational redesign of the RHD.

*"This RG thought that it would be better to have a flat direct structure as the Office of Social Development did not fulfill its important articulating role, and that it was better for the general management to deal directly with the sector RHDS. However this implied for us to have many Offices of Management. This system is unmanageable because you can coordinate and meet with eight, nine manager but here were are more than twenty."*

*Gerente Regional de Desarrollo e Inclusión Social*

In 2008, the executive boards of the RG constituted Sectoral Regional Directorates; therefore, La Libertad RHD was the new La Libertad RHD depending directly of the General Management of the RG (85). With this measure, the Managerial Office of Social Development and the Managerial Office of Economic Development disappeared and RG structure was flattened. Until that moment, the Managerial Office of Social Development was formally in charge of the articulation of education and health sectors, but without success. This fact put in evidence the weaknesses of this body to lead the Social

policy within the framework of the decentralization process.

In September of 2011, the Managerial Office of Social Development of the RG is reactivated under the name of Managerial Office of Development and Social Inclusion (GDIS) (86).

This process of flattening of the RG structure implied that the Managerial Office of Development and Social Inclusion were located at the same level of the rest of the Sectoral Offices. This fact initially was perceived as a serious difficulty for its functioning as responsible to lead the Social policy and the imperative need to articulate with the sectors involved in that task, like health and education. These facts were relevant to sustain the development of the redesigning in La Libertad RHD.

The analysis of this process will have two dimensions: an objective perspective through the revision of the relevant regulatory framework and technical documents; and a subjective perspective, through the perception of the regional actors<sup>2</sup>.

In this sense, the dissolution of the Managerial Office of Social Development let La Libertad RHD lead the social policy in health. This fact gave La Libertad RHD more possibilities to work with local governments, through what they called "the territorial management" with the subscription of *Territorial Agreements at the province level and the Trans-Sectoral Agendas* at the district level<sup>3</sup>.

---

<sup>2</sup> For formulating the present document a rapid qualitative evaluation was carried out regarding the process of reorganization of RHDS in the regions of San Martín, Cajamarca and La Libertad, within the framework of the process of decentralization. This evaluation consisted in the execution of qualitative interviews to key informants. In this sense, the regional actors must be understood as being the officials interviewed of the referred RHDS.

<sup>3</sup> The Territorial Pacts are developed at the level of the provinces and establish in a participating manner, the health priorities and the determinants of health. The trans-sector agendas establish responsibilities and commitments of the sectors involved in facing the priorities identified within the framework of the Territorial Pact.

These strategies were considered as one of their main accomplishments due to the positive impact in health indicators.

The design of a proposal of organizational redesign, with the technical assistance of USAID|Perú|PRAES, was one of its principal landmarks, and was finished in August 2008, through a participative process. Also, the proposal of the Organization and Functions Regulation of La Libertad RHD and its corresponding technical document, were formulated.

*“The great contribution of the work with PRAES was the definition of the kind of structure we need to face our nine regional health priorities as a decentralized unit of the Ministry of Health and as a de-concentrated Unit of the RG. Then, we carried out the restructuring of our areas, of our offices in the RHD, in order to comply with the regional policies, with the health priorities, and with the five axes of policies that we had to initiate in order to accomplish the health results in the future.” Regional Manager of Health – La Libertad RG*

In May 2011, it is approved a new Structural Organization Chart and the Organization and Functions Regulations of the RHD (87). It is worth mentioning that, with some changes, it was assumed almost all the proposal of organizational redesign.

In September of the same year, according to the new Structural Organization Chart and the Organization and Functions Regulations of La Libertad RG, the functions of the RHD were established, as well as the composition of its organic units and de-concentrated bodies (86). The previous Executive Offices turned into Sub-Offices. In response to this, the RHD declared itself in restructuring and modified its management documents (ROF, MOF, ST), through a Committee of Restructuring directed by the Executive Office of Development, Innovation and Research.

Regional stakeholders consider that the reorganization process began in 2007, with the definition of health priorities within the *Participative Health Regional Plan for La Libertad 2006 – 2010* (PHPR Salud)<sup>4 5</sup> and the building of a Regional Health Policy agenda(53, 54, 88).

For regional actors, the definition of the Regional Health Policy started the shift towards the *territorial* approach for health management. This approach was made possible through the subscription of Territorial Agreements and Trans-Sectoral Agendas with Local Governments, involving them in health issues and promoting investment in local health priorities, as stated within the Organic Law of Municipalities(13, 88).

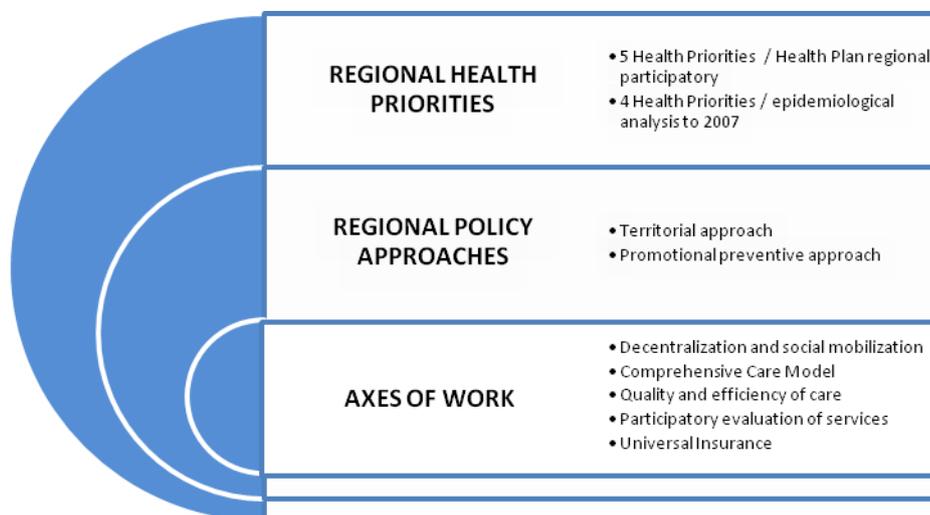
As synthesis, it can be said that the organizational redesign of La Libertad RHD, is carried out within the RG institutional adaptation, and looks after the generation of a decentralized structure for the exercise of the transferred health functions regarding direction, essential functions and support functions (72).

---

<sup>4</sup> Regional health priorities were defined by means of citizens’ consultation: Diarrheas, Respiratory Infections/pneumonia, unwanted pregnancies, intra-family violence, crime and gangs. Later, four additional priorities which were added in 2007: maternal-infant mortality, malnutrition, communicable disease, cancer.

<sup>5</sup> PHPR Salud was prepared with the technical assistance of USAID|Perú|PHR plus.

**Figure N° 9: Regional Health Policies. La Libertad 2007 – 2012(53)**

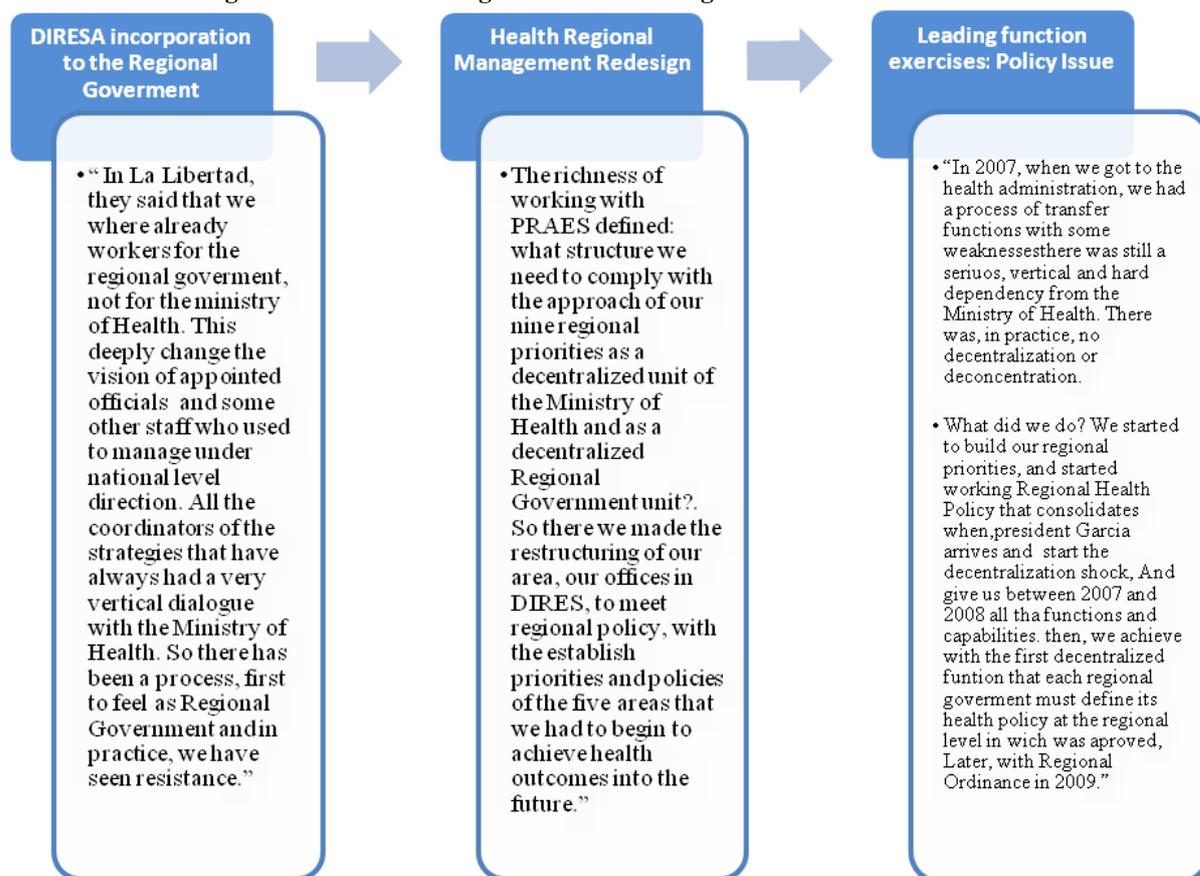


Source: USAID|Perú|Health Policy Reform

Regional actors consider that this process is unfinished. The redesign process is not only a structural and functional change but also the building of a new organizational culture where regional health workers feel themselves as part of the RG instead of the MoH. For regional actors, the Regional Health Policy is a symbolic reference to understand the RHD as the regional health authority, because: a) it expresses the exercise of the governance function especially in the management of policies (86)<sup>6</sup> and b) it establishes strategies, approaches, and axis of work in matters of health.

<sup>6</sup> The governance function is expressed through the faculty of formulating, executing, evaluating, managing, controlling and administrating the policies of health of the region in accordance with the national policies and the sector plans.

Figure 10. Process of Organizational Redesign in La Libertad RHD

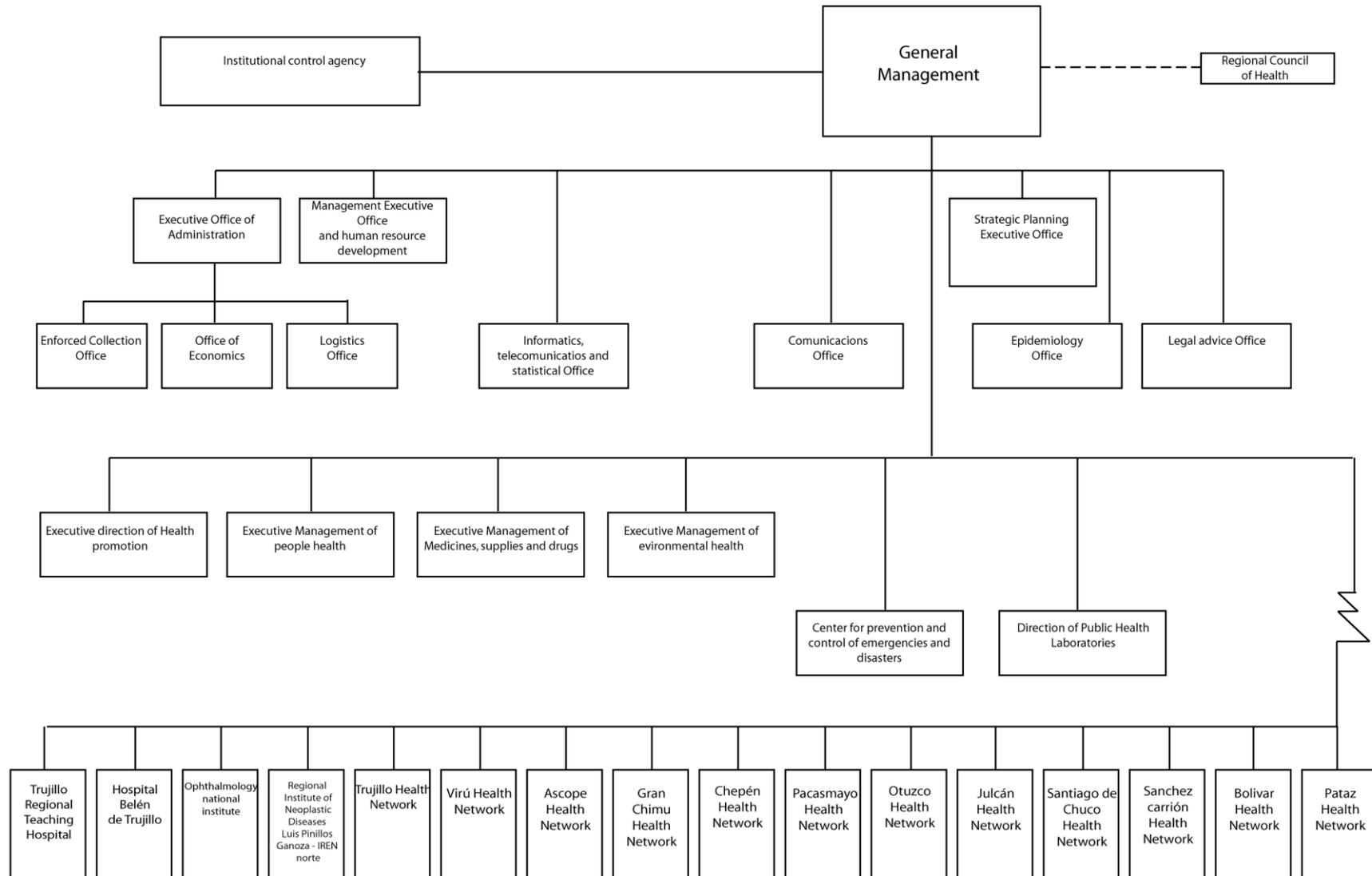


Source: Interview to Health Regional Manager – La Libertad. USAID|Perú|Health Policy Reform

### 5.3.1.2 Organizational structure of the RHD La Libertad before the process of reorganization

The organizational model of the RHD La Libertad before the process of organizational redesign was effective from 2006 until 2011 and is shown in figure 11 (89, 90).

STRUCTURAL ORGANIZATION HEALTH MANAGEMENT LA LIBERTAD



### 5.3.1.3 The proposal of the organizational model

The proposal of organizational redesign of the RHD La Libertad was developed with the technical assistance of USAID|Perú|PRAES through several technical meetings and workshops which were attended by experts, officials and workers of what was at that time the RHD La Libertad. None the less important was the participation of networks and micro-networks of the region.

The organizational model proposed is the product of three types of analysis:

1. *Functional Analysis*: Responds to the exercise of the functions transferred to the RGs where the RHD assumes the health authority at regional level, as decentralized body of the Ministry of Health and de-concentrated body of the RG.
2. *Structural Analysis*: It is based on the criteria of geographical or territorial scope and specialization by type of intervention.
3. *Analysis of consistency*: Emphasizes the level of organic structure as well as the development of the functions of the bodies of line and their units, in the establishment of responsibilities for formulation, execution and evaluation of public policies required to comply with the strategic objectives and axis outlined. It considers the Regional Policy of Health of La Libertad that defines the principal axis of the work on which the health labor of the region takes place(88).

#### *Objectives of organizational redesign*

The RG oriented its role towards the following objectives:

- Optimize the RHD structure for attaining an effective fulfilling of its goals.
- Promote a new organizational culture that summons all the actors in the process of change.
- Make as efficient as possible the RHD's resources and processes to achieve its institutional objectives.
- Strengthen the regional public network for provision of health services.

#### *Criteria for the organizational redesign of the RHD La Libertad*

Two different criteria for definition of the structure of the RHD La Libertad have been used:

- a) **Territorial Criterion.** This was considered as principal criterion. As a consequence, Health Networks continued as specialized de-concentrated bodies due to their distinctive geographical locations as well as their different epidemiological, social, economic, and cultural conditions.
- b) **Specialization Criterion.** The organic units of the RHD are organizations centered on health care as well as sectoral regulation and inspection.

#### *Definition of Institutional Vision and Mission*

**Vision:** La Libertad RHD contributes to human development with social justice through the generation of healthy environments, a better health status for the population, inter sectoral and

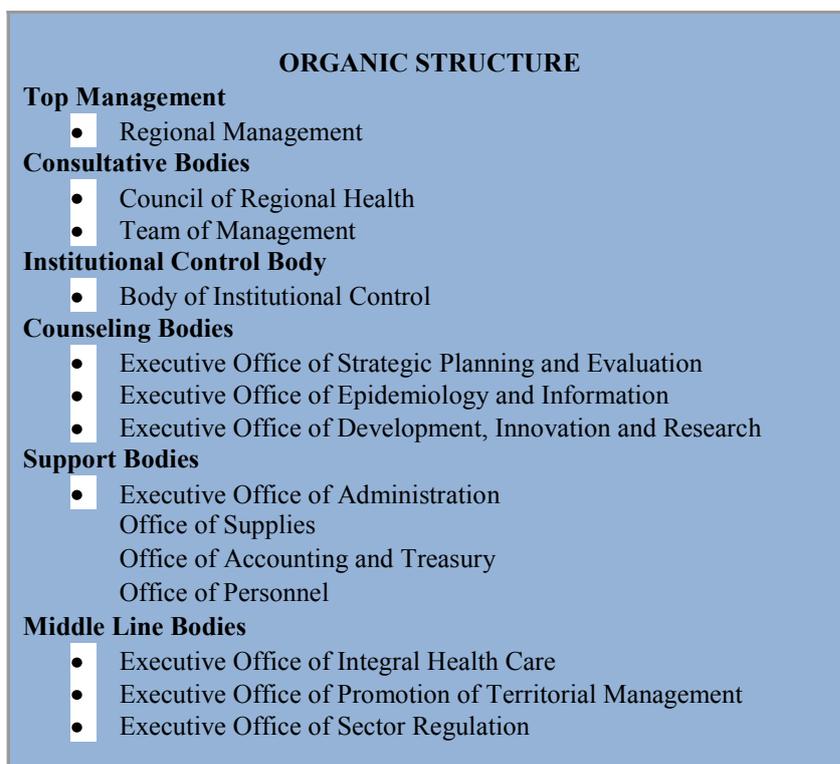
health decentralized policies, and increasing the exercise of the rights and duties of citizens on health matters.

**Mission:** The RHD is a technical body of line of the Executive Body of the RG, responsible for implementing national and regional health policies within its territorial domain in order to improve the health of the population. It is in charge of generating adequate health conditions through the integral care for people and the environment, universal health insurance, the sectoral direction, the promotion of rights and duties of citizens on matters of health with emphasis on health in the household and the community.

***Definition of functions and structure of the executive bodies***

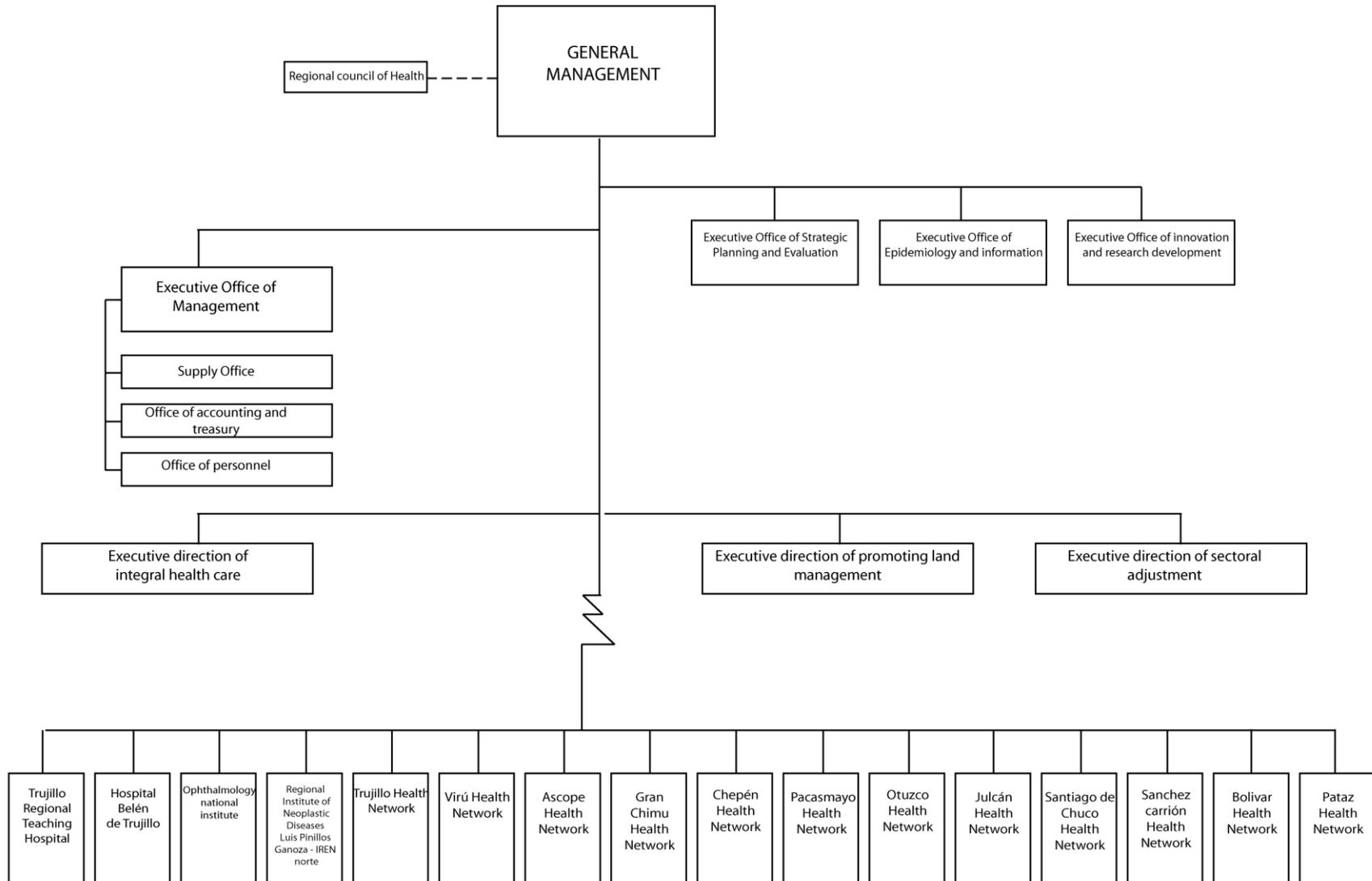
The definition of the bodies and organic units of the RHD were carried out by identifying their roles and attributions; outlining the individual duties of the units and working teams under the RHD structure. Consequently, the organic structure for the RHD was formed by bodies of top management, control, advice, support and execution, according to the Organic Law of RGs. The final version of the ROF approved in 2011 is shown in figure 12(87).

**Box 1. Proposal for La Libertad RHD organic structure**



Source: USAID|Perú|PRAES

STRUCTURAL ORGANIZATION HEALTH MANAGEMENT



### 5.3.1.4 Analysis of the current organizational structure

A brief comparative analysis between the previous organizational model and the current organizational model reveals deep changes, mainly at the middle line of the organization referred to:

- The creation of bodies for exercising typical functions of the new organizational model, such as the Executive Office of Sectoral Regulation.
- The re-sizing of some functions as in the case of the Executive Office of Promotion of the Territorial Management,
- The dissolution of the Executive Office of Medicines, Supplies and Drugs and the Executive Office of Environmental Health<sup>7</sup>.

Likewise, other bodies have been dissolved:

- Consultative bodies: Regional Council of Health, Committee of Management
- Counseling Bodies: Executive Office of Legal Advice
- Support Bodies: Executive Office of Management and Development of Human Resources, Office of Data-Processing, Telecommunications and Statistics<sup>8</sup>.

Hereunder follows a more detailed comparative analysis between the previous organizational model and the current organizational model in force (Table 13):

**Table 13. Analysis matrix of the organizational design of the La Libertad RHD.**

#### Top Management

Deconcentrated Body	Decentralized Body	Implications
General Management (89)	RHD (86, 87)	The functions assigned to the General Management in the ROF correspond to a Regional Authority. It is the leading authority in health, and directs and controls the formulation and implementation of health policies in the region.

<sup>7</sup> Their functions were assigned to the Executive Office of Integral Care and the Executive Office of Promotion of the Territorial Management, respectively.

<sup>8</sup> Their functions were been assigned to the Executive Office of Development, Innovation and Research and the Office of Epidemiology and Information, respectively.

**Control Body**

Deconcentrated Body	Decentralized Body	Implications
Body of Institutional Control	Body of Institutional Control (BIC)	Previously BIC was dependant on the RHD.

**Consultative Body**

Deconcentrated Body	Decentralized Body	Implications
Regional Council of Health	Does not have	<p>The Regional Council of Health was deactivated in 2008, since it turned into conflict generating instance due to the union's influence in it. CRS function has been decentralized and replaced by Territorial Agreements and Trans-Sectoral Agendas.</p> <p>The RHD Management Team is assuming the advisory role</p>

**Counseling Body**

Deconcentrated Body	Decentralized Body	Implications
<p>a. Executive Office of Strategic Planning</p> <p>b. Executive Office of Epidemiology</p> <p>c. Executive Office of Juridical Advice</p>	<p>a. Executive Office of Planning and Strategic Evaluation</p> <p>b. Executive Office of Epidemiology and Information</p> <p>c. Executive Office of Development, Innovation and Research</p>	<p>No major functional changes introduced for the planning office.</p> <p>Executive Office of Epidemiology assumes the functions of the Office of Data-Processing, Telecommunications and Statistics.</p> <p>The most important change is the creation of the Executive Office of Development, Innovation and Research, which assumes the functions of the Executive Office of Management and Development of Human Resources.</p>

**Support Bodies**

Deconcentrated Body	Decentralized Body	Implications
<p>a. Executive Office of Administration Office of Logistics Office of Accounting and Treasury Office of Personnel</p> <p>b. Executive Office of Management and Development of Human Resources</p> <p>c. Office of Data-Processing, Telecommunications and Statistics</p> <p>Office of Communications</p>	<p>a. Executive Office of Administration Office of Logistics Office of Accounting and Treasury Office of Personnel</p>	<p>No changes in the Executive Office of Administration.</p> <p>Human Resources Development functions transferred to the Office of Development, Innovation and Research.</p> <p>Information management has been transferred to the Office of Epidemiology and Information</p>

**Middle Line Bodies**

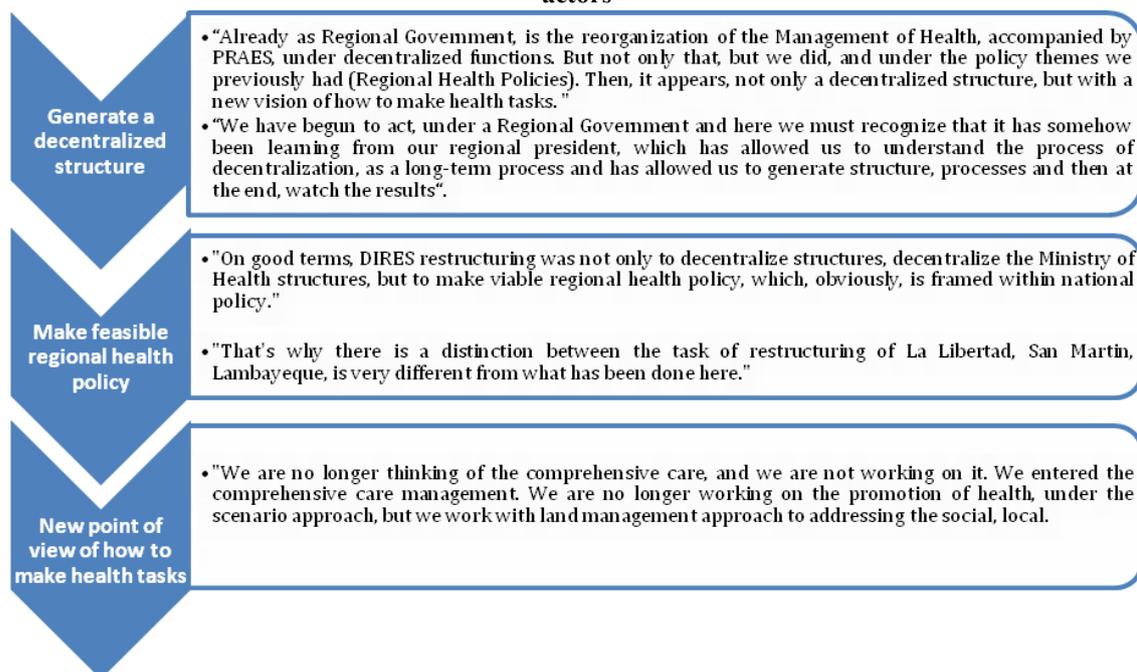
Deconcentrated Body	Decentralized Body	Implications
<p>a. Executive Office of Health Promotion</p> <p>b. Executive Office of Health of People</p> <p>c. Executive Office of Medicines, Supplies and Drugs</p> <p>d. Executive Office of Environmental Health</p>	<p>a. Executive Office of comprehensive Health Care</p> <p>b. Executive Office of Promotion of Territorial Management</p> <p>c. Executive Office of Sectoral Regulation</p>	<p>Executive Office of Sectoral Regulation and the Executive Office of Promotion of Territorial Management represent innovations over convention organizational designs.</p> <p>Emphasis is given to local governments and their participation in health.</p> <p>DIREMID is dissolved and its functions were absorbed by the Executive Office of comprehensive Care</p> <p>DESA is dissolved and its functions were absorbed by the Executive Office of Promotion of Territorial Management.</p> <p>Organizational changes are under way, since normative documents are not consistent. Regional mandate is consistent with the proposal while the RHD ROF is consistent with the past structure.</p> <p>In sum, changes introduce two additional bodies of line different from those established in the previous ROF, for the strengthening of territorial health management</p>

**Operational Bodies**

Deconcentrated Body	Decentralized Body	Implications
Health Networks	a. Ophthalmology Institute b. Neoplastic Northern Regional Institute c. Trujillo Regional Hospital d. Belen Hospital e. Health Networks Directorates	La Libertad is one of the few regions having a RHD with high complexity de-concentrated bodies (Ophthalmology Institute and Neoplastic Northern Regional Institute).

For regional actors the foundations of the organizational redesign are to: a) generate a decentralized structure to respond to the exercise of the transferred functions by the RHD as main health authority; b) make feasible the regional policy of health; c) establish regional strategies capable to respond to the work of the health authority. See Figure N° 13.

**Figure 13. Fundamentals of the organizational redesign of the RHD, according to the regional actors**



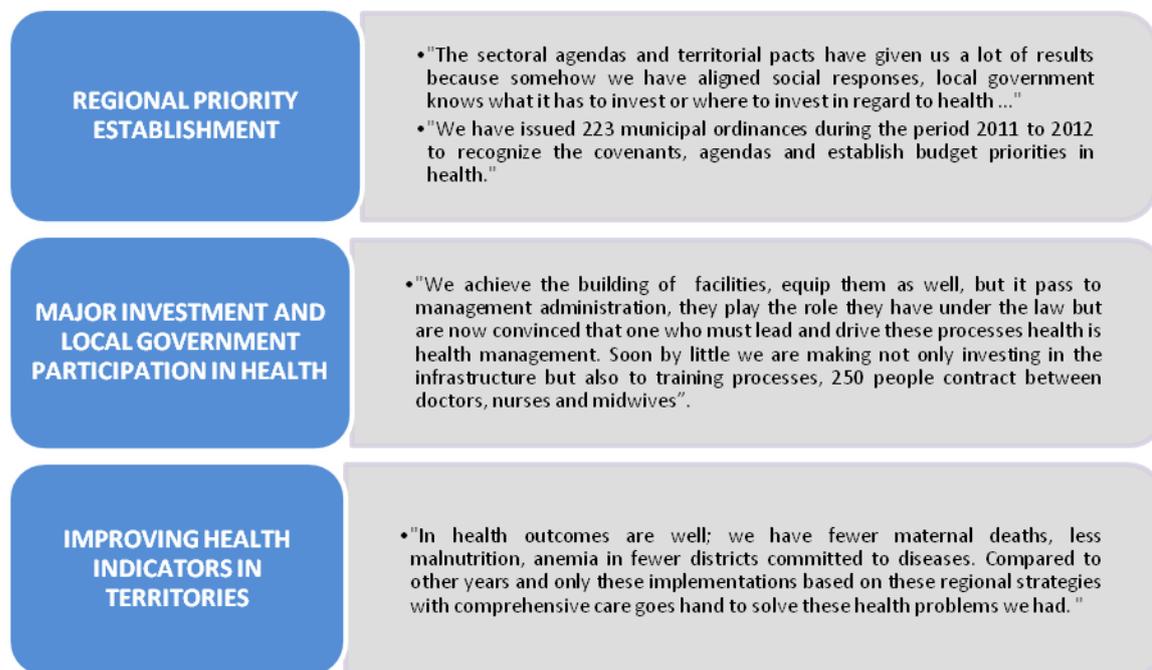
Source: Interview to Regional Manager of Health – La Libertad. USAID|Perú|Health Policy Reform

The *territorial management approach* is considered one of their principal accomplishments, due to the positive health impact observed in terms of health indicators. The work carried out with local governments promotes their participation and boost health investment in the territories. This work starts with the participative identification of health priorities, its determinants in the Territorial Agreements (provinces) and the multi-sectoral intervention through the trans-sectoral

agendas (districts). A subsequent step is the generation of public policies that recognize the Agreements and Agendas and assign the corresponding budgets for their implementation.

The sequential logic of territorial management is the following one: a) identification of health priorities and determinants of health in the territories b) Participation and investment in health by local governments c) Improvements of health indicators in the territories. See Figure N° 14

**Figure 14. Accomplishments of territorial management**



Source: Interviews to Regional Health Manager, Sub Manager of Promotion of Territorial Management, Director of the Office of Development, Innovation and Research. La Libertad RHD. USAID|Perú|Health Policy Reform

#### **4.3.1.4.1 Organizational adaptation of the Networks of Health**

In an interview, Officials reported that the adequacy of health networks, according to the new organizational model, is a pending issue. They mentioned that one of his main concerns is to strengthen networks with administrative staff, with the aim of decentralizing management tasks on these financial resources for budget execution, timely and efficiency.

#### **4.3.2 Development of Institutional Capacities**

Officials of the Health Management rated the institutional performance as outstanding and qualitatively significant for a decentralized management rectory on increased health and driving capabilities of the sector in the region.

Regarding to the process of institutional capacity building, the Health Management was experienced that have contributed to its current organizational performance, with the support and technical assistance from USAID/Peru/PRAES, such as the development of Decentralized Management Diploma (Local PROGRESA) which was aimed to strengthen capacities for the health decentralized management.

The formulation of an Institutional Performance Improvement Plan, consisting of a systematic capabilities assessment, as well as conditions, needs and institutional demands to achieve optimal

performance of the decentralized functions, and the development of strategies aimed to strengthen the critical priority.

However, none of the two experiences came to an end; it was not possible to complete all modules under PROGRESA, and the Institutional Performance Improvement Plan was not implemented; in both cases due to reasons of budget availability.

Currently, management is implementing its Development Plan for People which is aimed at strengthening personal capabilities (human workforce), by a) the ongoing evaluation of health staff performance and capabilities; b) the provision of post degree programs for professional and c) working with universities through an instance called Regional Council for Undergraduate (RCU) that calls for universities, teachers and health care providers to approach issues associated with the training of professionals health in the region at the undergraduate and graduate level.

### 4.3.3 Factors conditioning the process

Several factors have facilitated the formulation and implementation of the new organizational model of Health Management, which are classified as follows:

**Technical Factor:** The organizational redesign technical proposal is consistent with the objectives of creating a) a decentralized organization to produce quality health services, b) regulate the health care market and c) exercise the conduction system at the regional level; d) consideration of a new organizational model for networks and micronetworks. This organizational model represents the transition from a sectoral to a territorial approach, considering that development is a complex process for the understanding of the territory reality and the necessary connection and coordination between various sectors for a comprehensive approach to health problems.

The proposal was validated with the participation of all involved stakeholders, including the Civil Society. It was finally approved on 2011.

**Institutional Factor:** At an institutional level, proper conditions to start an organizational redesign were:

a) The participation of headquarters technical teams and the concerted instances, b) the permanency of experienced technical teams who know the dynamics of the organization and its main strengths and weaknesses c) management leadership to support the deep changes that took place at the structural, functional and cultural level (organizational culture) and d) There was also a shared perception about the obsolescence of the previous organizational model in the context of decentralization.

**Political Factor:** The organizational redesign of the Health Management is aligned to organizational adaptation process of the Regional Government and as such has the backing and political support from the highest regional authority. This has allowed institutionalize the process and establish the commitment of all staff within the management, making it binding.

The redesign of proposal was not only technically feasible but also politically consistent, obeying the need to create an organizational model of health capable of performing the functions transferred, strengthen the health authority, and be a decentralized and specialized body of the Regional Government.

#### **4.3.4 Balance of the reorganization process of the RHD within the framework of the decentralization and the exercise of transferred functions**

A balance of the reorganization process of the RHD within decentralization should answer the following questions:

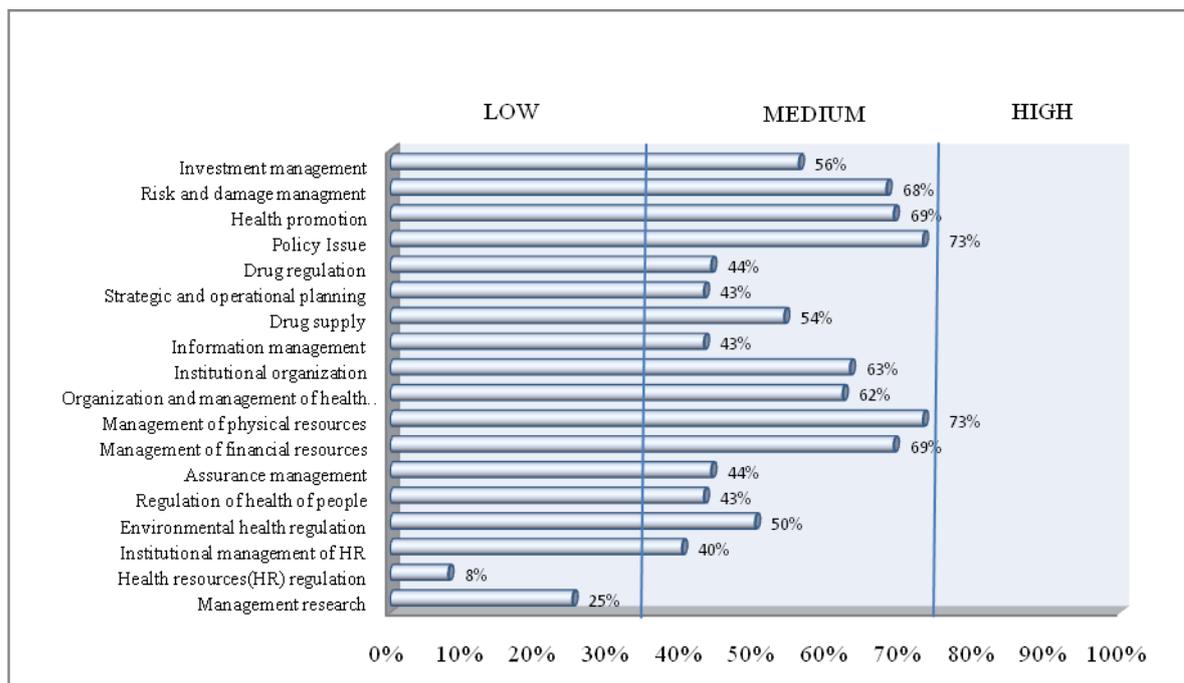
- Does the structure generated from the organizational redesign serve to the exercise of transferred functions?
- What is the perception of the regional actors with regard to the exercise of the functions?

The answers are facilitated by the results provided by the application of the Instrument of Monitoring and Evaluation of Decentralization in Health – MED (72). MED involves a qualitative tool of monitoring the exercise of transferred functions in health to the regional governments. It measures perceptions of key actors linked to the system of regional health. The methodology defined for this monitoring was self-evaluation through sessions of discussion and regional workshops.

MED was applied nationwide in 2009, by the Office of Decentralization of the MoH, under the name of “MED-Regional, Volume 1”(71), and helped to establish the decentralization baseline after the formal transfer of faculties. The results of “MED-Regional, Volume 1” for the Regional Government of La Libertad were the following(72):

1. La Libertad is among the three regional governments with the highest level of fulfillment in the exercise of functions in terms of global exercise, (considering the 16 functions).
2. La Libertad RG was exercising 51% of functions transferred. This regional government complied best the following functions: Stewardship (59%, Medium), Support (51%, Medium) and, Essential functions (49%, Medium).
3. Specific functions that were best exercised were Policy Management, Physical Resources Management, Risks and Damages Management facing Emergencies and Disasters, of Health Promotion and Financial Resources Management. Functions with medium-low exercise were Public Insurance Management, Strategic and Operative Planning, Regulation of Health for People, Regulation of Medicines, Management of Information and Human Resources. There was a low exercise in only two functions showed (Sectoral Regulation of Human Resources and Management of Research).

**Graphic N°1: Exercise of the health functions transferred in 2009, La Libertad**



Source: MoH. Office of Decentralization. 2010

The previous result is the reference for setting comparisons in the current context. A rapid qualitative evaluation was executed through qualitative interviews to key informants in order to know the perception of regional actors regarding the exercise of some priority functions (stewardship and essential). The results are the following ones:

**Table 15. Qualitative assessment of the function performance by La Libertad RHD strategic apex.**

Function	Bodies which exercise the function	Comment
Management of policies	RHD Executive Office of Planning and Strategic Evaluation.	<p>Stewardship functions, (e.g. policy management), have been strengthened in the last four years. La Libertad RHD demonstrates a significant advance in its capacity to exert health governance.</p> <p>The development and approval of the Regional Health Policy 2007 - 2012 and the "territorial management approach" has helped local governments to promote the creation of local health policies.</p> <p>The Regional Participatory Health Plan "La Liberty "2006 - 2010 has been foundational in the capacity building regarding regional health policy formulation.</p> <p><b>MED information:</b> MED Regional - Volume 1 (2009) driving functions for the Regional Government of La Libertad were rated as better compliance and policy management feature set with the highest score (73%).</p>

**Table 16. Qualitative assessment of the function performance by La Libertad RHD technostructure**

Function	Bodies which exercise the function	Comment
Strategic and Operative Planning	RHD Executive Office of Planning and Strategic Evaluation	The exercise of this function is limited.  Regional Health Management with adequate planning capacities as revealed by the preparation of Regional Health Plan 2007-2012 and the Regional Participatory Health  Significant difficulties for monitoring and evaluation duties. Limitations on their information system to support activities of strategic and operational planning.  <b>MED information:</b> The exercise of this function was rated medium low (43%) in the Regional MED - Volume 1.

**Table 17. Qualitative assessment of the function performance by La Libertad RHD support staff**

Function	Bodies which exercise the function	Comment
Institutional organization	Executive Office of Development, Innovation and Research	The level of performance of this function is high.  Regional Management of Health started its reorganization process in 2011 in accordance to the decentralization process.  Its achievement was the construction of a decentralized structure, in keeping as a regional health authority.  Currently, is working on the modification of its management documents and implementing its capacity building plan.  <b>MED information:</b> The exercise of this function was rated high in the Regional MED - Volume (63%)

**Table 18. Qualitative assessment of the function performance by La Libertad RHD middle line**

Function	Bodies which exercise the function	Comment
Sectoral regulation of health of people.	Executive Office of Sectoral Regulation	The exercise of this function is incipient. There is scarcity of staff with the right profile for the exercise of this function.  <b>MED information:</b> The exercise of this function was rated as medium low (43%) in the Regional MED - Volume 1.
Organization and management of health of people, environmental and occupational health services.	Executive Office of Comprehensive Health Care Executive Office of Promotion of Territorial	RHD has created teams for articulation of health promotion and health management with local governments. Local governments share part of the financial burden of increasing operational capacity and health personnel contracting (the latter for health promotion activities).  Civil participation has been promoted through the so called Communal ECOS S in Health

Function	Bodies which exercise the function	Comment
	Management.	<p>Main emphasis in increasing response capacity of the first-level facilities</p> <p><b>MED information:</b> The exercise of this function was rated as medium low (43%) in the Regional MED - Volume 1.</p>
Management of public insurance	Executive Office of Comprehensive health Care	<p>The exercise of this function is still under development.</p> <p>Main achievements are related to the capacity building with local governments on insurees' affiliation, and deploying communicational campaigns for the promotion of public health insurance</p> <p>Main achievement are related to the increase in the rate of SIS affiliation among pregnant women and children.</p> <p>No relevant advancement on the strategic purchasing and contracting of health services with non public providers</p> <p>No relevant advancement on accreditation of health providers for the public health insurance</p> <p><b>MED information:</b> The exercise of this function was rated medium low</p>
Health Promotion	Executive Office of Promotion of Territorial Management	<p>The exercise of this function shows the best performance based on the outstanding coordination with local governments. Special attention to the joint identification of health priorities with local governments so as to address health determinants and the signing of Territorial Agreements for Health and inter-sectoral Agendas.</p> <p>Strong technical team, in quantitative and qualitative (capacity) terms. Strong operational workforce comprised of community workers and health promoters who promote healthy lifestyles, behaviors as well as civil participation in health.</p> <p>Pending of further development are capacities to promote environmental and occupational health.</p> <p><b>MED information:</b> The exercise of this function is one that scored better (73%) in the Regional MED - Volume 1.</p>

In conclusion, there must be pointed out the following:

- La Libertad Regional Government is an advanced case of decentralization and its organizational redesign. An updated structure for complying with the exercise of the transferred functions has been done and it seems that this structure responds to the challenges that the RHD has as health authority.

- RHD had created coordinated spaces (Territorial Agreements) in order to establish conditions for decentralization from regional to local level which have been called *territorial management approach*. This approach seems to have a positive impact on regional health indicators, such as maternal mortality, malnutrition, control of transmissible diseases, among others.

## 4.4 Organizational redesign of the RHD of San Martín

### 4.4.1 Reorganization Process at San Martín RHD

In 2005, the reorganization of the RHD San Martín became a regional concern among health officials, personnel of the RHD, as well as among the organized population; in particular, the Committee of Defense of the Interests of San Martín. The objective put forward was to have an organized and implemented RHD to be a tool to help to improve the region's health indicators, for example, maternal and unborn child mortality rate, infant chronic malnutrition, malaria, dengue, among others.

Based on the guidelines defined by MoH in this period(91, 92), the process of organizational design was initiated by the structuring and functioning of a technical commission in charge of designing and proposing the institutional redesign: in the San Martín Region this commission was called the "Launching Group"<sup>9</sup>.

Simultaneously, the Regional Government requested USAID|Perú|PRAES to provide the technical assistance in order to redesign the organizational model of the RHD San Martín, as well as to provide support in formulating its management documents. So, the project provided technical assistance to the Launching Group, first, to learn about the current situation of the organizational structure of the RHD; then to prepare a consensual proposal of the new organizational design.

#### 5.4.1.1 Phases of the process of organizational redesign

The phases identified in the process of organizational redesign were:

1. Forming of the Launchig Group: when the process was initiated, in 2005, a launching group was formed for redesigning the RHD. The membership of these group suffered constant changes due to the recurrent changes at the RHD.
2. Analysis of the efficiency of current management: an evaluation was carried out of the health situation and the organizational, social and political response of the region.
3. Revision of the proposals of organizational redesign: the theoretic revision sustaining the new proposal.
4. Formalization of the new organizational redesign.
5. Socialization, discussion and adjustments to the proposal with GORESAM: instructions and guidelines were prepared together with the criteria of the organizational redesign.

---

<sup>9</sup> Launching Group ("*Grupo Impulsor*") was comprised by Dr. Neptalí Santillán; Dr. Mario Grandez; Dra. Noelia Salvador; Nurse Sofia Velásquez; Dr. José Paredes and Dr. Roger Rengifo.

6. Participative preparation of the proposal of the New Organization: this activity was re-initiated at the beginning of the year 2012. A number of workshops were carried out with the management team.
7. Implementation of the proposal of organizational redesign
8. Preparation of the regulatory and management documents (MOF, CAP, PAP, MAPRO).
9. Evaluation of the organizational redesign implementation process

**Table 19. Regional regulations based on organizational redesign process of San Martin Regional Health Directorate**

Period	Topic	Norm	Content
March 2004	Approval of the Organizational Structure, and the Rules of Organization and Functions. Health Regional Directorate.	Ministerial Resolution	Approval of Organizational Structure and Rules of Organization and Functions of San Martin Health Regional Directorate, under Ministerial Resolution No. 573-2003-SA/DM approving the Rules of Organization and Functions of Health Directorates and Health Network Directorates.
December 2008	Modification of the Organizational Structure and Rules of Organizations and Functions of the Health Regional Directorate.	Regional Executive Resolution N° 605-2008-GRSM/PGR	Reorganization Statement to the Health Regional Directorate of San Martin.
May 2009	Approval of the Organizational Structure and Rules of Organizations and Functions of the Health Regional Directorate.	Regional Ordinance N° 027-2009-GRASM/CR	Approval of the Rules of Organizations and Functions of the Health Regional Directorate.
August 2011	Restructuring Statement to the Health Regional Management.	Regional Ordinance No. 026-2011-GRSM/CR dated 03 /10/2011	Approval of the Rules of Organizations and Functions of the Health Networks.
June 2012	Approval of the Personnel Allocation Table of Networks and Micro Networks.	Regional Ordinance No. 008-2012-GRSM/CR dated 11/06/2012	Approval of the formulation for Personnel Allocation Table of health networks and micro networks.

Source: USAID|Perú|Health Policy Reform

#### 5.4.1.2 Organizational structure of the RHD SAN MARTIN before the process of reorganization

The RHD San Martín prepared its Regulation of Organization and Functions and approved its organizational model on the basis of laws issued between the years 2002 and 2005. These laws have been in force until 2009. Among them stand out the following:

- Law of the Ministry of Health and its Regulation<sup>10</sup>(93, 94)
- Ministerial Resolution that approves the Regulation of the Organization and Functions of the RHDs<sup>11</sup>(79, 95)

<sup>10</sup> As of this Regulation, it is established that the RHDs are dependent of MoH. On a similar line, therein is specified that any regulatory initiative must first be approved by MoH.

- Supreme Decree that approves the Regulation of Organization and Functions of the Ministry of Health<sup>12</sup>(96)

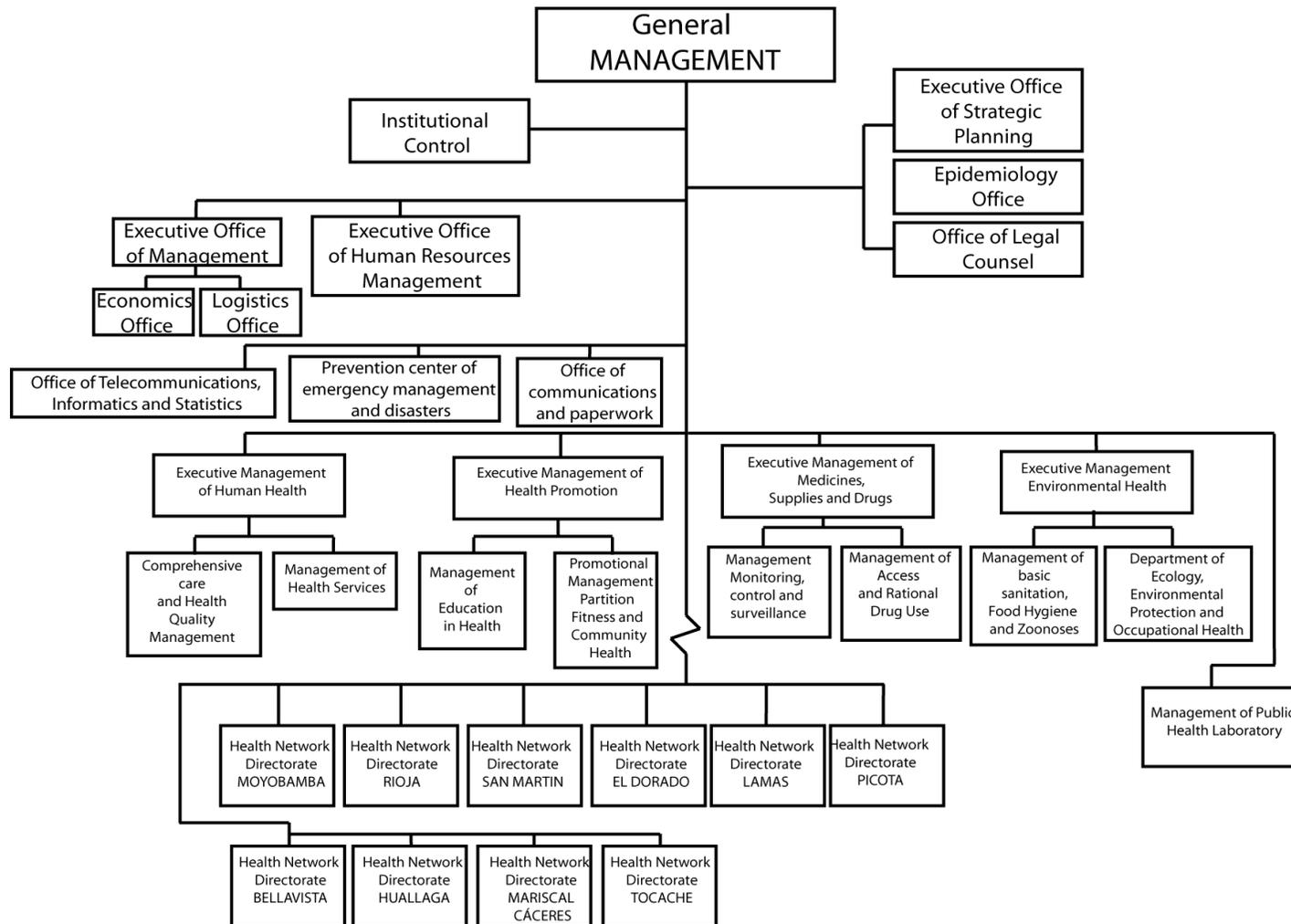
The laws mentioned above make evident the strong technical and administrative dependence of MOH. Product of this marked influence is the organic structure of the RHD San Martín which remained in force until the year 2009 (Figure 15).

---

<sup>11</sup> By means of these regulations, a standardized organization is established for all RHDs and therein is also stipulated that the Planning and Budgeting Office of the MoH shall issue its mandatory technical opinion with regard to the organization of the RHD. Similar measure stipulates the third transitory norm on presentation of CAP.

<sup>12</sup> This norm specifies that the management documents of the DIRESAs must contain the favorable technical opinion of the MoH.

Figure 15: Organizational estructural DIRES San Martin (2004)



The key officials interviewed during the preparation of this report<sup>13</sup> considered that this organizational model (in force until 2004) became outdated with regard to the challenges emerging in the sector, that is, health priorities as well as the strategies required to tackle them. The health accomplishments of the 90's were associated to the formation of functional teams and to the optimization on the supply side as established by the BHAP Program. Unfortunately, the new styles of management could not be sustained over time as they did not have a sufficiently strong structural and cultural platform. That organizational rigidity added to the centralized planning, -incoherent with those principles of delegation of authority and governmental complementariness- had not made possible an adequate and modern management.

The opinion of the launching group with regard to the existing model was quite categorical, arriving at the following conclusions:

- a) The current organizational model did not make possible the development of a Model of Decentralized Management with a broad base of participation, with transparency and results-leaded.
- b) The organizational structure set a divorce between provision and administrative duties. For this reason, this organizational structure had been non-effective and non-efficient and did not respond to the health priorities of the region.
- c) The functions established in its Regulation of Organization and Functions allowed the overlapping of functions or the non-specification of those functions.
- d) Deficient response to social demand due to the co-existence of multiple cultures and scarce protection for the environment.
- e) The impact of regional health system on the population was low. This fact determines the persistence of communicable diseases and the prevailing deficiencies.
- f) Limited access of the population to the health facilities and health information. Also, scarce citizenship and entrepreneurial participation in the social response to the health priorities.
- g) The human resources of the RHD maintained an organizational culture anchored in functional and structural dependence to MoH instead of the RG. Consequently, their capacities were limited for the exercise of new functions.
- h) Did not take into account the new regional challenges within the framework of the process of decentralization.
- i) Did not promote social development within its scope of responsibilities.

Likewise, the launching group witnessed the lack of coordination and articulation between the RHD and the Social Development Regional Authority; as well as the absence of synergies with other offices within the RG bodies. When the launching group looked into the interior the RHD,

---

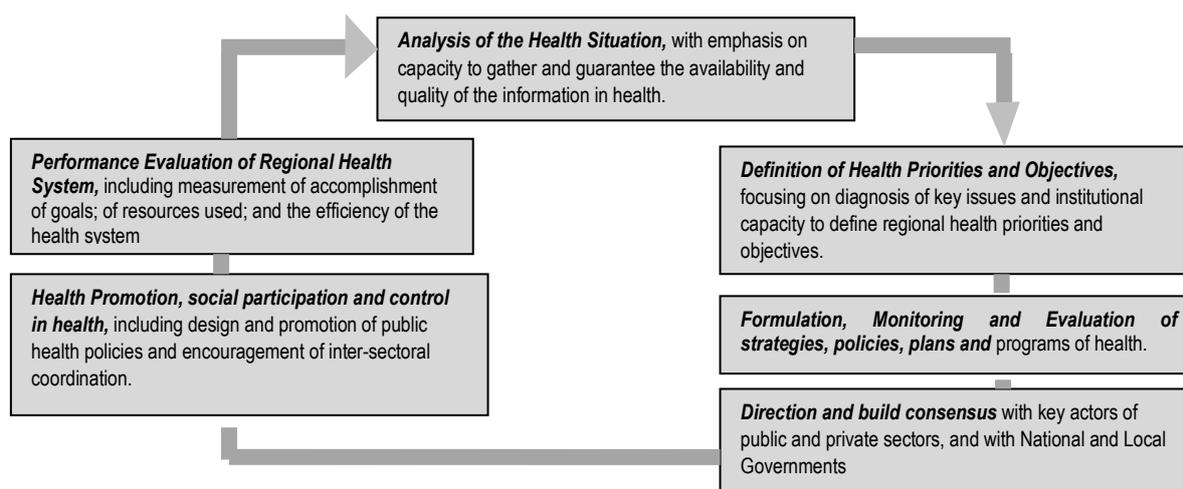
<sup>13</sup> Dr. Neptalí Santillán, Advisor to the Regional Government; Nurse Sofía Velásquez, Regional Coordinator of PAIMNI; Nurse (Obstetrics) Militza Huibin Advisor to the Managerial Office of Social Development

could appreciate the weakness in the institutional development of health networks and micro-networks; in particular, in those which were not budgeting execution units and lacked administrative autonomy.

#### 5.4.1.3 The proposal of organizational model

In this scenario, the launching group began working on the proposal of organizational redesign with the technical assistance of USAID|Perú|PRAES Project. It was established -as a guiding goal of the organizational redesign- the building of the stewardship of the RHA. Consequently, the roles played by the RHA in stewardship, regulation and supervision should be well incorporated into the functions of the different bodies of the new organizational structure. These functions are: 1) design and direct the health regional policies according to the national policies issued by the MoH; 2) define the regional objectives in health; 3) work with an inter-sectoral approach in order to promote and develop public policies consistent with health priorities; 4) define or adapt norms and tools to evaluate the quality of care; 5) strengthen performance of essential public health functions for public and private entities; 6) regulate and supervise individual and collective health activities at the regional level. These functions were considered by the launching group, as shown in Figure 16

**Figure 16. Interrelationship between the functions undertaken by the health authority in San Martin Region**



#### **Objectives of the organizational redesign**

The objectives of the organizational redesign were:

- Build and strengthen the governance function of the RHD in the region, articulating it to the Social Development Regional Authority of the RG and transferring the operational functions related to health service provision towards health networks, micro-networks and the Regional Hospital.
- Implement a decentralized, participative, transparent and results-oriented management that improves the effectiveness and efficiency of the regional health system.
- Organize the health care with focus in the people, individually or collectively (family, school and community).
- Strengthen leadership of the RHD with regard to local governments.

### *Criteria for the organizational redesign of San Martín RHD*

The criteria used for organizational redesign were:

- a) **Alignment of policies.** San Martín RHD is a body of line of the Social Development Regional Authority of San Martín RG. Consequently, health regional policies from the RHD must be consistent with the regional social policies of the RG.
- b) **Specialization Criterion.** RHD functions must take into account: 1) the provision of health services, and 2) health sectoral regulation. In the latter, the following functions should be included: standardization; regulation; supervision; monitoring; inspection; and monitoring the alignment of public and private institutions with regional health priorities.
- c) **Territorial Criterion.** Health networks, considered as part of the organizational design of RHD, must organize into technical and operative units that are delimited according to geo-social corridors. Based on this principle, health networks have social, economic and cultural conditions which are different one from the other.
- d) **Organizational levels.** The organizational levels of the RHD structure must be as flat as possible. More than two organizational levels must not be considered.
- e) **Gradual character.** Implementation of the organizational design must be gradual and capable to adapt to the scenarios that may arise.

### *Definition of Institutional Vision and Mission*

The institutional mission and vision of the future organization of the RHD were defined after several workshops wherein participated the staff of the RHD with the support of the USAID|Perú|PRAES Project. The following are the definitions made on a consensus base:

**Vision:** By the year 2012, the RHD contributes to improve the conditions for the human and environmental development in an integral way, thus guaranteeing equal access of the population to quality health services and to the full exercising of the citizens' right to health.

**Mission:** San Martín RHD is the de-concentrated technical body of the Regional Government responsible for formulating, adapting, implementing and executing the policies of the health sector in the region. San Martín RHD is in charge of health promotion, prevention, risks and damages control with equality, efficiency and quality. It regulates and inspects the environmental conditions, services and goods related with health; and direct and organize the provision of public sub-sector health. To this end, the San Martín RHD turns itself into an institution centered in satisfying the health needs of its people.

As can be seen, the vision has developmental, rights and quality approaches; and in the definition of its mission it is fully expressed the identification of the RHD with the RG. It defines its role in the promotion, prevention and control of damages and clearly expresses its purpose: to be a regional health authority.

### *Definition of the functions and structure of the Middle Line Bodies*

The following steps of the Launching Group were directed to determine the role, functions and then the structure of the middle line bodies of the RHD. This was one of the most difficult, complicated and traumatic tasks that had to be carried out. The RHD functions were related to standardization; regulation; supervision; inspection and monitoring of compliance of the public

and private institutions with health priorities. The specialized functions were concentrated in two primary aspects: in one hand, the provision of health services and in the other hand the regulation and inspection.

The functions of health care provision are directed to implement, execute and evaluate the policies referring to the comprehensive health care of persons, their families and the community as well as environmental and occupational health. In this sense, they must work in 1) the planning of services under a regional criterion; 2) the development of regulation mechanism to habilitate, qualify and categorize the public and private health facilities, 3) the development of tools to guarantee minimum standards of quality in the provision of health services, 4) the forge of alliances with local governments and other health providers.

In order to comply with the general functions of these bodies, the general functions were disaggregated into specific functions. In this way, the specific functions were grouped into four great bodies:

<b>Office of Health of persons and of the family</b>	This body integrates the activities of individual and family health, promotion, prevention, recovery and rehabilitation of health within the services dependent of the regional government.
<b>Office of Collective and Environmental health</b>	This body is related to the collective health of the family, the community and the environment as well as the community's health occupations.
<b>Office of Health Services and Medicines</b>	This body is associated with the functions of regulation, organization of the logistic of medicines and supplies and the evaluation of public and private services.
<b>Office of Control of epidemics, emergencies and disasters</b>	This body integrates the functions related to the implementation, execution and evaluation of policies for the prevention and control of epidemics, emergencies and disasters under the scope of the regional government.

Regard the regulation and inspection functions, the corresponding bodies of line shall assume the functions related with:

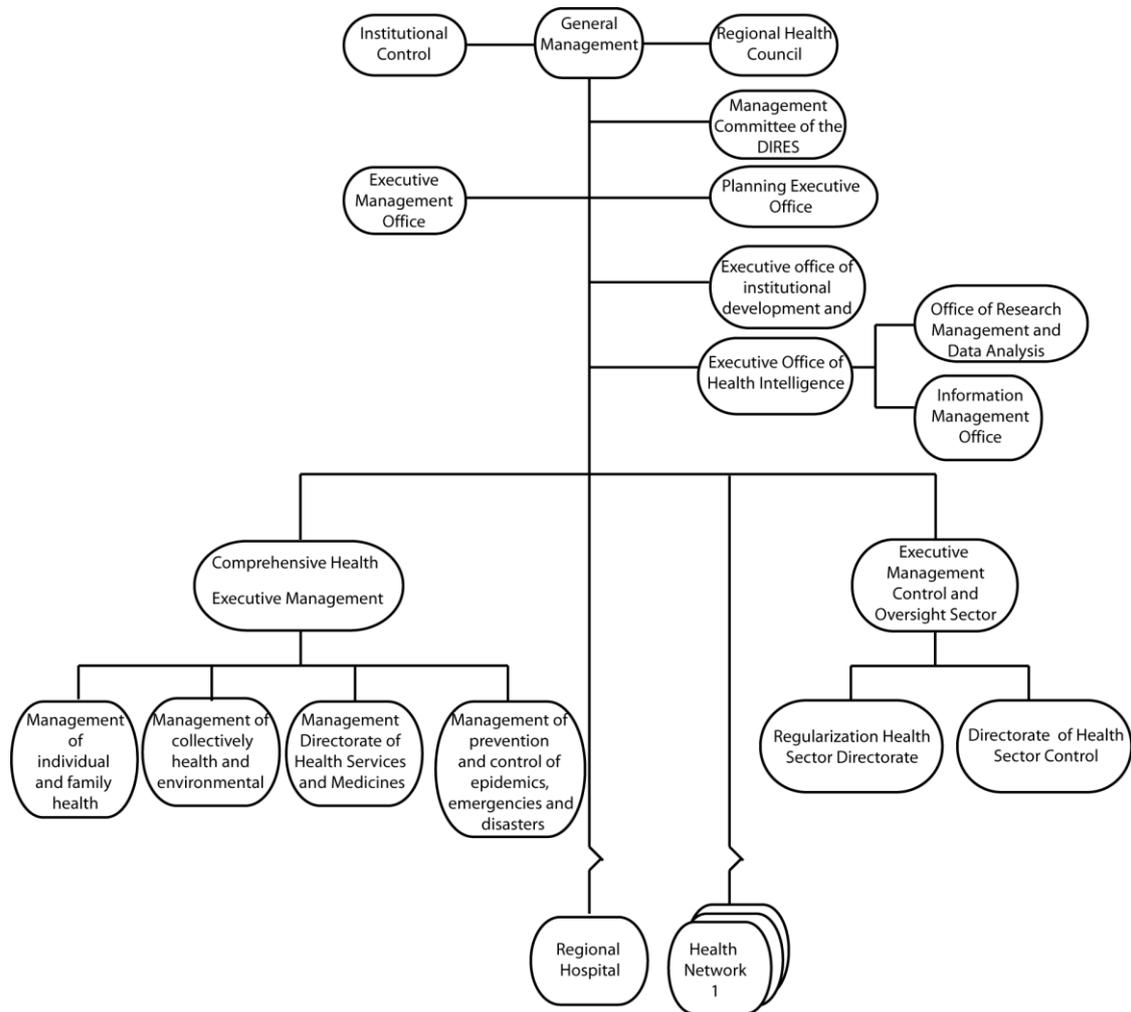
<b>Health Sectoral Regulation</b>	This body integrates the functions related to 1) regulation of the health markets, both public and private, 2) regulation of medicines, goods, and health technologies, 3) regulation linked environmental health and 4) regulation of occupational health.
<b>Health Sectoral Inspection</b>	This body exerts the functions related to the 1) inspection of health markets, both public and private, 2) inspection of medicines, goods, and health technologies, 3) inspection linked to environmental and 4) inspection of occupational health of the region; applying the corresponding actions according to their competences.

The next steps were directed to define the functions of the bodies of the Top Management and the Techno-structure bodies, in this way, the last version of the ROF was prepared and was approved by the RG in 2009(97). The summary of the approved ROF is specified in the following organizational model:

**Table 20. Composition of the bodies within San Martín RHD**

<b>ORGANIZATIONAL LEVELS</b>	<b>BODIES</b>
TOP MANAGEMENT	✓ Regional Management
CONSULTATIVE BODIES	✓ Committee of Management ✓ Council of Regional Health
INSTITUTIONAL CONTROL BODY	✓ Office of Institutional Control
COUNSELLING BODIES	✓ Executive Office of Planning ✓ Executive Office of Institutional Development and Quality ✓ Executive Office of Sanitary Intelligence ✓ Office of Management of Information ✓ Office of Management of Research and Analysis of Information
SUPPORT BODIES	✓ Executive Office of Administration <ul style="list-style-type: none"> <li>• Office of Economy</li> <li>• Office of Logistics</li> <li>• Office of Personnel</li> </ul>
MIDDLE LINE BODIES	✓ Executive Office of Integral Health <ul style="list-style-type: none"> <li>• Office of Individual and Family Health</li> <li>• Office of Collective and Environmental Health</li> <li>• Office of Health Services and Medicines</li> <li>• Office of Prevention and Control of Epidemics, Emergencies and Disasters</li> </ul> ✓ Executive Office of Regulation and Sectoral Inspection in Health <ul style="list-style-type: none"> <li>• Office of Sectoral Regulation in Health</li> <li>• Office of Sectoral Inspection in Health</li> </ul>
DECONCENTRATED BODIES	✓ Tarapoto Referral Hospital ✓ Health Network Units ✓ Health Networks

Figure 17. Organic Structure of San Martín RHD



#### 5.4.1.4 Analysis of the current organizational structure

The new structure of the RHD is innovative and suitable to the decentralization process. There are two bodies at the strategic apex of the new model that the previous model did not have: the Committee of Management and the Regional Health Council (the former as a body of intra-institutional coordination and the latter as a body of consensus with the DHR representatives).

In the techno structure there have been the following changes: In addition to the Planning and Sanitary Intelligence of the previous structure, the Executive Office of Institutional Development and Quality was added. This office has the role to oversee the permanent development and evaluation of the organizational model and its updating. Accordingly, this Office has to formulate management documents and has to design and implement the human resources development plan.

In the support staff appears the Executive Office of Administration. Changes that occurred were the following: the Office of Human Resources Management is absorbed by the Executive Office of Administration; the Office of Communications and Filing of Documents disappears and its functions passed to the responsibility of the RHD; the Office of Prevention and Control of Disasters becomes part of the Executive Office of Integral Health (in the middle line).

At the Middle Line, the following bodies disappear: Persons Health; Environmental Health, Health Promotion, and Medicines and Supplies. Two new bodies are created: the Executive Office of Integral Health and the Executive Office of Sectoral Control and Inspection. Both of them are responsible for issuing regulations, and supervising and evaluating the regional health actions. As expected, control and inspection actions are the responsibility of the Executive Office of Sectoral Control and Inspection.

The operational core is occupied by the Hospital of Tarapoto and the Health Networks. The changes which have occurred between one structure and the other as well as a qualitative evaluation of their functioning are presented in the next tables.

**Table 21. Matrix of the Structure of San Martin RHD**

#### Top Management

De-concentrated Health Directorate (HD)	Decentralized Regional Health Directorate (RHD)	Implications
<b>Health Directorate (HD)</b> ROF establishes that HD exerts health authority by delegation from the Top Office of MoH	<b>Regional Health Directorate (RHD)</b> ROF establishes that RHD is a de-concentrated body of the RG	RHD responds to the policies and strategic objectives of RG instead of MoH's. It is the regional health authority

#### Control Body

De-concentrated Health Directorate (HD)	Decentralized Regional Health Directorate (RHD)	Implications
<b>Body of Institutional Control</b> Office of Institutional Control maintains technical and functional dependence from the Office of the Comptroller General of the Republic and depends administratively from the HD	<b>Body of Institutional Control</b> Office of Institutional Control (OIC) depends functionally and administratively from the Office of the Comptroller General of the Republic.	The OIC becomes autonomous from the RHD

### Consultive Body

De-concentrated Health Directorate (HD)	Decentralized Regional Health Directorate (RHD)	Implications
<b>Did not Have</b>	<b>Management Committee</b> The Committee of Management is the consultive body of the RHD	It has a micro-administrative character, introduces internal changes. It is comprised by officials of the RHD, Hospital, Networks and Micro-networks.
<b>Did not Have</b>	<b>Health Regional Council</b> The Council of Regional Health is the consultive body and the body for concerted actions in health	It supports the regional authority of health to promote concerted action, coordination, and the articulation of policies, plans and the programs of health of the region.

### Counseling Bodies

De-concentrated Health Directorate (HD)	Decentralized Regional Health Directorate (RHD)	Implications
<b>Executive Office of Strategic Planning</b>	<b>Executive Office of Planning</b>	No major changes. Staffing functions have been passed to Executive Office of Institutional Development Office.
<b>Office of Legal Advice</b>	<b>Did not have</b>	Function assumed by a position in General Management Office.
<b>Did not have</b>	<b>Executive Office of Institutional Development</b> Formulates and manages policies related with institutional development and quality in health Responsible of organizational development and capacity building	Functions previously assigned to the Executive Office of Planning. Assumes strategic planning of human resources, as well as internship, SERUMS and second specialization programs.
<b>Office of Epidemiology</b>	<b>Executive Office of Sanitary Intelligence</b> Drive, regulates, organizes and maintains health information systems as well telematic system and manage the technical documentation center. In charge of Report of the Health Situation Analysis.	No major changes in comparison with previous structure.

### Support Bodies

De-concentrated Health Directorate (HD)	Decentralized Regional Health Directorate (RHD)	Implications
<b>a. Executive Office of Administration</b> <ul style="list-style-type: none"> <li>• Executive Office of Human Resources Development</li> <li>• Office of Data-Processing, Telecommunications and</li> </ul>	<b>Executive Office of Administration</b>	Economy and Logistics Offices become dependent of the Executive Office of Administration New ROF has flattened the organization due to the elimination of three units: The Center of Prevention of

<p>Statistics</p> <p><b>b. Center of Prevention and Control of Emergencies and Disasters</b></p> <p><b>c. Office of Communications and Filing of Documents</b></p>		<p>Emergencies and Disasters was transferred to the Executive Office of Integral Health.</p> <p>Absorption of the Office of Data-Processing, Telecommunications and Statistics by the Executive Office of Administration.</p> <p>Office of Communications and Filing of Documents absorbed by General Management Office.</p>
--	--	--

**Middle Line Bodies**

De-concentrated Health Directorate (HD)	Decentralized Regional Health Directorate (RHD)	Implications
<p><b>a. Executive Office of Health Promotion</b></p> <p><b>b. Executive Office of Health of Persons</b></p> <p><b>c. Executive Office of Medicines, Supplies and Drugs</b></p> <p><b>d. Executive Office of Environmental Health</b></p>	<p><b>Executive Office of Comprehensive Health Care</b></p> <p><b>Executive Office of Control and Sectoral Inspection</b></p>	<p>Executive Office of Comprehensive Health Care has four Offices:</p> <p>a. Individual and Family Health</p> <p>b. Collective and Environmental Health;</p> <p>c. Health Services and Medicines and;</p> <p>d. Prevention and Control of Epidemics, Emergencies and Disasters.</p>

**Operational Bodies**

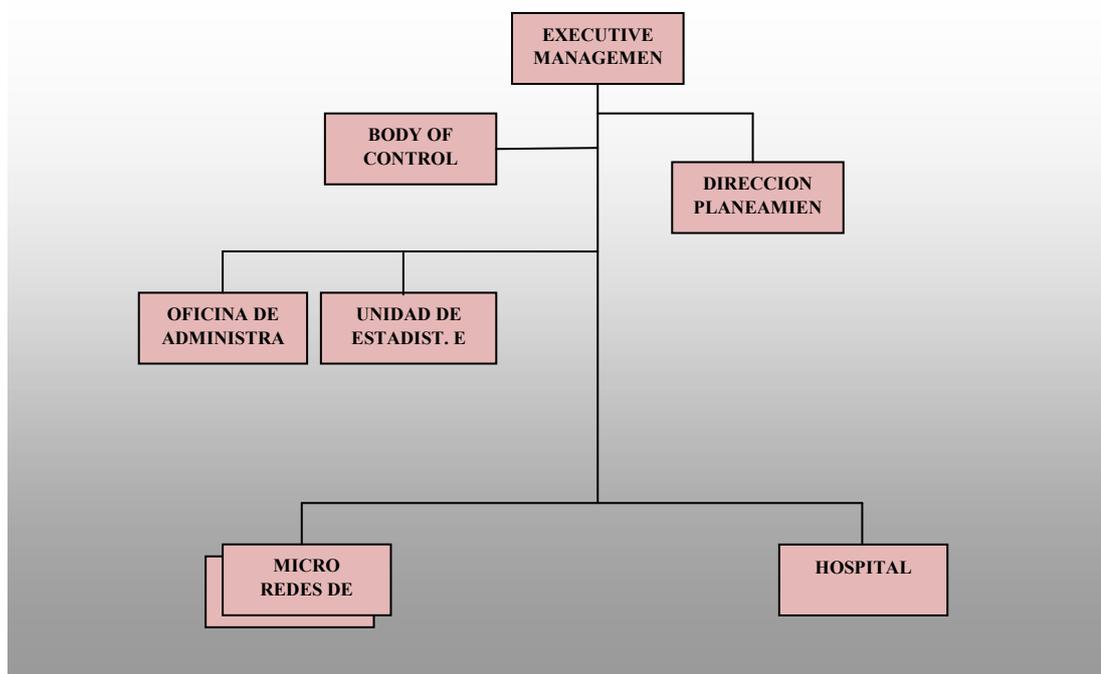
De-concentrated Health Directorate (HD)	Decentralized Regional Health Directorate (RHD)	Implications
<p><b>Networks of Health</b></p> <p>Without defined functions</p>	<p><b>Networks of Health</b></p> <p>Responsible for the provision of health services within their competence. They have to take into account population health needs to define health priorities.</p>	<p>Networks and micro-networks were redesigned according to population, access and territory. Four socio-environmental and economic corridors have been identified: Alto Mayo (Moyobamba and Rioja), Bajo Mayo (Lamas, San Martín, El Dorado and La Picota), Center (Bellavista, Mariscal Cáceres, Huallaga) and Bajo Huallaga (Tocache).</p> <p>Due to local political pressure 10 networks exist, but only 4 of them can manage public budget. There are 39 micro-networks.</p>

**5.4.1.4.1 Organizational adaptation of the Networks of Health**

A pending task is the organizational adaptation of the Networks of Health. The previous organizational arrangement of health networks had: the micro-networks and the local hospital as Operational bodies; the Office of Planning as the Counseling Body; and the Office of Administration and the Office of Statistics and Data-Processing as Support Bodies.

The organizational chart is described in Figure XX, and was considered by the Launching Group as an organization disconnected with the new institutional context.

**Figure 18. Structural Chart of Health Network before the organizational redesign**



In June 2011, the proposal of ROF of the Health Networks and Micro-Networks San Martín(98), were submitted, and in October of the same year were approved (99), this norm is complemented with the approval of the corresponding Chart of Staffing(100).

The Health Network is defined as a de-concentrated operational technical body of the RHD, and it's constituted by a group of health facilities inter-related by social corridors which are functional and administratively articulated, and responsible for the provision of health services under its competence (99). Health networks are in charge of provide technical assistance to its micro-networks, besides is in charge of the organization of the referral systems; the management of communication systems; the training of its staff; the epidemiologic surveillance, the development of ill-health prevention and health promotion activities; and the management of the intermediate services. Its functions are:

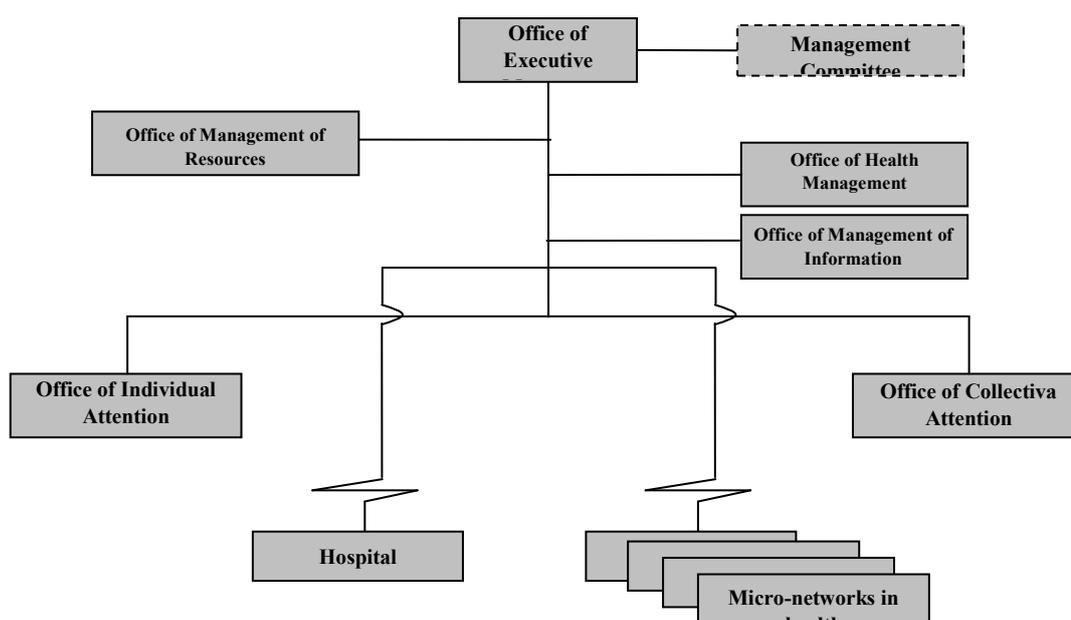
- a) To formulate and propose to the RHD, methodologies, guidelines, regulatory projects and management procedures which can be applied to the health networks level, in order to disseminate, apply and control their compliance within the scope its competence.
- b) To organize and direct, on a consensus basis, the processes of sectoral strategic planning; to formulate, propose, sustain, execute, control and evaluate the corresponding strategic and operative plans, programs and projects of intervention and investments in health.
- c) To formulate, propose to the RHD and implement the organizational management documents for health networks and micro-networks.
- d) To select and hire, in coordination with local governments, the chiefs of the micro-networks.

- e) To manage, allocate and execute the economic resources in health for its scope of responsibility.
- f) To organize, implement and control the administrative and support systems in the health network.
- g) To direct, organize and control the management units of health networks and micro-networks and the systems of support of the public services related to ill-health prevention, health promotion, recovery and rehabilitation; and environmental and occupational health, as well as the portfolio of services and the systems of support of its micro-networks in coordination with the local governments.
- h) To organize the provision of comprehensive health care in the micro-networks in coordination with local governments.
- i) To participate in the selection, recruitment, training and performance evaluation of human resources.

The new ROF defines two types of networks: The Executing (of public budget) Health Network, which is the de-concentrated technical and administrative body of the HRD, in charge of managing human resources; financial resources; goods and services and to provide technical support to Operative Networks (that are not public budget executing units) and their micro-networks.

On the other hand, the Operative Health Network which is the de-concentrated technical and operative body of the HRD, and is in charge of facilitating the assistance and technical control to its micro-networks, besides it organize the referral and contra-referral system, communication system, training, epidemical surveillance, prevention and health promotion, and to manage the intermediate services(99). The Organization Chart, proposed and approved by Regional Ordinance is shown hereunder.

**Figure 19. Structural Organizational Health Network after redesign**



The organization of the health networks is directed toward the provision of two kinds of services; individual and collective health; so the organization is structured into two middle line bodies: the Office of Individual Health and the Office of Collective Health which serve as technical support to the de-concentrated bodies which are micro-networks and local hospitals.

The Office of Individual Health is in charge of coordinating, organizing, planning, directing, controlling and evaluating the process of production of the individual services of promotion, prevention, recovery and rehabilitation for the health of persons and families. The Office of Collective Health is in charge of coordinating, organizing, planning, directing, controlling and evaluating the interventions towards the population and the environment with the aim of reducing the probability of occurrence of diseases, acting against the risk factors or health determinants, facilitating the factors of protection for the preservation or improvement of health.

One aspect that adds to the complexity in the process of implementation is that the Budget Executing Networks, when managing financial resources, besides attending to their own needs, must also attend the requirements of other operative networks under their responsibility. This fact overflows their management capacity due to the lack of managerial competencies of the administrative staff. This fact generates serious problems in the management of medicines and supplies that are required by the functioning of health facilities.

#### **4.4.2 Development of Institutional Capacities**

With the aim of strengthening the Health Human Resources capacities for improving health management and care, San Martín RG formulated the Plan of Development of Persons 2012-2016(101). On the basis of this document, San Martín RHD prepared, with the support of USAID|Perú|Quality in Health the *Five-year Plan of Development of Persons of HRD San Martín 2013 - 2017*(102). A key reference for this document have been the health priorities of the region and the commitment of San Martín RG to reduce 10 percentage points the Child-Chronic Malnutrition rate by the year 2014 through the Comprehensive Action Program to Improve Child Nutrition in San Martín Region (PAIMNI for its acronym in Spanish). This program was designed under the technical assistance of USAID|Perú|Health Policy Reform between 2010 - 2011.

Regional Government considers as a training strategy the Permanent Education in Health (EPS for its acronym in Spanish) that uses the daily performed working tasks as a process in which therein is produced the inter-action learning-teaching. This permits the development of the human resources and the development of the organization in the Development Competences Centers for the development of effective and efficient capacities.

Regarding to management skills, the individual competences that the staff of the San Martín RHD must achieve are:

- a) Competences for the development of policies in health/ management of plans, programs, projects, strategies in health.
- b) Competences for the organization and functioning of the services of health (UPSS).
- c) Competences for the management of the provision of services of health.
- d) Competences for the financial management of projects.
- e) Competences for the management of human resources and organizational development.

- f) Competences for management of the information, communication and research in health.
- g) Competences for management of logistics, maintenance and supply of medicines.
- h) Competences for management of the environmental sanitation.

These managerial competencies were defined with the technical assistance of USAID|Perú|HPR project.

Key informants reported that the RHD has not yet laid out an Annual Training Plan in accordance with the Five-Year Plan prepared. In contrast, there have been advances in the design and execution of Clinical Training to implemented effective interventions against child-chronic malnutrition as a part of PAIMNI. The second clinical training round shall take place as of the middle of February of 2013.

On the side of the development of management capacities, USAID|Perú|PRAES offered technical assistance to the RHD in for preparing the Plan for the development of management skills. Unfortunately this offer could not be advanced further, due to the regional instability that was observed at that moment at the Regional Government and on the RHD itself.

#### 4.4.3 Factors conditioning the process

All processes of organizational change imply not only the modification of the structure but also that of the mission, vision, and organizational values.

**In the regulatory level** a facilitating element was the detailed and careful work planning. This component could not close the regulatory cycle that was foreseen to be carried out; with the exception of the Regulation of Organization and Functions (ROF) and the Staffing Chart. There has not been any major advance in the design and formulation of the other regulatory or management documents such as, Manual of Organization and Functions (MOF), profiles of competences, annual plan for development of human resources on management matters, regulatory labor framework based on job profiles having tools for incentives, among others.

**At the internal institutional level**, a limiting factor of the process of organizational design was the frustrated process of strengthening and development staff capacities. Although the new regional health authority had the USAID|Perú|PRAES advice in the design of the Plan of Development of Competences, its implementation was no significant. Recently, as a part of support to the PAIMNI implementation by the project, the following weaknesses of the RHD staff have been identified:

- Partial knowledge of effective interventions to reduce chronic child malnutrition as a part of an integral health care model.
- Low capacity for the management of health services at RHD, health networks and micro networks levels.
- Limited coordination and recognition regarding the labor carried out by health community agents.

Another limiting factor for the effective functioning of the new organizational design has corresponded to the limiting role that networks exercise on the micro-networks on their initiatives to execute funds linked to the operative management of services. Although the Strategic Plan of

the Government of San Martín for the 2001-2014 period shows an orientation to simplify the execution procedures, this action is currently not being attended.

**At the external institutional level** for the RHD, a facilitating element has been the technical assistance of USAID projects which have provided guidance on the technical matters linked to the organizational design and redesign. With the USAID|PRAES Project the technical monitoring was permanent as of the construction of the Competences Concerted Map, the technical advice in the organizational redesign of the RHD, the redesign of networks and micro-networks until the approval through regional resolution of their corresponding ROFs.

**At the technical-political intermediate level**, the core of support for the process involved the recruitment of directors advocating on the need of change and also responsible to hire staff to occupy critical positions. This group could not be constituted. An effective communication strategy could not be established in order to inform on the advantages of the new organizational model. An important omission was the consensus building between the workers of the RHD (with their expectations) and senior staff (with their corresponding mandates).

**At the internal political level**, there were restricting forces that overran those promoting forces for organizational change. During the last two years, 2010 and 2011, the health workers union of the RHD carried out two strikes which lasted three months each one of them. The union argued that the health workers showed their discontent due to the transfer of the principal office of the institution from the city of Tarapoto to the Region's capital: Moyobamba. These labor interruptions seriously affected the functioning of the hospitals, health networks and health micro-networks.

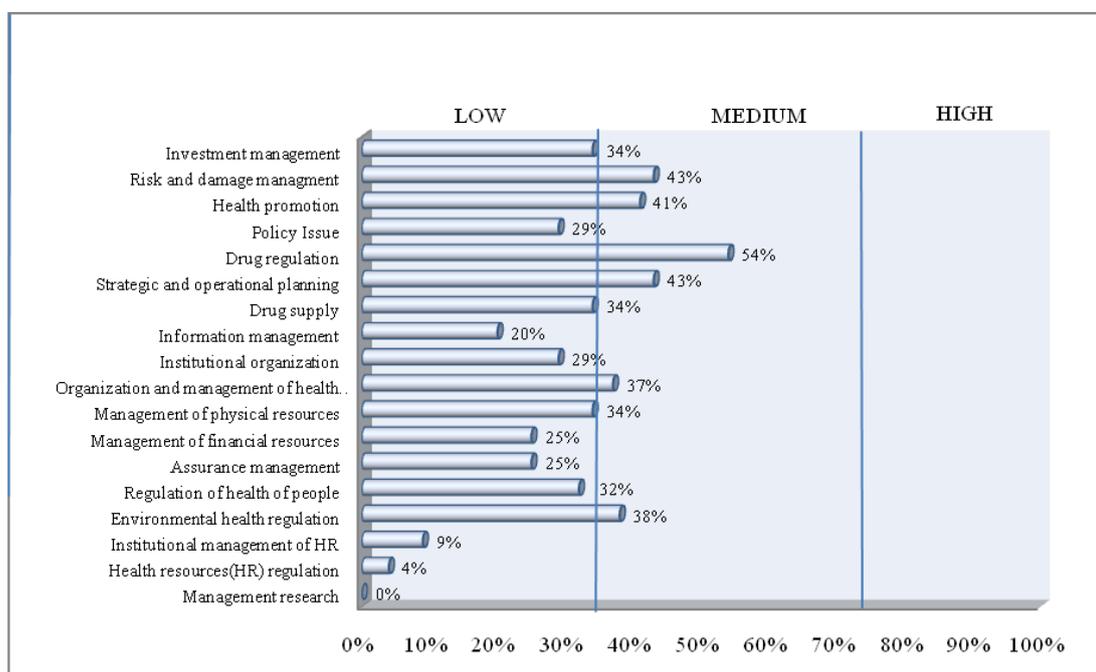
Among the promoting forces pro-change it is worth mentioning the incorporation into the RHD of a new Regional Health Director hired through the *National Authority of Civil Service*. This measure permitted to lower local union political pressure upon the RHD and RG.

**At the external political level of the HRD**, a key factor in favor in this process is the Presidency of the Regional Government of San Martín. During its second tenure, social issue is a priority for the President (in a previous tenure the priority was strengthening the physical infrastructure). Along this line of thought, it has been marked as a political objective of the region the reduction in 10 percentage points the chronic-child- malnutrition rate. This result is expected to be accomplished through the execution of PAIMNI program. In that sense, the highest regional authority has a very favorable opinion toward all processes of institutional strengthening of the RHD that have concrete in health results.

#### **4.4.4 Balance of the process of reorganization of the RHD**

In 2009, the MoH evaluated the San Martín RHD San Martín with regard to the degree of the exercising of the transferred functions within the framework of the process of decentralization. To this end the MoH used the Matrix of Evaluation of Functions prepared by USAID|Perú|PRAES. According to the evaluation only one (regulation of medicines) out of the 18 transferred functions was exercised at a medium rate and surpassed the 50%. The average exercise of the other functions was on the range of 30 to 40%. When the interested parties were asked if this evaluation had been taken into account to strengthen the functioning of the corresponding bodies, the answer was a negative one.

**Graphic N°2: Exercise of the health functions transferred in 2009, San Martín**



Source: Ministry of Health. MED 2010

Although three years have passed since the formal transfer of functions to the RHD, these functions are not being exercised in full. One of the most relevant limitations is the scarcity of qualified and experienced personnel for key managerial and operational positions. Hereunder is shown the analysis of the exercise of the functions of the ROF in San Martín RHD.

**Table 22. Qualitative assessment of the function performance by San Martin RHD**

Transferred Function	Bodies exercising the function:	Comment
Management of Policies	RHD Executive Office of Planning	<p>The exercise of the function is limited.</p> <p>On average a Regional Health Director is in duty for one year. During this period he is used to face prolonged strike</p> <p>Regarding public health policies they are limited to comply with the national health policies. However, in 2012, regional health priorities have been defined and the Regional ASIS has been approved.</p> <p><b>MED information:</b> The exercise of this function was rated as medium low (29%) in the Regional MED - Volume 1.</p>

**Table 23. Qualitative assessment of the function performance by San Martin RHD**

Transferred Function:	Bodies exercising the function:	Comment
Strategic and operative planning	Executive Office of Planning	<p>RHD without a Strategic Plan. Replaced by the Plan of the Government in health (2008-2011)</p> <p>Technical assistance of USAID Perú Health Policy Reform has been relevant for advancing important management documents: operational plan, budget proposal for 2013, multi-annual health investment plan, and capacity building plan.</p> <p>Critical Staffing gaps for the performance of the office</p> <p><b>MED information:</b> The exercise of this function was rated as medium (43%) in the Regional MED - Volume 1.</p>

**Table 24. Qualitative assessment of the function performance by San Martin RHD**

Transferred Function:	Bodies exercising the function:	Comment
Institutional organization	Office of Institutional Development and Quality	<p>One of the weakest offices at the RHD.</p> <p>Currently the office perform routine functions like: Preparing administrative documents Adapting processes for health networks Creating administrative and operational units.</p> <p><b>MED information:</b> The exercise of this function was rated as medium low (29%) in the Regional MED - Volume 1.</p>

**Table 25. Qualitative assessment of the function performance by San Martin RHD**

Transferred Function:	Bodies exercising the function:	Comment
Sectoral regulation of health of persons	Office of sectoral regulation of health	<p>The exercise of this function is limited to the inspection of public and private health facilities in matters of medicines and supplies.</p> <p>Inspection on private health facilities is incipient</p> <p>Lack of experienced staff in occupational health.</p> <p>Inspection on environmental health is weak since trained staff has remained in Tarapoto where their work is limited to the health network territory</p> <p><b>MED information:</b> The exercise of this function was rated as medium low (32%) in the Regional MED - Volume 1.</p>

**Table 26. Qualitative assessment of the function performance by San Martin RHD**

Transferred Function:	Bodies exercising the function:	Comment
Organization and management of the services of health for persons, environmental and occupational health.	Office of Individual and Family Health  Office of Collective and Environmental Health	Integrated functions previously deployed by People’s Health Office, Health Promotion; Environmental Health and the Office of Medicines and Supplies  Functions exerted by non medical junior professionals due to lack of experienced staff.  Functions limited to the conventional ones (supervision, development of workshops, reports preparation).  Family and community integral health care is not being implemented due to scarcity of trained professionals.  Lack of an incentives policy may explain the absence of qualified staff at the RHD.  <b>MED information:</b> The exercise of this function was rated as medium low (37%) in the Regional MED - Volume 1.

**Table 27. Qualitative assessment of the function performance by San Martin RHD**

Transferred Function:	Bodies exercising the function:	Comment
Management of public insurance	Executive Office of Planning  Executive Office of Integral Health	Health insurance has not been considered important for the RHD, and there is no organic unit responsible for its impulse  <b>MED information:</b> The exercise of this function was rated as medium low (25%) in the Regional MED - Volume 1.

**Table 28. Qualitative assessment of the function performance by San Martin RHD**

Transferred Function:	Bodies that exercise the function:	Comment
Promotion of health	Office of Collective and Environmental Health (in the Office of Integral Health)	Internal agenda on the RHD (design of health networks and micro-networks has prevented further advance in relevant areas)  Initial coordination being held with local governments, education, RENIEC, for starting a multi-sectoral intervention for the reduction of child malnutrition. Coordination facilitated by USAID Perú Healthy Communities and Municipalities.  The health networks do not assign resources for health promotion activities to be carried out by their staff, specially when performed on an outdoors basis

		<p><b>MED information:</b> The exercise of this function was rated as medium low (41%) in the Regional MED - Volume 1.</p>
--	--	--

## 4.5 The organizational redesign of the DIRES Cajamarca

### 4.5.1 Reorganization Process at Cajamarca RHD

Considering the organizational model of Cajamarca DIRESA approved in 2006 was outdated, The Regional Government dispose its reorganization in 2007, constitute a Technical Committee for that purpose and requested technical assistance to USAID / Peru / PRAES. The reorganization Proposal submitted by the committee to the regional government was unsuccessful because there was not political, institutional or approval and subsequent implementation.

#### 5.5.1.1 Phases of the process of organizational redesign

The reorganization of both, the Regional Government and the DIRESA Cajamarca were frustrated by the above conditions. Therefore, in this case does not apply to make reference to the organizational redesign process.

#### 5.5.1.2 Organizational structure of the RHD Cajamarca before the process of reorganization

In 2003, Cajamarca RHD applied what was indicated by the MoH regarding to the organizational structure at the regional level (93-95). This structure was as follows: (103).

**Table 29.**

<b>Body of Management</b>	General Management
<b>Body of Control</b>	Executive Office of Institutional Control
<b>Body of Advice</b>	Executive Office of Strategic Planning Office of Epidemiology Office of Legal Advice
<b>Bodies of Support</b>	Executive Office of Administration Office of Logistics Office of Economy Executive Office of Management and Development of Human Resources Office of Data-Processing, Telecommunications and Statistics Center of Prevention and Control of Emergencies and Disasters Office of Communications
<b>Bodies of Line</b>	Executive Office of Promotion of Health Office of Education for Health Office of Promotion of Healthy Life and Community Participation in Health Executive Office of Health of Persons Office of Comprehensive health care and Quality in Health Office of Services of Health Executive Office of Medicines, Inputs and Drugs Office of Inspection, Control and Sanitary Surveillance

	Office of Access and Rational Use of Medicines Executive Office of Environmental Health Office of Basic Sanitation, hygiene in foods Zoonosis Office of Ecology, Protection of the Environment and Occupational Health Office of Laboratories of Public Health
<b>De-concentrated Bodies</b>	Regional Hospital of Cajamarca DIRESA DIRESA Jaén DIRESA Cajamarca II Chota, DIRESA Cajamarca III. Cutervo Networks of Health Network of Health I Alta Jequetepeque Network of Health II Cajamarca Network of Health III Celendín Network of Health IV Crisnejas

In 2005, three years after the beginning of the decentralization in Peru, the Regional President Luis Felipe Pita Gastelumendi ordered the design of a proposal for the functioning of the Cajamarca RHD. For this purpose, MoH's regulations were taken into consideration. These regulations stated that it is the RG that approves the administrative organization of the RHD(104). It was also considered the MoH's regulation that situates the RHD as an operational body of the Office of Social Development of the Regional Government, with capacity to formulate and propose health regional policies; as well as to direct, evaluate and regulate the functioning of health facilities according to national policies(105).

Cajamarca RG formed a Technical Commission in charge of the organizational redesign of the RHD. This commission was composed by the Regional Manager of Planning and Budget; the Manager of Social Development and the Regional Health Director (106). Afterwards, the commission was enlarged with the participation of Health Directors from Chota, Jaén and Cutervo. The commission recognized that, within the decentralization process in course, the RHD organizational arrangement was obsolete. Finally, a proposal for the Regulation of Organization and Functions was designed, which was subsequently approved by the Regional Government(107, 108).

The main changes in the model of organization were

### Support Bodies

- a) Executive Office of Administration. The Office of Personnel was created. Its functions were transferred from the Executive Office of Human Resources Management and Development.
- b) Executive Office of Human Resources Development. The Office of Human Resources Management and Development left alone with HR development functions and capacity building for health staff, due to the fact that the functions of human resources management had been transferred to the Executive Office of Administration.
- c) Office of Public and Private Insurance. This new Office was created in order to facilitate the execution of the national and regional policy on public health insurance.

## Middle Line Bodies

- a) **Executive Offices of Health Promotion; Health of Persons; Medicines, Supplies and Drugs; and Environmental Health.** These Offices maintained their previous names and functions. However, they did not longer keep their executive offices. Instead, they organized themselves on the basis of functional teams. Interviewed informants declared that this organizational structure was assumed to facilitate the coordination of its activities and actions with the corresponding bodies of the MoH.
- b) **Executive Office of Planning and Development.** This Office was organized on the basis of the previous Office of Strategic Planning. It migrated from a Counseling Body towards a Middle Line Body of the RHD. The explanation for this change was that the management of the Regional System of Planning required “more operations and work with the social actors in the planning, organization and financing of health ”(107).
- c) **Executive Office of Information.** This office was the transformation of the Epidemiology Office. It was considered as a RHD middle line body due to the fusion of the former Office of Data Processing, Telecommunications and Statistics (OITE), National Defense and the Office of Laboratories and Public Health. Fusion allowed that “starting from an integrated health information system, strategies could be designed to face health problems as well as health emergencies, both of which require coordinated research actions”(107).

## Operational bodies

- a) **Sub-Regional Offices of Health.** Chota, Jaén and Cutervo Health Directorates modified their denomination to Sub-Regional Health Offices. According to the technical report, this change in the denomination was aimed at improving levels of coordination. This change was executed after the assessment of the administrative capacity and the corresponding agreement with key social and political actors.
- b) **Offices of Health Networks.** The Regulation only specifies the health networks that are part of Cajamarca RHD. It omits the health networks pertaining to the sub-regional Health Offices in Chota, Cutervo and Jaén. Seven health networks are mentioned: Contumazá, San Marcos, San Miguel, San Pablo, Cajabamba, Cajamarca and Celendín.
- c) **Regional Hospital of Cajamarca.** It is the only regional referral facility and is also a budgetary execution unit.

## The proposal of organizational redesign

Less than a year after the approval of the RHD ROF, the RG ordered the reorganization of the RHD (109). To this end, a commission was formed to prepare the proposal of the new regional health organization(109). Unfortunately, this commission could not fulfill its objectives. For this reason, the RG decided to give this task to a new commission. This new commission was comprised by representatives of the RG and of the RHD (110). Additionally, Cajamarca RG requested the technical assistance of USAID|Perú|PRAES for the organizational redesign process. To this end, the USAID|Perú|PRAES Project and the commission agreed to the execution of a working agenda with the following phases(111):

1. Definition of the objective of the organizational redesign.
2. Definition of the institutional strategy: vision, mission and the institutional principles of the RHD.
3. Assignment of sectoral competences between the executive body of the RG and the RHD.
4. Define the RHD institutional configuration on the basis of the following steps:
  - a. Definition of the guiding principles of RG reorganization.
  - b. Identification of the implications of the institutional strategy on the organizational structure.
  - c. Determination of the basic characteristics of the organization's architecture based on the organizational specialization criterion.
  - d. Distribution of the specific functions into the organic units.
5. Design of the systems of follow-up of goals and incentives.
6. Define institutional practices on human resources.
7. Formulate the plan of the organizational change.

The Commission made an analysis of the organization of the RHD to clarify the objective of the organizational redesign. It arrived to the following conclusions (111):

- Current organizational design of the RHD is the reflex of MoH units. Its organizational structure does not consider the regional reality and the institutional role as technical body of the RG with specialty in health. To a great extent, its staff identifies itself as pertaining to the MOH instead of the Regional Government.
- Articulation of the RHD with the RG is limited. There is no clear relationship between the Office of Social Development and the RHD.
- Limited governing capacity of RHD as related to its Health Directorates. An adequate incorporation of Health Directorates into the RHD structure has not been accomplished.
- RHD does not have the capacity to exert transferred functions. This situation is evident on emission of policies; planning; sectoral regulation; management of investments; organization and management of health services; institutional management of human resources.
- Institutional performance on the transferred functions cannot be followed up due to the lack of a proper monitoring system. Consequently, measures on impact, processes and activities are not readily available. This situation is amplified by the excessive autonomy of the Sub-Regions, since it is more difficult for the RHD to implement a regional follow-up mechanism on management and health provision grounds.
- Insufficient leadership shown by the RHD over local governments for the execution of health activities. Local governments have a key role to play in controlling many

determinants of health by exerting their exclusive and shared health functions. However, RHD technical leadership over local governments is very limited.

Based on these conclusions, the Commission agreed on the need to adapt the RHD to the new decentralizing scenario and improve the articulation between RG and its RHD.

### *Criteria for organizational redesign of Cajamarca RHD (2008)*

The technical assistance of USAID|Perú|PRAES consisted in putting in the agenda of the members of the Commission the need to build and formalize the regional health authority. To this end it used the criterion of specialization to form its middle line bodies. Of these, one was destined to the provision of health services and the other one to the regulation and inspection of the markets of health.

### *Definition of institutional vision and mission (2008)*

In June 2008, workshops to define vision and mission were organized.

**Vision:** In the year 2012, Cajamarca RHD is the leading health authority in the region which guarantees, by concerted actions, universal access to health care and full satisfaction of the health needs of the population, having in mind the citizens' right to health. The RHD is successful in the regulation of health services, the public provision of a comprehensive healthcare and the control of health determinants.

**Mission:** The RHD is the operational body of the Office of Social Development of Cajamarca RG, with regulatory functions. It is responsible for formulating, adapting, implementing, controlling and evaluating health policies in the region. RHD promotes health and prevents risks and damages; regulates and inspects health goods and services; organizes and provides comprehensive health care in public facilities taking into consideration the determinants of health. To this end, it constitutes itself in an institution centered in satisfying the health needs of persons, families and communities giving priority to the most vulnerable population.

### *Definition of functions and organizational structure (2008)*

The following innovations were introduced on the basis of the specialization criterion:

#### **Middle Line Bodies**

- a) **Executive Office of Provision of Health Services**, entity specialized and responsible for the formulation, implementation, execution and evaluation of policies regarding public provision of comprehensive healthcare for persons, families communities and the environment of the region. It is in charge of planning, directing, organizing, regulating and evaluating the provision of public services of the Region, that perform activities in promotion, prevention, recovery and rehabilitation of health directed to persons, families, communities and the environment. For this reason this entity has become a specialized office regarding individual and collective interventions as well as on services management.

**Executive Office of Sectoral Regulation and Inspection of Health**, entity specialized and responsible for formulation, implementation, execution and evaluation of policies related to sectoral regulation of medicines; goods related to health of persons; health services and the environmental conditions related to health. It is in charge of supervising,

regulating and inspecting the environmental health conditions under the competence of the region; the public and private health services; the production, storing, distribution and allocation of medicines; and the medical technology. For this reason this entity has become a specialized office on health sectoral regulation and inspection.

### Counseling Body

- b) **Office of Research and Organizational Development**, body responsible for the formulation and management of regional policies of institutional development; the development of research; and quality control, as well as of human resources management at the institutional level. This would be counseling body in the analysis, design, implementation and evaluation of the processes and systems of institutional organization and management; research management and quality control as well as in directing the processes of sectoral and institutional human resources development; including its regulation, planning, promotion and implementation.

The Commission worked with the support of USAID|Perú|PRAES the following organizational model of Cajamarca RHD:

**Table 30.**

<b>Body of Top Management</b>	Regional Office
<b>Consultive Bodies</b>	Committee of Management Regional Council of Health
<b>Body of Institutional Control</b>	
<b>Bodies of Advice</b>	Executive Office of Planning Executive Office of Institutional Research and Development Office of Development of Projects Office of Organizational Development and Research Executive Office of Sanitary Intelligence Office of Operation, Analysis and Dissemination of Information Office of Systems of Information and Telematics
<b>Body of Support</b>	Executive Office of Administration
<b>Bodies of Line</b>	Executive Office of Provision of Services of Health Office of Comprehensive health care of Persons Office of Collective Interventions of Health Office of Management of Services of Health Executive Office of Sectoral Regulation and Inspection in Health Office of Sectoral Regulation in Health Office of Sectoral Inspection in Health
<b>De-concentrated Bodies</b>	Regional Hospital of Cajamarca Network of Health Micro-network of Health

### 5.5.1.4 Analysis of the current organizational structure

#### 5.5.1.4.1 Organizational adaptation of the Health Networks

As a complementary work in the redesigning of the RHD, health networks also were redesigned. Two middle line bodies were defined, based on the analysis of the different kind of goods, services and health interventions developed by RHD, such as individual care; collective interventions of health promotion, environmental health and epidemic control.

The proposed model of organization of the networks was the following:

**Table 31.**

<b>Body of Management</b>	Executive Office of the Network of Health
<b>Consultive Bodies</b>	Committee of Management of the Network Provincial Council of Health
<b>Bodies of Advice</b>	Office of Planning and Institutional Development
<b>Bodies of Support</b>	Executive Office of Administration Office of Sanitary Intelligence
<b>Bodies of Line</b>	Office of Comprehensive health care of Persons Office of Collective Health
<b>De-concentrated Bodies</b>	Hospital Micro-network of Health

Source: USAID|Perú|PRAES

Members of the Commission and USAID|Perú|PRAES did not agree on the technical relevance of having Sub-Regional Health Offices in Cutervo, Chota and Jaén. USAID|Perú|PRAES proposed the transformation of these Sub-Regional Health Offices into Health Networks. USAID|Perú|PRAES considered that Sub Regional Health Offices would cause disarticulation and weaken the steward role of the RHD. In spite of the Commission was agreed with the foundations of the technical recommendation, the Commission did not agree to implement it due to political considerations.

#### 4.5.2 Development of institutional capacities

Doctor Freddy Regalado was the Regional Health Director from 2008 to 2010. Within this period, the transfer of functions from the MoH to Cajamarca RG took place. Doctor Regalado organized an internal evaluation to find out if the staff of the RHD was in condition to assume the new responsibilities. There were disappointing results and a very wide gap was observed regarding the existing capacities and the required capacities.

In this scenario, the Management Committee of the RHD recommended the preparation of a Regional Plan of Competitiveness and a Regional Plan of Research and Development. Technical assistance was provided by the National Institute of Health and other entities of the MoH. Cajamarca National University and local NGOs also participated in the definition of the proposal. The Social Fund of Yanacocha Mining Company provided funds for hiring specialists to carry out the technical training based on the content of the plan. The general idea was to develop capacities regarding the new required functions to implement the organizational model. Due to internal conflicts within the Commission and despite of having the respective financing, the only advance was the design of a proposal of plan. These conflicts weakened the technical leadership of the Commission in front of the RG.

### 4.5.3 Factors determining the process

According to Doctor Marco Gamonal, there were three factors regarding the lack of progress in the proposal of organizational redesign.

**At the external institutional level of the RHD**, a limited articulation between the Commissions of both processes of restructuring of the RG and the RHD, which could not define the inter-relations existing between these two entities. There were no synergies to solve common problems of organizational design.

**At the internal institutional level**, a serious limitation was originated by the composition of the organizational redesign commission. This commission was composed by the directors of the model of organization. During the phase of the redesign they supported technical initiatives. However, when the definitive organizational model had to be defined, in particular, regarding the middle line bodies, they changed their position from a proactive one to a position of resistance. On the other hand, the proposal suggested reducing the four Sub-Regional Health Offices to two. Resizing of the rest of the Sub-Regional Health Offices into health networks was linked to the risk of losing the power that directors had. This concern was, transferred to the health workers who initiated protests and strikes against the proposal of organizational redesign.

**At the external political level of the RHD**; a serious limitation was the rapidly decreasing of political support by the Regional President due to the closeness to the election of the Regional President and the risk of generate or maintain protests by health personnel. It is worth mentioning that the Health Sector together with the Education Sector have the highest number of workers in the Region. Consequently, it was not surprising that under these conditions the work initiated was put aside.

### 4.5.4 Balance of the process of reorganization of the RHD of Cajamarca

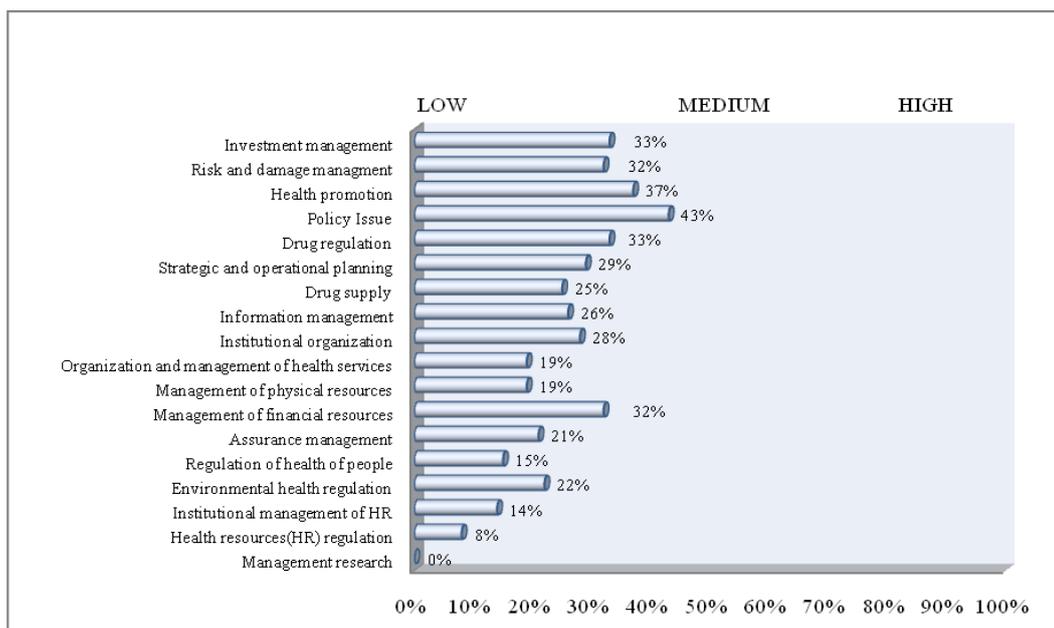
Due to the considerations which were shown above the current organizational model is the model approved in the year 2006; since then ROF has not been modified. Consequently, the functions transferred by the MoH according to the decentralization process do not have correlation with the current bodies. For instance, there is no identification of the instance that exerts functions related with the sectoral regulation of the human resources (usually a responsibility of the Executive Office of Human Development) (112, 113). Management of research pose another example in which the function has not been incorporated within the Executive Office of Information and Health Action (112, 113).

Key informants for the preparation of this report<sup>14</sup> declared that in 2009, the MoH made an evaluation of the exercise of the transferred functions. Figure XX shows the results of such evaluation. It can be appreciated the magnitude of the gaps of the exercise of functions as compared to a desirable level. For this reason, a plan of capacity building is critical, and should receive financial and technical support.

---

<sup>14</sup> Doctor. Marco Gamonal. Manager of Social Development of the Regional Government of Cajamarca, Lic. María Nakarino, Director of the Office of Planning of the DIRESA, Lic. Maritza Salcedo, Tulia Ramírez and Engineer Alfonso Morales of the Office of Execution (Racionalización).

**Graphic N°3 Exercise of the health functions transferred in 2009, Cajamarca**



Source: MoH. Office of Decentralization. 2010

Hereunder is shown the analysis of the exercise of the functions of the ROF at Cajamarca RHD.

**Table 32. Qualitative assessment of the function performance by the Cajamarca RHD**

Function transferred	Bodies exercising the function:	Qualitative evaluation of the exercise of the transferred function
Management of Policies	RHD  Executive Office of Planning and Development	<p>Functions on management of policies not well defined.</p> <p>RHD staff with limited capacities for:</p> <ul style="list-style-type: none"> <li>• Preparing diagnosis of health and of the systems involved.</li> <li>• Preparing diagnosis of the situation and of the system of health.</li> <li>• Evaluating and following up of health policies</li> <li>• Each the Sub-Regional Health Office design its own health policies of health without coordination with the Regional Office.</li> </ul> <p><b>MED information</b> The exercise of this function was rated as medium low (43%) in the Regional MED - Volume 1.</p>

**Table 33. Qualitative assessment of the function performance by the Cajamarca RHD**

Function transferred:	Bodies exercising the function:	Comment
Strategic and Operative Planning	Executive Office of Planning and Development	<p>RHD formulates and implements the Sectoral Strategic Plan that includes:</p> <ul style="list-style-type: none"> <li>• Identification of health priorities</li> <li>• Definition of sectoral strategic objectives</li> </ul>

		<ul style="list-style-type: none"> <li>• Quantification of goals</li> <li>• Selection of strategies</li> <li>• Articulation with other sectors</li> </ul> <p>Neither follow-up nor evaluation of Plan. Plan is not used as a document of management. Operational Plan prepared by RHD covers the principal office and the networks of health that are under its dependence.</p> <p>Each Sub-Regional Health Office prepares its own operative Plan without coordinating with the DIRESA.</p> <p><b>MED information</b> The exercise of this function was rated as medium low (29%) in the Regional MED - Volume 1.</p>
--	--	--

: Table 34. Qualitative assessment of the function performance by the Cajamarca RHD

Function transferred:	Bodies exercising the function	Quantitative evaluation of the exercise of transferred function
Institutional organization	Executive Office of Planning and Development	<p>Function formally exerted by the Office of Planning and Development.</p> <p>Current function exertion has not been verified, e.g. supervision, monitoring and evaluation of the organization of the RHD, hospitals and health networks</p> <p>Regularly updates management documents</p> <p><b>MED information</b> The exercise of this function was rated as medium low (28%) in the Regional MED - Volume 1.</p>

: : Table 35. Qualitative assessment of the function performance by the Cajamarca RHD

Function transferred	Bodies exercising the function	Comment
Sectoral regulation of health of persons	Executive Office of Health of Persons	<p>Function is limited to the inspection of public and private services in matters of medicines, supplies and drugs.</p> <p>Inspection of the private health facilities is incipient</p> <p>No technical capacity to set sectoral regulations on peoples health</p> <p>Lack of qualified staff with expertise in occupational health.</p> <p><b>MED information</b> The exercise of this function was rated as medium low (15%) in the Regional MED - Volume 1.</p>

::

**Table 36 Qualitative assessment of the function performance by the Cajamarca RHD**

Function transferred	Bodies exercising the function	Qualitative evaluation of the exercise of the transferred function
Organization and management of services of health for persons, environmental health and occupational health.	Executive Office of Health for Persons	Exertion of function limited to authorizing opening of health facilities, both public and private. Grants certifications and accreditations to health facilities.  Collective health function not developed  Occupational health regulating function, not developed  <b>MED information</b> The exercise of this function was rated as medium low (19%) in the Regional MED - Volume 1.

:

**Table 37. Qualitative assessment of the function performance by the Cajamarca RHD**

Function transferred	Bodies exercising the function	Comment
Management of public insurance	Office of Public and Private Insurance	Public insurance related function not exerted  Strategic purchasing of health services to public and private providers not implemented  <b>MED information</b> The exercise of this function was rated as medium low (21%) in the Regional MED - Volume 1.

**Table 38. Qualitative assessment of the function performance by the Cajamarca RHD**

Function transferred	Bodies exercising the function	Comment
Promotion of Health	Executive Office of Promotion of Health	Functions on supervision, monitoring and evaluation of health promotion with participation of local governments are not carried out.  Staff with limited capacities for exerting functions linked to health promotion.  RHD limits itself to promote compliance with the norms related to citizens' rights to health. Its summoning power is very limited.  <b>MED information</b> The exercise of this function was rated as medium low (37%) in the Regional MED - Volume 1.

## 5. Lessons Learned

1. Decentralization is a long-term reform that reconfigures the structure of the State and its relationship with citizens. It is a complex process in which steps forward are followed by steps back, emphasizing the existence of a non linear approach for its implementation. President Fujimori's administration proceeded to deconstruct the decentralization already begun; and President Toledo's administration main achievement was to re-launch it, configuring an irreversible State policy that was further advanced by President Garcia's administration. However, it is not unlikely that this experience will have to have adjustments, rebalancing national and regional roles, competencies and responsibilities as required by new health, administrative, and political scenarios.
2. Political support of a profound reform such as decentralization cannot be divorced from the financial resources and the capacity building interventions that are needed for its successful implementation. Otherwise, it mutates from a profound political transformation of the State into a minor administrative adjustment regarding documentary processing. This represents a very clear example of what should be a shared responsibility between the MoH and the RHDs nationwide.
3. Organizational redesign of RHDs requires that top management cadres at the regions understand and accept the fact that decentralization will introduce deep changes in the way their day to day duties are arranged and executed. Such understanding is a necessary condition for the consensus building process that has to be part of every functional and structural change initiative.
4. Changes introduced by decentralization generate varying degrees of uncertainty. Resistance to structural and functional changes is mainly based on this uncertainty rather than on the decentralization process itself. Consequently, it is necessary to start a consensus generation initiative with key actors before any changes are introduced. Mapping of actors, their interests and uncertainties shall anticipate any organizational change initiative. This measure will help to identify and work strategies to make acceptance of changes more likely.
5. Stability of top and medium management cadres at the RHD helps to set a predictable rhythm and direction on the implementation of the decentralization reform. It also facilitates the design, development and execution of the local methodology to be used to monitor advances in the process. None the less important, it helps to make immediate corrections of any misalignment between the general objectives of decentralization and the way it is being implemented through the RHD organization. The experience of La Libertad RHA shows the advantages of stability in the decentralization implementation process. Its regional health manager has been in the position for more than four years and has kept his core management team. Accordingly, there have been important advances in what is called the health territorial management approach, an experience whose deployment has been facilitated by the health decentralization reform.

6. Health decentralization has opened new opportunities of joint work between regional and local authorities regarding health interventions. The territorial approach for the organization and management of effective interventions has shown that it is possible to make an efficient expansion on the production possibilities frontier in health, especially when specific and very well studied health priorities are faced, e.g. child malnutrition control in San Martin.

## 6. Methodological Annex

### Rapid qualitative assessment on the reorganization of Regional Health Directorates

In November 2012 there was a rapid qualitative assessment on the reorganization process of Regional Health Directorates of La Libertad, San Martín and Cajamarca. The evaluation consisted of qualitative interviews with key informants in both regional governments and in the regional health directorates.

The objective of the assessment was to obtain information regarding the implementation of the organizational redesign the Health Regional Directorates, the exercise level of health functions transferred to regional governments and regional stakeholders' perception on these issues. For this, individual semi-structured interviews were applied.

The information obtained was analyzed under the methodological approach of grounded theory, which starts from the data to generate an explanatory theory about the phenomenon under study.

**Table N° 1**  
**List of key informants**

Región	Institución	Entrevistado
<i>La Libertad</i>	Gobierno Regional	Gerente de Desarrollo e Inclusión Social
	Gerencia Regional de Salud	Gerente Regional de Salud
		Sub gerente de Promoción de la Gestión Territorial
		Sub gerente de Cuidado Integral
		Responsable de Cuidado Integral Individual
<i>San Martín</i>	Gobierno Regional	Coordinadora del Equipo de Gestión
		Asesor del Gobierno Regional
		Asesor de la Gerencia de Desarrollo Social
<i>Cajamarca</i>	Dirección Regional de Salud	Coordinadora Regional del PAIMNI
		Gobierno Regional
		Gerente de Desarrollo Social
		Directora Ejecutiva de Salud de las Personas
		Responsable de Unidad de Proyectos y Cooperación Externa – Oficina Ejecutiva de Planeamiento Estratégico
		Coordinadora del Área de Desarrollo de Recursos Humanos
		Ex Director Regional de Salud

**Table N°2: Qualitative Assessment Tool  
Semi-structured qualitative interview guide  
Reorganization of the Regional**

Region	Process	Stakeholders	Question Guide
<b>La Libertad, San Martín and Cajamarca</b>	<b>Background / Transfer of functions and faculties</b>	<b>Health Regional Directorate</b>	How was the development of the process of constructing the Concerted Capabilities Map?
			What was the involvement of regions in building the Concerted Capabilities Map in Health?
			What were the achievements of this process?
			How was the transferring process of health functions in the region?
			What were the proposed challenges that for the exercise of transferred health functions?
	<b>Organizational Adequacy of health sector to the Regional Government</b>	<b>Regional Government - RHD</b>	What is the focus / concept under which the adjustment is made in the health sector on the institutional design of RG?
			What were the key changes implemented to the institutional design of the RG with the incorporation of the regional sector?
			How were these changes expressed in the institutional design of the RG (organization chart)?
			How does the RG institutional design respond to the exercise of the transferred health functions?
			Make an exercise balance on the transferred health functions and explain the way the institutional design of the RG responded to it.

**Table N°3: Qualitative Assessment Tool  
Semi-structured qualitative interview guide  
Reorganization process of Regional Health Directorates**

Region	Process	Stakeholders	Question Guide
<b>La Libertad, San Martín and Cajamarca</b>	<b>Organizational Redesign of the Regional Health Directorate</b>	<b>RHD</b>	Does the Health CCM was an input for organizational redesign of RHD? How?
			Did the regulation of the MoH dated 2003 and guidelines dated 2005 of the same norm play a role in the organizational design of the RHD?
			Are the results of the Regional MED - Vol 1 considered for this process?
			How does the organizational redesign of the RHD respond to the exercise of transferred health functions?
			What functions? How is it expressed on the organizational design (organization chart)?
			Which body is responsible for the exercise of that function? (Referred to previous question).
			There was technical assistance to carry out this process?
			What was it about?
			What was the result of that technical assistance?
			Was there any type of needs assessment on institutional capacity building?
			Is there a plan to strengthen institutional capabilities?
			How is it being developed?
			Was there technical assistance to carry out this process?
			What was it about?
			What was the result of that technical assistance?
			What has been the impact caused by the reorganization of the RHD on terms of health outcomes?
			Does the reorganization of the RHD involved modifications on the networks organizational design?
			What implications had this on the organization and management of services? Make an exercise balance on the transferred health functions. Period 2008 – 2012.
			What have been the lessons learned in the context of the reorganization of the RHD?

## 7. References

1. Constitución Política del Perú. Perú: Asamblea Constituyente; 1979.
2. Ley de Bases de la Regionalización. Ley 24650 Lima: Congreso de la Republica; 1988.
3. Guevara Ruiz G. Política Monetaria del Banco Central: Una Perspectiva Histórica. Revista de Estudios Económicos del Banco Central de Reserva del Peru. 1999(5).
4. Ley que norma transitoriamente la organización y funcionamiento de los Gobiernos Regionales. Decreto Ley 25432. Lima: Presidencia de la República; 1992.
5. Constitución Política del Estado Peruano. Perú: Congreso Constituyente Democrático; 1993.
6. Ugarte O, Bardalez C. La Descentralización en Salud. Lima: Proyecto USAID|Peru|Promoviendo Alianzas y Estrategias; 2006.
7. Reforma Constitucional del Capítulo XIV del Título IV sobre Descentralización. Ley 27680. Perú: Congreso de la Republica; 2002.
8. Ley de Bases de la Descentralización. Ley 27783. Perú: Congreso de la Republica; 2002.
9. Ley Orgánica de los Gobiernos Regionales. Ley 27867. Perú: Congreso de la Republica; 2002.
10. Ley que Modifica la Ley Orgánica de los Gobiernos Regionales. Ley 27902. Perú: Congreso de la Republica; 2002.
11. Acuerdo Nacional. Lima: Foro del Acuerdo Nacional; 2002.
12. Ley Marco de Modernización del Estado. Ley 27658. Perú: Congreso de la Republica; 2002.
13. Ley Orgánica de Municipalidades. Ley 27972. Perú: Congreso de la Republica; 2002.
14. CND. Plan Estratégico del Proceso de Descentralización. 2007 - 2011. Consejo Nacional de Descentralización; 2006.
15. Disposiciones relativas al proceso de transferencia de la gestión de la atención primaria de salud a las municipalidades provinciales y distritales. DS 077-2006-PCM Lima: Presidencia del Consejo de Ministros; 2006.
16. Establece disposiciones relativas a la culminación de las transferencias programadas a los gobiernos regionales. DS 068-2006-PCM Lima: Presidencia del Consejo de Ministros; 2006.
17. Modifica el Plan Anual de Transferencia de Competencias Sectoriales a los Gobiernos Regionales y Locales del año 2006. DS 076-2006-PCM Lima: Presidencia del Consejo de Ministros; 2006.
18. Autoriza al Ministerio de Educación llevar a cabo un plan piloto de municipalización de la gestión educativa. DS 078-2006-PCM Lima: Presidencia del Consejo de Ministros; 2006.
19. Identifica y cuantifica los recursos presupuestales asociados a transferencias de funciones. RM 664-2006-EF/10 Lima: Ministerio de Economía y Finanzas; 2006.
20. Aprueban el nuevo reglamento del Sistema Nacional de Inversión Pública. DS 102-2007-EF Lima: Ministerio de Economía y Finanzas; 2007.
21. Aprueba la fusión por absorción del Consejo Nacional de Descentralización para pasar a la Presidencia del Consejo de Ministros como Secretaría Nacional de Descentralización. DS 007-2007-PCM Lima: Presidencia del Consejo de Ministros; 2007.
22. Ley de Presupuesto del Sector Público para el año fiscal 2008. Ley 28927 Lima: Congreso de la República; 2007.
23. Ley de la Mancomunidad Municipal. Ley 29029. Perú: Congreso de la República; 2007.

24. Ley Orgánica del Poder Ejecutivo. Ley 29158 Perú: Congreso de la República; 2007.
25. Define y establece las Políticas Nacionales de obligatorio cumplimiento para las entidades del Gobierno Nacional. DS 027-2007-PCM Lima: Presidencia del Consejo de Ministros; 2007.
26. Crea la Autoridad Nacional del Servicio Civil. Decreto Legislativo 1023 Lima: Presidencia de la República; 2008.
27. Establece un régimen especial facultativo para los Gobiernos Regionales y Locales que deseen implementar procesos de modernización institucional. Decreto Legislativo 1026 Lima: Presidencia de la República; 2008.
28. Ley del Sistema Nacional de Planeamiento Estratégico y del Centro Nacional de Planeamiento Estratégico. Decreto Legislativo 1088 Lima: Presidencia de la República; 2008.
29. Ley del sistema de acreditación de los gobiernos regionales y locales. Ley 28273. Lima: Congreso de la República; 2004.
30. CND. Plan de transferencias sectorial del quinquenio 2005 - 2009. Consejo Nacional de Descentralización; 2005.
31. Plan Anual de Transferencia de Competencias Sectoriales a los Gobiernos Regionales y Locales del Año 2007. DS 036-2007-PCM Lima: Presidencia del Consejo de Ministros; 2007.
32. PCM. Informe Anual sobre el Proceso de Descentralización. Presidencia del Consejo de Ministros; 2008.
33. Dispone medidas para la identificación y cuantificación de recursos asociados a la transferencia de funciones sectoriales a los gobiernos regionales. DS 093-2007-PCM Lima: Presidencia del Consejo de Ministros; 2007.
34. Normas para la Ejecución de la Transferencia del año 2007 a los Gobiernos Regionales y Locales, de las Funciones Sectoriales incluidas en los Planes Anuales de Transferencia. Resolución de Secretaría de Descentralización 003-2007-PCM/SD. Lima: Secretaría de Descentralización de la Presidencia del Consejo de Ministros; 2007.
35. Normas para la ejecución de las transferencias del año 2007 a los gobiernos regionales y locales. Resolución 003-2007-PCM/SD Lima: Secretaría de Descentralización de la Presidencia del Consejo de Ministros; 2007.
36. Aprueba requisitos específicos, indicadores y procedimientos de verificación para el proceso de transferencia. Resolución 011-2007-PCM/SD. Lima: Secretaría de Descentralización de la Presidencia del Consejo de Ministros; 2007.
37. Normas que amplía el plazo para culminar las transferencias de las funciones sectoriales incluidas en el Plan de Transferencias. Resolución 001-2008-PCM/SD Lima: Secretaría de Descentralización de la Presidencia del Consejo de Ministros; 2008.
38. Dictan medidas complementarias para la transferencia a los Gobiernos Regionales de la función sectorial prevista en el art. 51, literal n) de la Ley N° 27867. Resolución 028-2008-PCM/SD Lima: Secretaría de Descentralización de la Presidencia del Consejo de Ministros; 2008.
39. Reporte de supervisión de la Defensoría del Pueblo sobre la transferencia de competencias sectoriales a los Gobiernos Regionales. Lima: Defensoría del Pueblo; 2006.
40. Informe anual 2006 sobre el proceso de descentralización para el Congreso de la República del Perú. Lima: Presidencia del Consejo de Ministros. Secretaría de Descentralización; 2006.
41. Desarrollo de la Función Salud en los gobiernos locales. RM 366-2007/MOH. Lima: Ministerio de Salud; 2007.
42. Guía de implementación de los proyectos pilotos de descentralización en salud a los gobiernos locales. RM 614-2007/MOH. Lima: Ministerio de Salud; 2007.
43. Ley de Presupuesto del Sector Público para el año 1994. Ley 26268. Perú: Congreso de la República; 1994.

44. Cruz M. El Gasto en Salud. Revista de la Facultad de Ciencias Económicas de la UNMSM. 1997(5):79-84.
45. Crea el Programa de Administración Compartida de Servicios de Salud. DS 001-94-SA Lima: Ministerio de Salud; 1994.
46. Vera JJ, Sobrevilla A, Bendezu C. Los Comités Locales de Administración en Salud (CLAS). Organización y Modelo de Gestión. El Plan de Salud Local. Lima: Ministerio de Salud; 1996.
47. Altobelli L. Case Study of CLAS in Peru: Opportunity and Empowerment for Health Equity. Lima: Future Generations; 2008.
48. Ley que establece la cogestión y participación ciudadana para el primer nivel de atención en los establecimientos de salud del Ministerio de Salud y de las Regiones. Ley 29124 Perú: Congreso de la Republica; 2007.
49. PSNB. Modelo de Organización de la Red de Laboratorios del Primer Nivel de Atención. Lima: Ministerio de Salud; 2000.
50. MOH. Guía para orientar su trabajo de planificación estratégica. Lima: Ministerio de Salud - Proyecto 2000; 2000.
51. MOH. Descentralización en Salud. Lima: MOH - Oficina de Descentralización; 2011.
52. Lozano R. Interculturalidad. Desafío y Proceso de Construcción. Manual de Capacitación: SERVINDI; 2005.
53. Salud: La Voz de La Libertad. Trujillo: Gobierno Regional de La Libertad; USAID-Proyecto PRAES; 2005.
54. Ordenanza que aprueba el Plan Participativo Regional de Salud de La Libertad 2006-2011. Ordenanza Regional 019-2005-CR/RLL Trujillo: Gobierno Regional de La Libertad; 2005.
55. Plan Participativo Regional de Lambayeque. Para Vivir Mejor. Chiclayo: Gobierno Regional de Lambayeque; USAID-Proyecto PRAES; 2005.
56. Plan Participativo Regional de Ucayali. Pucallpa: Gobierno Regional de Ucayali; USAID-Proyecto PRAES; 2005.
57. Plan Participativo Regional de San Martín. Tarapoto: Gobierno Regional de San Martín; USAID-Proyecto PRAES; 2006.
58. Reglamento de la Ley 28273. Ley del Sistema de Acreditación de Gobiernos Regionales y Locales. DS 080-2004-PCM. Lima: Presidencia del Consejo de Ministros; 2004.
59. Bardález C, Ugarte O. Mapa concertado de competencias y proceso de transferencia de funciones de descentralización del sector salud. Lima: USAID|Peru|Proyecto PHRplus; 2005.
60. Muñoz F, López-Acuña D, Halverson P, Macedo CGd, Hanna W, Larriue M, et al. Las funciones esenciales de la salud pública: un tema emergente en las reformas del sector salud. Revista Panamericana de Salud Pública. 2000;8(1/2):126-34.
61. OMS-OPS. Funciones Esenciales de Salud Pública. 42° Consejo Directivo 52° Sesión del Comité Regional. Washington DC: OPS-OMS; 2000.
62. Bardález C. Guía Metodológica del Mapa Concertado de Competencias en Salud. Lima: USAID|Peru|Proyecto PRAES; 2006.
63. PHRplus. Exitoso III Encuentro MOH - Gobiernos Regionales. Boletín Quincenal de PHRplus. 2004(Octubre 2004):2.
64. MOH. Aprueba Convenio de Delegación de Facultades entre el MOH y el Gobierno Regional del Cusco. In: MOH, editor. RM 879-2004/MOH. Lima: Ministerio de Salud; 2004.
65. Declaran concluido proceso de transferencia de funciones sectoriales en materia de salud, respecto de los Gobiernos Regionales de Amazonas, Arequipa, Cajamarca, Cusco, Junín, Lambayeque, Loreto, Tumbes y Ucayali. RM 612-2006/MOH. Lima: Ministerio de Salud; 2006.

66. Declaran concluido proceso de transferencia de funciones sectoriales en materia de salud, respecto de los Gobiernos Regionales de Ancash, Huánuco, Ica, Madre de Dios y Pasco. RM 680-2006/MOH. Lima: Ministerio de Salud; 2006.
67. PRAES. Proyecto Promoviendo Alianzas y Estrategias - PRAES. Informe de Actividades. Octubre 2006 - Septiembre 2007. Lima: Proyecto USAID|PRAES; 2007.
68. Amplía el plazo para culminar la transferencia a los Gobiernos Regionales y Locales. DS 083-2008-PCM. Lima: Presidencia del Consejo de Ministros; 2009.
69. Medidas para regular el procedimiento de conformación de comisiones de transferencia y su funcionamiento. Resolución 001-2009-PCM/SD. Lima: Secretaría de Descentralización de la Presidencia del Consejo de Ministros; 2009.
70. MOH. Constituyen la Comisión Intergubernamental de Salud. In: MOH, editor. RM 871-2009/MOH. Lima: Ministerio de Salud; 2009.
71. MOH. Sistema de Monitoreo y Evaluación de la Descentralización en Salud: MED. Ejercicio de las Funciones Descentralizadas en Salud en el ámbito regional. In: MOH, editor. RM 739-2009/MOH. Lima: Ministerio de Salud; 2009.
72. MOH. Sistematización del proceso de implementación del monitoreo y evaluación de la descentralización en salud a nivel regional. Lima: Ministerio de Salud; 2010.
73. Harrington H. Mejoramiento de los procesos en las empresas. Bogotá: McGraw Hill; 1986.
74. Bardález C, Spelucin J. Metodología de rediseño organizacional de direcciones regionales sectoriales en el marco de la descentralización. Lima: Políticas en Salud - Abt Associates; 2011.
75. Bardález C. Metodología de rediseño organizacional de direcciones regionales sectoriales en el marco de la descentralización. Lima: Promoviendo Alianzas y Estrategias - Abt Associates; 2008.
76. Galbraith J. Designing Organizations: An executive briefing on Strategy, Structures and Process. San Francisco: Jossey-Bass; 1995.
77. Kates A, J G. Designing your organization. Using the Star Model to solve 5 critical design challenges. San Francisco: Jossey-Bass; 2007.
78. Mintzberg H. Diseño de organizaciones eficientes. Buenos Aires: El Ateneo; 1991.
79. Mintzberg H. Structure in fives. Designing effective organizations. New Jersey: Englewood-Cliffs; 1993.
80. Unger J, Macq F, Bredo F, Boelaert M. Through Mintzberg's glasses: a fresh look at the organization of ministries of health. Bulletin of the World Health Organization. 2000;78(8).
81. PRAES. Proyecto Promoviendo Alianzas y Estrategias - PRAES. Informe de Actividades. Abril - Setiembre 2008. Lima: Proyecto USAID|PRAES; 2008.
82. Salcedo E. Guía para la elaboración del Plan de Mejoramiento de Desempeño Institucional de la DIRESA. Lima: USAID|Peru|Proyecto PRAES; 2009.
83. Ley que regula el régimen transitorio de las direcciones regionales sectoriales en los gobiernos regionales. Ley 28926. Perú: Congreso de la Republica; 2002.
84. Declaran que los Gobiernos Regionales de Cajamarca, La Libertad y Huancavelica han culminado procesos de transferencia de las funciones sectoriales en materia de salud. RM 386-2008/MOH. Lima: Ministerio de Salud; 2008.
85. Aprueban modificación de la Estructura Orgánica del Gobierno Regional La Libertad. Ordenanza N° 023-2008-GR-LL/CR. Trujillo: Gobierno Regional La Libertad; 2008.
86. Modificación del organigrama estructural y del reglamento del organización y funcione (ROF) del Gobierno Regional de La Libertad. Ordenanza N° 008-2011-GR-LL-CR. Trujillo: Gobierno Regional La Libertad; 2011.

87. Aprueban modificación del Organigrama Estructural y del Reglamento de Organización y Funciones (ROF) Año 2011 de la Gerencia Regional de Salud del Gobierno Regional de La Libertad Ordenanza N° 004-2011-GR-LL/CR. Trujillo: Gobierno Regional La Libertad; 2011.
88. Aprueban Política Regional de Salud de La Libertad 2007 - 2012. Ordenanza Regional N° 020-2009-GR-LL-CR. Trujillo: Gobierno Regional La Libertad; 2009.
89. Aprueba el Organigrama Estructural y el Reglamento de Organización y Funciones (ROF) de la Dirección Regional de Salud. Ordenanza Regional 004-2006-CR-RLL. Trujillo: Gobierno Regional La Libertad; 2006.
90. Crea el Instituto Regional de Enfermedades Neoplásicas "Dr. Luis Pinillos Ganoza". Ordenanza Regional 021-2006-CR-LL/CR. Trujillo: Gobierno Regional La Libertad; 2006.
91. Reconocen que las Direcciones Regionales de Salud constituyen la única autoridad de salud en cada Gobierno Regional. 405-2005/MOH. Lima: Ministerio de Salud; 2005.
92. MOH. Lineamientos para la adecuación de la organización de las Direcciones Regionales de Salud en el marco del proceso de descentralización. RM 566-2005/MOH. Lima: Ministerio de Salud; 2005.
93. Ley del Ministerio de Salud. Ley 27567. Lima: Congreso de la Republica; 2002.
94. MOH. Aprueba Reglamento de la Ley del Ministerio de Salud. RM 013-2002-SA. Lima: Ministerio de Salud; 2002.
95. MOH. Aprueba Reglamento de Organización y Funciones de las Direcciones de Salud y de las Direcciones de Red de Salud. In: MOH, editor. RM 573-2003-SA/DM. Lima: Ministerio de Salud; 2003.
96. MOH. Texto Concordado del Reglamento de Organización y Funciones del Ministerio de Salud. DS 023-2005-SA. Lima: Ministerio de Salud; 2005.
97. Aprueba el Reglamento de Organización y Funciones de la Dirección Regional de Salud de San Martín. Ordenanza Regional 027-2009-GRSM/CR. San Martín: Gobierno Regional de San Martín; 2009.
98. GORESAN. Informe de sustentación técnica de la propuesta de Reglamento de Organización y Funciones de las Redes de Salud de San Martín. Moyobamba: Gobierno Regional de San Martín; 2011.
99. GORESAN. Reglamento de Organización y Funciones de las Redes de Salud. OR 026-2011-GRSM/CR. Moyobamba: Gobierno Regional de San Martín; 2011.
100. GORESAN. Cuadro de Asignación de Personas de las Redes y Microrredes de Salud. OR 008-2012-GRSM/CR. Moyobamba: Gobierno Regional de San Martín; 2012.
101. GORESAN. Plan de Desarrollo de las Personas 2012-2016. Resolución Ejecutiva Regional 1116-2011. Moyobamba: Gobierno Regional de San Martín; 2011.
102. Plan Quinquenal de Desarrollo de las Personas de la DIRES San Martín 2013-2017. Moyobamba: Gobierno Regional de San Martín; 2012.
103. Aprueba Reglamento de la Ley del Ministerio de Salud. Resolución Ejecutiva Regional 729-2003-GRCAJ/P. Cajamarca: Gobierno Regional de Cajamarca; 2003.
104. MOH. Reconoce a la DIRES como única autoridad de salud en el Gobierno Regional. In: MOH, editor. RM 405-2005-SA. Lima: Ministerio de Salud; 2005.
105. MOH. Aprueba los lineamientos para la adecuación de la organización de las Direcciones Regionales de Salud. In: MOH, editor. RM 566-2005-SA. Lima: Ministerio de Salud; 2005.
106. Constituye Comisión para adecuar la organización de la DIRES Cajamarca. Resolución Ejecutiva Regional 305-2005-GR-CAJ/P. Cajamarca: Gobierno Regional de Cajamarca; 2005.

107. Informe Técnico de la Comisión de Rediseño Organizacional de la DIRES. Oficio 601-2006-GR-CAJ-GRPPAT. Cajamarca: Gobierno Regional de Cajamarca; 2006.
108. Aprueba Reglamento de Organización y Funciones de la Dirección Regional de Salud de Cajamarca. In: Libertad GRdL, editor. Resolución Ejecutiva Regional 162-2006-GR-CAJ/P. Cajamarca: Gobierno Regional de La Libertad; 2006.
109. Declaran en reorganización a la Dirección Regional de Salud de Cajamarca. Ordenanza Regional 001-2007-GRCAJ-CR. Cajamarca: Gobierno Regional de Cajamarca; 2007.
110. Crean Comisión para elaborar Propuesta de Organización de la Dirección Regional de Salud Cajamarca. Cajamarca: Gobierno Regional de Cajamarca; 2007.
111. Rediseño Organizacional. Cajamarca: Comisión de Reorganización de la Dirección Regional de Salud Cajamarca; 2009.
112. Aprueba la estructura orgánica y funciones básicas de la Dirección Regional de Salud Cajamarca. Resolución Ejecutiva Regional 162-2006-GRCAJ/P Cajamarca: Gobierno Regional Cajamarca; 2006.
113. Reglamento de Organización y Funciones de la Dirección Regional de Salud Cajamarca. Adecuado a la RM 566-2005/MOH. Peru: Gobierno Regional Cajamarca - Dirección Regional de Salud; 2006.