Evaluation of the Peru Integrated Health and Family Planning Projects (219 and 230)

Final Report

Submitted to:
United States Agency
For International Development
Lima, Peru

May 1985

Submitted by:
Clapp & Mayne, Inc.
and
University Research Corporation

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ACKNOWLEDGEMENTS

This report is the product of interviews and meetings held with the people indicated in Annex 1 and others who provided many of the comments regarding the current status of primary health care in Peru and suggestions for improvements. We are especially grateful to the people named below for all of their support and help during our work in Peru and the preparation of the report.

We would like to thank Ms. Norma Parker, Mr. Arthur Danart, and Ms. Joan La Rosa of USAID/Peru, for having facilitated the investigation through their ever-appropriate observations and suggestions, and Dr. Daniel Alzamora and Dr. Hernan Farje of the Ministry of Health, for their support and collaboration in setting up the interviews and trips to the health regions and for orienting the team regarding primary health care in Peru.

We thank Dr. John Gillespie, Mr. Jack Wolff, and other representatives of Westinghouse Health Systems for sharing with the evaluation team members their experiences and points of view on problems and obstacles hindering the efficient implementation of projects 219 and 230.

We are grateful to Ms. Rosana Herran for her efficient handling of the administrative and logistical work in Peru and to Ms. Mercedes Susuki for her help in the gathering and analysis of data. Ms. Dora Rojas Pinto and Ms. Teresa Pfieffer were of great assistance in typing the first draft of this report in Peru.

The evaluation team also extends its thanks to the hardworking and efficient team in Washington who participated in the editing, revision, translation, and production of the evaluation report by the staff of Clapp and Mayne, Inc., and the University Research Corporation: Ms. Lani Rice and Ms. Brenda J. Arnold for coordination, editing, and translation, Ms. Teresa Gottlieb for translation into Spanish, Ms. Connie Costta and Ms. Edna Motaghi for their efficient typing work on the report, and Ms. Pat Bryant for the graphics work.

ACRONYMS

AMIDEP	=	Asociación Multidisciplinaria de Investigación y Docencia en Población
ASPEFAM	=	Asociación Peruana de Facultades de Medicina
ATLF	=	Asociación de Trabajo Laico Familiar
CBD	=	Community-based Distribution
CDC	=	Centers for Disease Control
CNP	=	Consejo Nacional de Población
DASA	=	Directorate of Supplies and Ancillary (Support) Services
DGA	=	General Division of Customs
DGSS	=	General Directorate of Health Services
DGTP	=	Public Treasury Office
DISAR	=	Directorate of Rural Sanitation
DPE	=	Directorate of Programming and Evaluation
DSMIP	=	Directorate of Maternal and Child Health and Population
ESAN	=	Escuela de Administración de Negocios para Graduados
FAG	=	Fertile Age Group
FENDECAAP	=	Federación Nacional de Cooperativas Agrarias Azucareras del Perú
FIC	=	Fondo de Inversión y Contrapartida
FP	=	Family Planning
GOP	=	Government of Peru
GTZ	=	German Agency for Technical Cooperation
IAVS	=	International Association for Voluntary Sterilization
IDB	=	InterAmerican Development Bank
INE	=	National Institute of Statistics
INIDE	=	Instituto Nacional de Investigación y Desarrollo de la Educación
IPSS	=	Peruvian Social Security Institute
IUD	=	Intrauterine Device
JHPIEGO	=	Johns Hopkins Program for International Education in Gynecology and Obstetrics
LUSA	=	Laboratorios Unidos S. A.
MOH	=	Ministry of Health
NNHS	=	National Nutrition and Health Survey
OB/GYN	=	Obstetrics/Gynecology
OECPF	=	Executive Accounting Office
OGA	=	General Administration Office
OGIE	=	Office of Information and Statistics
OGII	=	General Office of International Exchange
OGP	=	General Planning Office
OGR	=	General Office of Organization and Methods
ORS	=	Oral Rehydration Salts
ORT	=	Oral Rehydration Therapy
PAHO	=	Pan American Health Organization
PECOSA	=	Request and Delivery Voucher
PHC	=	Primary Health Care
PLAS	=	Plan de Alfabetización Sanitaria
PVO	=	Private Voluntary Organization
SMVA	=	Minimum Annual Subsistence Salary
SPH	=	School of Public Health
TA	=	Technical Assistance
TBA	=	Traditional Birth Attendant
UNFPA	=	United Nations Fund for Population Activities
UNICEF	=	United Nations Children's Fund
USAID	=	United States Agency for International Development Mission to Peru
WHO	=	World Health Organization

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1.0 INTRODUCTION

1.1 Purpose and Scope of the Evaluation

This is the first external evaluation of primary health care projects financed by the United States Agency for International Development (USAID) and implemented by the Government of Peru (GOP) through the Ministry of Health (MOH). It analyzes the relationship between inputs used in projects 219 and 230, the organizational structure for the handling of the projects, and some of the results that are being achieved in the delivery of primary health care services. The focus of the evaluation is on improving processes that hamper the project. Relatively less attention is paid to the impact of the projects, which would have been the case for an impact evaluation at the end of the project.

This evaluation was planned in the original design of projects 219 and 230. The basic purpose of the evaluation is to make specific recommendations to improve the primary health care (PHC) services delivered through improvements in the administrative aspects, logistics, financing and other parts of the systems involved in PHC. It is also convenient now to look ahead to the end of projects 219/230 to anticipate the transition to a totally integrated operation with no special differences between these projects and the other operational activities of the MOH.

1.2 The Evaluation Team

USAID contracted for this evaluation with Clapp and Mayne, Inc. (C&M) and the University Research Corporation (URC) using Indefinite Quantity Contracts for Design and Evaluation that the Agency has with these organizations. Six evaluators participated in the data collection and analysis work in Peru in late 1984. The team leader/management specialist arrived in October for detailed planning, followed shortly by four evaluators with strong credentials in family planning, health planning, logistics, and financial systems. An evaluation coordinator came for a week at the end of November. The health planner returned to Peru in January for further discussions and observations. Results from the data-gathering work in Peru were developed into a draft report submitted in English and Spanish to USAID and the Government of Peru. In March 1985, three team members returned to Lima for "consensus building" - the team leader, the coordinator, and the Health Planner.

1.3 Method of Investigation

The most important steps to carrying out the evaluation were the following:

The USAID Project Manager, the General Director of Health Services of the MOH, and the Executive Director of Maternal and Child Health and Population were interviewed to determine the assumptions to take into account and the people and regions that should be visited.

The team reviewed national data available at the statistics office of the MOH, project documents at the central and regional levels, USAID project documents, and related reports and studies. The team requested a special financial analysis from MOH regarding budget performance, which was kindly provided.

The team interviewed USAID officers, the technical advisers contracted through Westinghouse Health Systems, Ministry of Health personnel and all levels, and representatives of other international organizations involved in primary health care in Peru. A partial list of people interviewed appears in Annex 1 of the evaluation.

The team observed and interviewed in nine of the fifteen regions assisted by the three USAID-funded Primary Health Care projects. They interviewed MOH personnel at eight hospitals, eleven health centers, and five health posts. The places to be visited were selected based on geographic and cultural representativeness, scope of the delivery of PHC services, and the anticipated degree of effectiveness and efficiency of the administrative, financial, and logistics support systems known to be problem areas within the project. Because the selection process used was far from random, it should be assumed that the least developed facilities were not visited by the evaluators. The field visits were relatively short with more than one site visited in the same day. The team attempted to collect comparable data in various sites to facilitate responsible generalizations and tables summarizing conditions at the facilities visited by the team.

The field work was done in November 1984 and supplemented by a trip to Ica by the health planner in January 1985.

The data and interviews were analyzed in Lima to clarify the findings of the evaluation and the conclusions about the status of the project. Identification of important problems and opportunities promptly led to discussion of practical approaches to improve the situation both within the team and with others involved in the project. Out of these discussions came working papers with tentative recommendations which were discussed with USAID at the end of November 1984, prior to departure of the team from Peru.

The results of the work in Peru, including comments and reactions to the working papers, were refined by the individual consultants and transmitted to Washington for integration, refinement, and translation as necessary into complete reports in English and Spanish. The team leader and health planner came to Washington to participate in this process in January 1985. Home office staff from University Research Corporation and Clapp and Mayne, Inc. assisted in the editorial, translation, and production work. The result was a "Draft Report" in English and a translation into Spanish with Executive Summaries in both languages to be circulated on a limited basis by USAID/Peru for comments.

In March 1985, the "Draft Report" was the basis for discussions in Lima to elicit comments and suggestions, and for "building consensus" about what actions should be taken to improve the projects, taking into account the

"Draft Report." The evaluators took note of the feedback, made corrections in the report where appropriate, and documented significant feedback from the March session for the Final Report readers not involved in the discussions. The revisions, refinements, and translations were done in Washington and incorporated into the "Final Report" in English and Spanish.

2.0 PROJECT BACKGROUND

2.1 Summary of Project History

In 1978, Peru suffered the same mortality and morbidity patterns caused by diarrheal and respiratory diseases, malnutrition, and inadequate health and hygiene practices as other Third World nations. Forty-four percent of all deaths were among children under the age of five; most of these deaths were preventable. The public health system was responsible for providing preventive and curative services to the majority of the population, but was oriented to curative care. All health resources were concentrated in Lima and in other larger urban areas, leaving a major portion of the population without access to modern health care.

The delivery of health services was made difficult by several other factors. Twenty percent of the population still lived in towns of less than 200 inhabitants, and twelve percent in towns of 200 to 2,000 inhabitants. The great variation in geographic and socio-cultural characteristics of Peru and its people, including climate, terrain, dispersion of the population, language, literacy, and occupation and economic level, contributes to problems in service delivery. Natural disasters such as earthquakes and the floods and droughts precipitated by the El Niño current have not made the task of delivering health services any easier. Finally, the gross domestic product has declined by about 16 percent in the last few years, an indicator of the deep crisis currently affecting the economy. In the last twenty years the health sector has received a relatively small portion of the national budget. During the last few years this proportion has decreased even further to where it now stands at four and a half percent in 1984.*

The Government of Peru in 1979 formally adopted a national plan for the delivery of primary health care (PHC) services to improve the health conditions of its people in response to the 1978 Alma Ata Conference. The objectives were further specified in 1980: to reduce mortality and morbidity in rural and marginal urban areas; to promote maternal and child health; to integrate family planning into the program; and to extend coverage and improve the efficiency of health services. The Ministry of Health was given a major role in implementing Peru's national population policy, including the provision of family planning services. The specific goals of the population policy included reduction of mortality among mothers and children, provision of protection against unwanted pregnancies, and improvement in the quality and coverage of maternal and child health services. The GOP strategy to accomplish these objectives included reorganization of the Ministry of Health; improvement of supervision, evaluation, information and logistics systems; improvement of the physical infrastructure; and strengthening of intersectoral and donor coordination.

*Source: Annual Budget Statute of the Public Sector for 1981, 1982, and 1983; Laura Altobelli, "Human Resources Development in Peru"; also see Section 4.2.7 of this report.

USAID funded three integrated primary health care delivery projects in 1978 and 1980. The first was a pilot integrated primary health care project in the Ica region, the Sur Medio Project (527-224). This project was intended to be a model project including delivery of family planning services, and was originally supported by AID/Washington. Then in 1979, project 527-0219, Extension of Integrated Primary Health Care, was approved with a total of US$7.15 million from USAID and counterpart funds of US$2.4 million. Project 527-0230, Integrated Health and Family Planning, began in 1980 with a budget of US$10.8 million from USAID and counterpart funds of US$3.6 million. Since the two national projects are considered by USAID to have the same objective and similar strategies, they are being implemented as one project.

The projects do have different completion dates. Project 219 is due to end in January 1985, and project 230 is due to end in June 1986. The two national projects assist 14 out of the 17 health regions in Peru. USAID considers the three projects as first steps toward further support to Peru in primary health care, expecting that these projects show opportunities for important improvements in health services. Other donors also actively support Peru's PHC program: the World Bank, the Pan American Health Organization (PAHO), UNICEF, the Interamerican Development Bank (IDB), the German Agency for Technical Cooperation (GTZ), and several other governments. Descriptions of the activities of these agencies are included in Annex 2.

2.2 Project Design

The goal of projects 219 and 230 is to improve the health and well-being of the poorest segments of the Peruvian population, consistent with the GOP's primary health care plan. The purpose of the projects is to strengthen and extend the delivery of primary health care services to rural and marginal urban areas, integrating family planning services into health care through both the public and private sectors. These PHC services at a minimum include prenatal care, postnatal care, family planning services, immunizations, oral rehydration therapy, community health education, and environmental sanitation including latrine installation and water source protection. A project amendment in December 1984 has added an emphasis on growth monitoring of children and nutritional services.

An essential component of the strategy of these projects is an affordable, low cost health delivery system. Two low cost approaches were chosen to extend these PHC services to the most needy: 1) community workers and health auxiliaries would form the core staff for service delivery into the geographic areas lacking PHC services; and 2) the MOH systems necessary to improve the delivery of PHC services would be strengthened.

The major project outputs anticipated as a direct result of projects 219 and 230 were the following:

1. an effective general management, and administrative system (see section 4.1 Administrative Structure and Project Management);

2. an effective financial management system (see section 4.2 Financial Systems);

3. a logistics system which effectively delivers the necessary materials, equipment and supplies to the establishments providing primary health care (see section 4.3 Logistics and Supplies);

4. an effective health information system (see section 4.4 Health Information System);

5. an effective supervisory system (see section 4.5 Supervision System);

6. trained promoters and traditional midwives to extend PHC services to the community level, plus trained health auxiliaries, health professionals, and related personnel (see section 4.6 Training).

Projects 219 and 230 provide support for the development of each of these systems through the training of health personnel and the provision of technical assistance, materials, equipment, supplies, medicines, and contraceptives.

This report is organized so as to deal specifically with each of the major outputs or system components of projects 219/230. Chapter Three describes the current status and trends regarding the project purpose, i.e., the MOH's delivery of primary health care services. Chapter Four discusses the projects' outputs, that is, the six systems to be strengthened through the project which are necessary for the extension and improvement of the coverage of PHC services. Chapter Five describes the current status and trends in private sector and non-MOH public sector family planning programs. Chapter Six summarizes the status of the technical assistance (TA) component of the project.

Specific recommendations for improvements in the project components are presented in each respective chapter or section. A summary of all the recommendations is included as Chapter Seven.

3.0 CURRENT STATUS OF THE DELIVERY OF PRIMARY HEALTH CARE SERVICES

Significant progress has been made in project implementation during the last two years after an initial two year period of relative inactivity. The impressive improvement has been the result of primarily three factors: 1). active USAID mission management and its flexibility with respect to meeting project technical assistance needs has increased project momentum, 2) technical assistance has improved project activity, and 3) the MOH has been more aggressive and energetic in implementing the project, especially since the change in location of the administration of the project to the Directorate of Maternal Child Health and Population (DSMIP). The Ministry has been trying harder to spend its donor funds. Due to the gravity of the Peruvian economic situation, the funds from donors have become critical for the MOH to implement its national primary care program.

This midterm evaluation is not an impact evaluation, but it is important to summarize current project status with respect to the project purpose in order to interpret the significance of project outputs. As noted earlier, the improvement and extension of the delivery of primary care services in rural and marginal urban areas is the purpose of these projects. Thus, good indicators of achievement of project purpose are increases in the number of PHC services provided by health centers and health posts and by community health workers in the fourteen regions covered by the projects. Since projects 219/230 have provided inputs for certain categories of primary care services, we focus attention on these: family planning services, oral rehydration therapy, environmental sanitation, and community education.

To evaluate the relationship of PHC services to the USAID-supported projects 219/230, the evaluation team reviewed national data available at the statistics office of the MOH. Also reviewed were MOH project documents at the central and regional levels and many project-related reports to get better information about the quantity and quality of PHC services delivered. The evaluation team interviewed MOH personnel at all levels, USAID officers, other donor officials, and Westinghouse advisers funded under project 230. Finally, the team made site visits to nine of the fifteen regions assisted by the three projects, visiting eight hospitals, eleven health centers, and five health posts.

The sites visited were selected in consultation with regional MOH officials and local project coordinators, which may introduce some bias. In otherwords, the worst facilities were probably not seen. A structured questionnaire was utilized which contained sections on delivery of specific services, users of contraceptives by method, staffing levels, record keeping (including the separation of new and continuing contraceptive users), transportation, supply and channels of resupply, and knowledge about other private or public institutions providing health and family planning education or services in the respective areas. The field visits were typically only one day per region with more than one institution visited per site.

Data on PHC services at the central level are not collected systematically nor aggregated in a way that facilitates the measurement of progress in the delivery of PHC services to the target groups. The data at the central MOH are not complete, reliable or accurate. It is estimated that data from only appproximately 50 percent of facilities reaches the MOH's central statistics office. Thus, these data must be interpreted and used with caution. Nevertheless, some estimates of the current status of the delivery of PHC services can be made from the sources used by the team - project documents, data gathered on evaluation team field visits, and annual PHC service data available at the MOH statistics office.

The evaluation team has drawn on these sources to make its assessment, fully aware of the mixed quality of the data. There has been extensive discussion of its findings and inferences whenever possible with the appropriate project personnel. The team's emphasis has been on producing constructive and useful suggestions for the remainder of the project.

The general trends in the delivery of PHC services since 1980 appear positive from national level data, despite the fact that Peru has only recently started implementing a national PHC plan. These national data do not permit an analysis of differences of areas supported by USAID monies compared to other geographic areas, nor disaggregation by type of PHC provider (i.e., health centers, health posts, promoters, etc.). Finally, no data are available for PHC services delivered by health promoters and traditional birth attendants (TBAs) to support any statement about aggregate improvement through these key PHC providers.

The data available about selected primary care services provided by health centers and health posts in Peru between 1980 and 1984 (annualized from six months of data) are summarized in Table 1. From 1980 to 1984 there appears to be considerable increase in the aggregate level of PHC services delivered. The increase in the activity level for family planning services is especially impressive, increasing over forty-fold. The rate of home visits, prenatal and postnatal consultations increased substantially from 1980, but appear to have declined from 1983 to the first half of 1984. Interestingly, the number of women receiving services increased, but the number of services per woman decreased. Since these decreases are relatively small, they may be attributable to deficiencies in the data.

Table 1 provides selected indicators of performance of the Primary Health Care system based on the information available to the evaluation team in November 1984 and March 1985. Several suggestions appear below to help improve the estimates. Performance monitoring can be valuable even if coverage is partial or the information available is not conceptually ideal, as long as the data are collected systematically to identify important trends over time. Approximate estimates of the size of the target group will frequently be necessary.

1. ORT use and coverage are dealt with in the PRITECH "Disease Control Strategy Assessment," Peru, October 1984, "Annex C." The target group is the population under three years old. PRITECH estimates national coverage in 1983 at "36% of what was programmed"

Table 1

Selected Primary Health Care Services
Provided by Health Centers and Health Posts
Peru, 1980-1984*

Type of PHC Service	Years				
	1980	1981	1982	1983	1984*
ORS packets distributed	NA	NA	NA	NA	495,768
Prenatal consultations	462,406	NA	NA	751,792	662,818
Postnatal consultations	63,329	NA	NA	114,100	96,058
Women receiving prenatal Care	184,328	NA	NA	248,952	291,784
Women receiving postnatal Care	36,955	NA	NA	60,417	62,314
Prenatal consultations per woman	2	NA	NA	3	2.3
Postnatal consultations per woman	1.7	NA	NA	1.9	1.5
Home visits	165,249	NA	NA	281,339	230,472
New family planning acceptors	NA	3054	37,266	78,020	101,632
Total FP visits	NA	8390	128,004	288,393	365,012
Children newly "protected" for polio	237,814	302,292	361,923	351,849	NA
No. of latrines installed	NA	NA	NA	NA	NA

NA = Data not available to the evaluation team
*Data annualized from six months of data for 1984.
Source: Oficina General de Información y Estadística

Deriving Measures of Coverage for PHC Services

PHC Services	Beneficiaries	Estimated Number	Coverage
Prenatal visits	Live births	580,000 (1981)	1.14 visits/birth 1984
Prenatal visits	Live births	580,000 (1981)	0.17 visits/birth 1984
Immunizations	Children 0-1	494,784 (1981)	71% (polio 1983)
Develop't/growth	Children 1-4	1,939,545 (1981)	ND
ORT Packets ORS - (children x2x2)	Children 0-3	1,716,061 (1981) 6,864,244 pkts.	7% (1984)
Family Planning	Fertile age women	4.5 million	
	66.8% for the MOH	3.0 million	Not calculated

Source: Informal approximations by the evaluation team

without indicating actual usage or coverage. A plausible coverage target is two ORS packets per episode of diarrhea, times two episodes per year, times the number of children in the target group.

2. For family planning the most important single indicator is the number of "current users of modern effective contraceptives" who are protected against unwanted pregnancies. The number of "new acceptors" and "family planning consultations" is also a useful measure of MOH performance. The MOH statistical unit estimated that "users attended" were 55,163 in 1982; 74,054 in 1983; and 75,752 in the first nine months of 1984. The definition of "users attended" should be clarified.

3. The target group for family planning is estimated in the "1981 Contraceptive Prevalence Survey" based on 23% of Peru's population's (approximately 19 million people) being women of the Fertile Age Group, and 65% of their being "Married Women (in Union) in the Fertile Age Group (15-49)." An internal AID document projected that in 1984 the coverage of this group would be 19%.

4. Immunization performance and coverage are dealt with in the PRITECH report in Annex D. For polio the target group is children under one year, perhaps 500,000 children in the early 1980s. Third dose coverage is reported in Figure D1, fluctuating near 20% with slight improvement from 1979 to 1983. No numbers are given.

5. The Banco Central de Reservas del Perú published "Mapa de Salud del Perú" in December 1984. The document itself lacks the absolute numbers that would be helpful, but they may be available from the authors.

3.1 Family Planning Services Delivered Through the MOH

The Family Planning program was added officially to the MOH Primary Health Care services in 1981 and service delivery began actively in 1982.

The MOH has set a coverage goal of reaching 66.8% of women in the fertile age group (FAG). This implies a target for the MOH of 2,957,000 women, based on a total Peruvian population of 19 million and an estimated 23.3% women in the FAG (66.8% of the 4.4 million women in the FAG to be served through the MOH). The other 33.2% of the FAG were to be served by Social Security (IPSS), and other governmental and private sector channels. The MOH has set an immediate target of serving a minimum of 10% of women of the FAG, approximately 440,000 women.

Table 2 demonstrates the wide variability in delivery of selected PHC services that the team found on its visits. These variations did not appear to be related to staffing levels. Numerous other reports also indicate this variability of activity. The director of the Ica region reported that the region was successful in using this type of data in semi-annual evaluation meetings of the directors of the respective facilities to stimulate improved

Table 2

Selected Primary Health Care Services Delivered in 1983
by Health Centers and Posts Visited by Evaluation Team

Establishment	Type of Staff		ORS Packets Distributed	Prenatal Consultations	Post Natal Consults
	Professional*	Auxiliary			
Health Center					
No. 1**	7	8	2677	2712	756
No. 2**	3	4	3456	2267	1152
No. 3	2	1	60	50	25
No. 4	3	1	1641	433	101
No. 5	12		1820	0	36
No. 6	4		420	60	
No. 7	5	4	669	511	30
Health Post					
No. 1		1	0	10	6
No. 2		1	240	60	48
No. 3		4	480	120	NA

*Professional = physician, nurse, midwife.
**1984 figures annualized from six months of data.

Source: Health center/health post records.

service delivery. No other regions used data in this fashion. The team noted particularly low numbers of visits for prenatal and postnatal care, both in the national data and in health center and health post data.

The target of 10% of women in the fertile age group is probably a realistic target and is the one actually being used by the program. A rough estimate of women actually obtaining services through the MOH is 4.7 to 8% of women in the FAG, according to current data in the regions visited by the evaluation team.

There are several promising indicators for future progress in family planning in the MOH. First, even though the coverage of the total population at risk is quite low, the number of family planning services delivered in MOH institutions has increased dramatically since 1980 (see Table 1). Second, family planning appears to be integrated into primary health care in spite of the relatively short time this has been MOH policy. At least some contraceptives are available in all MOH establishments and MOH staff are at least minimally aware that family planning is a component of PHC. Third, the current mass media campaign for health includes family planning messages. Finally, the rampant inflation that is currently causing economic distress is a strong incentive for couples to limit the size of their families. It is with this background that the progress to date and future assistance may be considered.

Family planning services thus appear to be well institutionalized within MOH facilities at all levels. (Family planning services through the private sector as well as through other public institutions are discussed in Chapter 5.) The actual number of services delivered, however, varies greatly both between levels of facilities and among facilities of equal sophistication. Services provided at the health center and health post levels are limited in comparison to those provided at area and general hospitals.

The variations in family planning services observed among health centers and health posts visited by the evaluation team are illustrated in Table 3. Health center No. 3, with half the staff of health center No. 1, provided more than double the number of family planning services. The variation in services delivered appears not to be related as much to staffing patterns as to the creativity and motivation of key staff. An example of positive initiative by staff members was observed at a health post staffed by a nurse and two auxiliaries - they had distributed 400 condoms in one day, distributing condoms to all clients (both men and women) before a fiesta. We interpret this as a good example of translating the perceived need for contraceptive protection into appropriate action (condom distribution).

The Ica region provides another encouraging example of a region which is delivering family planning services actively. Table 4 illustrates how productive, well organized and integrated family planning activities are in Ica at all levels of the delivery system, including promoters and traditional birth attendants. In the Ica region, 50% of contraceptors use orals, 30% IUDs, and 20% other methods, i.e., 70% are using the more effective methods of contraception. It should be noted that over 40% of the acceptors in 1984 received service in the two hospitals, and that the number of continuing users increased from year to year, suggesting that good follow-up is in place. The Callao region is another example of active efforts in family

Table 3

Family Planning Consultations in 1984
and Staffing Patterns at Health Centers and Health Posts
Visited by Evaluation Team

Type of Institution	Number of Staff		Number of Family Planning Consultations in 1984**	
	Professional*	Auxiliary	New Acceptors	Total Consultations
Health Center				
No. 1	7	8	144	180
No. 2	5	4	99	426
No. 3	3	4	228	456
No. 4	2	1	60	108
No. 5	3	1	88	216
Health Post				
No. 1	-	1	0	0
No. 2	-	1	55	324
No. 3	-	2	57	96
No. 4	-	4	-	400

*Professional = physician, midwife, nurse.

**The number of acceptors and consultations are estimated for 12 months in 1984, based on data available at each site for the period up to the time of the visit in November 1984, with an upward adjustment for the remainder of the year.

Source: Health center and health post records at the facilities visited in November 1984.

Table 4

Family Planning Acceptors in the Sur Medio Region (Ica)
by Type of Facility Providing Services and Method of Contraception
by Year (1982-1984)

Year	Hospitals (2)	Health Centers (30)	Health Posts (90)	Promoters (Parteras) (1024)	New Acceptors	Continuing Users	TOTAL
1982	4,640	4,200	3,280	4,875	7,896	9,009	16,995
1983	7,296	4,910	2,271	3,142	6,143	11,476	17,619
First 6 mos. 1984	7,025	4,162	2,080	3,957	3,770	13,454	17,224
	(41%)	(24%)	(12%)	(23%)			(100%)

Source: Ica region records.

planning where four health centers have recently started using promoters in a community-based distribution system.

Which contraceptive methods are most in demand is nearly impossible to determine. Observed usage appears to be influenced by MOH regulations, the individual service provider, and local beliefs and customs. Orals and tablets appear to be the most used in coastal and more modernized areas. Greater usage of IUDs is found in the more traditional regions. Creams and condoms are the least used according to official records. At the area hospitals, orals and IUDs (both Lippes and Copper T's) are the methods most commonly used. OB/GYN doctors were also enthusiastic about surgical contraception for high risk patients and requested equipment for this purpose.

There are several factors slowing progress, despite the Ministry's positive family planning policy. Large parts of the country have been devastated by natural disasters which have impeded service delivery and diverted resources into other activities. Pioneering any innovation would be difficult in Peru: the terrain is difficult for transport, communication with a dispersed rural population is difficult, and the population is quite heterogenous, speaking several languages. With these constraints, innovations such as family planning are likely to spread somewhat slowly, and quick results should not be anticipated.

Two factors internal to the MOH system also slow the development of the family planning program. First, MOH procedures have resulted in a system which allows only doctors and midwives to provide orals and IUDs. In health posts, the auxiliary nurses or technicians were not allowed to dispense orals, so the only methods offered were condoms, creams, or foaming tablets. Also, little or no service was being provided by nurses, even though they had received training in family planning. Promoters rarely distributed even temporary methods such as condoms. The important and promising exceptions to this pattern were in the Ica region and in a pilot project in the Callao region, which has started a community-based distribution system using promoters.

A second important factor seemed to be attitudinal. Because of real shortages of medicines, health post staff perceive that there is a shortage of contraceptives when in fact there is none. MOH staff often were not aware of family planning services available through other institutions. Nowhere were MOH staff at the area hospital or lower levels observed to be coordinating their activities with other institutions offering family planning services in their area.

The MOH family planning program is governed by the "Family Planning Norms" of December 1980. This document is comprehensive and generally provides a thorough discussion of all components of a public sector approach to providing family planning services. The norms were developed at the beginning of the program (1980), but now it appears that some of the norms may be impeding delivery of family planning services. Revision based on experience is needed to improve coverage. A discussion of some of the specific norms which are slowing the growth of family planning activities follows.

With respect to targets and goals, paragraph 1.1.7 states that at least 10 percent of the women in the fertile age group should be provided services each year as a minimum. There is one problem with this statement: minimum achievement may be construed as satisfactory performance, so when this number is reached the staff tend to relax.

Concerning family planning methods, paragraph 1.1.12 of the MOH Norms defines the type of family planning method to be provided at each level. Our team observed that in some cases MOH staff interpret this norm to restrict the supply of orals to health centers so that health posts should only be supplied with condoms. Although the statement specifically states that orals can be provided at the health post level, in fact orals are not provided to the health posts. Several health posts were staffed by nurses and auxiliary nurses who were trained to counsel oral acceptors, but did not have orals to distribute. This forces women using orals to bypass the health post nearest to their home and go to a health center for resupply.

Paragraph 1.1.14 establishes targets by method: 40% orals, 40% IUDs, and 20% condoms and others. The use of such targets may not be productive since the number of acceptors using each contraceptive method is dependent on the availability of services and client preference. In the Callao report on family planning achievements, the recommended percentages by contraceptive method were followed exactly, which suggests that the figures were adjusted to meet the target and not consumer preference.

The norm concerning service providers in paragraphs 1.1.17 and 1.1.18 of the MOH Norms addresses the matter of who should provide family planning services. Paragraph 1.1.17 states that the first visit should be attended by a doctor. Paragraph 1.1.18 states that in the absence of a doctor, a professional midwife or nurse trained in family planning can provide the service. However, this statement could be taken to mean that the presence of a doctor is necessary at the first visit and that when no doctor is present, persons seeking service should be turned away. This policy may cause considerable inconvenience for new acceptors, who might never return after being sent away.

Another important document of MOH is the "Norms for the Prevention of Pregnancy for Women of High Risk" (MOH Resolution dated October 27, 1983). This directive allows doctors to perform surgical contraception in cases where it is determined that future pregnancies would endanger the health of the woman. It contains a form (found in the first annex of the document) which includes a voluntary declaration by the woman and her husband requesting the operation and an authorization by the "Jefe del Departamento y el Médico." This is not in violation of the civil code and while a bit cumbersome, is a decided step forward in allowing couples to limit their family size when needed.

The team found a great deal of support for the use of surgical contraception on the part of OB/GYN specialists in regional, general, and area hospitals.

In summary, recognition should be given to the MOH for its efforts to increase family planning services since 1981. Still, there is much room for further improvement. It appears that the public sector PHC system is providing very little family planning service in relation to need through promoters, traditional birth attendants, health posts, and health centers. Access to family planning services is primarily available at hospitals and places where doctors and midwives are the service providers. So long as services are constrained in this fashion, poor families with high fertility will continue to be dependent on services in a few locations which are inconvenient for many of them. This is likely to cause low acceptance and high discontinuation rates and result in little impact on fertility rates by the public sector PHC distribution system.

Considering the problems of the PHC system described in other sections of this evaluation and the deliberate integration of the family planning program into the PHC system, we reluctantly conclude that family planning service delivery through the PHC system is likely to continue to have limited impact on the number of unwanted pregnancies and on the Peruvian fertility rate, until the other constraints on the integrated system are better managed. Despite this discouraging conclusion, it appears that hospitals are able to serve a significant number of contraceptive users. There are promising examples of effective projects within the MOH PHC system. Also, the private sector may be able to provide access to many people who are not adequately served by the MOH. Private sector channels are described in Chapter 5 of this evaluation.

Recommendation 3.1-1 regarding improved provision of family planning services. Make orals, condoms, creams, and tablets available at all health posts. Allow all the health staff, including auxiliaries and nurses, of all facilities to distribute orals to continuing users. Unless non-physicians are allowed to resupply continuing users with orals, use of this important contraceptive method will probably remain low in areas without doctors.

Recommendation 3.1-2 regarding MOH Norms for service providers. Paragraphs 1.1.17 and 1.1.18 should be combined and changed to clarify that those seeking family planning services for the first time be counseled by a person trained in counseling in the various contraceptive methods and be provided a temporary method such as condoms or foaming tablets. If the client wants a more permanent method such as orals or an IUD, an appointment should be made with a person qualified to provide this service. It should also include a statement that a person requesting service for the first time be provided a temporary method regardless of where he or she lives. This accommodates a mobile population. Paragraph 2.5 under technical services mentions that services should be provided to everyone requesting them, but the wording is too general.

Recommendation 3.1-3 on increasing support and assistance to hospitals for family planning services. There seemed to be much interest on the part of the MOH hospital staff and selected MOH facilities to provide family planning services, and efforts should be made to find ways to support these interested groups.

Service statistics indicate that hospitals are already major providers of family planning. More family planning equipment, supplies, and training should be given to hospitals where the program is more productive without neglecting health posts and health centers.

Recommendation 3.1-4 on quantities of contraceptives distributed. Inform MOH staff at all facilities that plenty of contraceptives are available, and that they should distribute contraceptives in larger quantities per visit to each acceptor to foster higher continuation rates. This is especially important when acceptors have to travel long distances to obtain family planning services. Specifically, it is recommended that users at each visit be given the following quantities of contraceptives: three cycles of orals, two dozen condoms, two tubes of cream spermicide, or two tubes of vaginal tablets.

Recommendation 3.1-5 on training in family planning methods. Strengthen training of all MOH personnel in family planning methods, particularly health post personnel.

Recommendation 3.1-6 to evaluate current community-based distribution efforts. Assess the community-based distribution experiments in Callao and Ica for their effectiveness. If warranted, use these as training sites for other areas which have the potential to implement the same model.

3.2 Oral Rehydration Therapy

The World Health Organization has endorsed oral rehydration therapy (ORT) as the best way of reducing diarrheal disease mortality in children under the age of five. ORT is important because of its simplicity and potential accessibility to all socioeconomic levels of the population.

In Peru beginning in 1980, the MOH adopted an oral rehydration strategy which involved providing ORT through its hospitals, health centers, and health posts. USAID, PAHO, UNICEF, and the German Agency for Technical Cooperation have been the most active advocates of the Ministry's ORT strategy through support of educational activities and provision of oral rehydration salts (ORS).

The most complete analysis of the ORT program was done by PRITECH in 1984, and the team has drawn extensively on that report. The PRITECH report estimates that countrywide coverage of the target population in 1983 was 36% of that programmed, with a range from 4% to 88% among reporting health regions. While data for national trends in coverage are unavailable, figures for Lima indicated an increase in coverage from 8.0% to 18.4% in three years.

The evaluation team's visits confirmed the wide variation in distribution of oral rehydration salts reported by the PRITECH team. As noted earlier in Table 2, the evaluation team observed considerable variation in distribution of salts during its visits to health centers and posts. While some of this variability appeared to be due to supply and distribution problems in 1983, much appeared related to staff knowledge, commitment, and initiative.

The PRITECH report notes that oral rehydration salts are either imported or produced locally. The raw materials used for local production are imported and are extremely expensive. The major Peruvian producer, LUSA (Laboratorios Unidos S.A.), sells ORS to the MOH and also distributes ORS commercially. LUSA was operating at approximately 30% of capacity according to a PRITECH study in June 1984. The PRITECH study analyzed ORT in depth and found that the more expensive brands were sold at least as much as the Peruvian brand, probably based on pharmacists' recommendations.

The team found supplies of ORS in all Ministry facilities it visited, and they were also available in pharmacies. It appears that the 1983 supply problems were being handled better in late 1984. Even when there were supply and distribution problems in the MOH, the availability of ORS in pharmacies makes ORT feasible. Many MOH staff also recommend homemade solutions, which indicates widespread knowledge and acceptance of ORT by the staff.

The team found important improvements in the ORT situation, compared to the situation in 1983, and also found important opportunities for accelerating the spread of ORT in Peru. ORT is a major component of the Peruvian PHC program. It is one of the three major themes in the mass media health campaign currently underway. MOH staff members at all levels throughout the country are aware of ORT and have some knowledge of it, although the actual use of ORT varies greatly. Supplies <u>are</u> available in local pharmacies, even when supply and distribution of ORS packets to MOH facilities is limited. Moreover, substantial local production capacity exists, albeit at a high cost.

Much remains to be done, however, to make ORT a viable component of primary health care and accessible to the population at risk. First, as noted, use of ORT is still very low compared to need, and data are not collected in such a way as to be able to estimate national service delivery levels for oral rehydration therapy. The PRITECH report and the team's visits confirm that the major difficulty in the ORT program appears to be the inconsistent flow of oral rehydration salts from the MOH to the delivery level. To their credit, many local health facilities have responded to the lack of ORS packets in a creative fashion by recommending "suero casero", or homemade solutions, to their patients. The PRITECH report noted that the homemade solutions recommended did not always comply with WHO standards. Many facilities with professional staff, however, still appear to prefer intravenous and antibiotic therapy. There is also a history of resistance from the pharmaceutical firms.

Another important constraint appears to be the lack of a clear or concrete implementation plan for the use of ORT. While the Ministry has national level standards and has taken some very important actions, the delivery level does not appear to have a clear action strategy. With the exception of the mass media campaign, the ORT component of primary health care is still a demand-based service, is not well articulated in its implementation strategy at the delivery level, and is not yet reaching out to the population in need.

While these factors look disappointing, it should be remembered that the MOH has only recently revived its activities in ORT. Likewise, the problems with the USAID shipment of salts have been resolved only recently.

The MOH is to be commended for the start it has made in this important area and should be encouraged to take the next steps to make ORT an effective primary health care service. Thus, while the evaluation team found no lack of ORS in the health establishments visited, the MOH's limited capacity to store and distribute salts adequately, continuing problems of getting imported salts out of customs, and MOH's lack of a clear implementation strategy for all levels of care appear to be the principal constraints to fully implementing the oral rehydration component of primary health care. Correcting these problems would greatly enhance the effectiveness of ORT.

Recommendations - Oral Rehydration Therapy

Recommendation 3.2-1 to develop an action plan for ORT. The MOH should continue to give high priority to ORT and USAID should continue to support MOH efforts because of the high potential for reducing mortality with ORT. An action plan for more effectively extending ORT to the community level should be prepared without making it into a vertical program. ORT should continue to be an integral part of the PHC strategy.

Recommendation 3.2-2 regarding local production of ORS. Pursue any opportunities to increase Peruvian production, lower costs, and encourage the passing through of the cost savings. For example, WHO has recently approved the preparation of ORS with a citrate base. Since citrate is available locally it might reduce the cost of production significantly. Several Peruvian scientists have conducted studies on ORS. These scientists should be brought together with private sector representatives interested in production of the new formula to assess the feasibility of production in Peru.

Recommendation 3.2-3 to educate pharmacists and physicians. A program to educate pharmacists about ORT and the WHO standards for ORS should be considered. The public is accustomed to buying medications from private pharmacies with a physician's recommendation so they are also likely to go to pharmacies for ORS. There may be ways to integrate pharmacists into the advertising and education of communities about ORT. A promotion effort through the Colegio Médico to reach MDs deserves exploration.

Recommendation 3.2-4 on promoting homemade solutions. Standardized and medically appropriate information about homemade solutions should be prepared and distributed to health centers, health posts, and promoters. Similar information should be prepared for broader public dissemination using mass media (especially radio), particularly for use in areas where the distribution of ORS packets will continue to be deficient, such as where the population is highly dispersed.

3.3 Environmental Sanitation

Environmental sanitation activities are an important part of a more comprehensive primary health care strategy because of their critical role in reducing mortality and morbidity from diarrheal diseases. Peru has great need

for both potable water and sewerage systems in its rural areas and in its "pueblos jovenes." The environmental sanitation component in project 219 was quite small and oriented specifically to protection of water sources, installation of latrines, and hygiene education. In 1980 USAID expanded its support of environmental sanitation and signed a project agreement with the GOP for a $5.5 million project in rural water systems and environmental sanitation in six health regions. This was extended to another four health regions with an additional $5.5 million in 1982. This project, the Rural Water and Environmental Sanitation Project, project No. 527-0221, is being executed by the Directorate of Rural Sanitation (DISAR) at the Ministry of Health and has a project completion date of September 1987.

The environmental sanitation component in the original project 219 design called for 1,800 protected wells and improved houses and 3,600 installed latrines in twenty-five selected communities. The evaluation team is using latrine installation as the indicator of extension of environmental sanitation services into the community under project 219, since more data are available for latrines than for other environmental sanitation services. The provision of latrines involved four phases, including construction of the latrine components at a central location, education of the community by health workers to use latrines, distribution of latrine components to the relevant communities, and installation of the latrines by community members and/or health promoters.

A review of project documentation revealed that only six regions reported any activity at all in latrine installation. Of these, the average percentage of latrine components constructed was approximately 60 percent of the approximately 700 programmed, and only three regions reported actual installation of latrines. Twenty-five percent of latrines programmed have been installed. The activity levels of the non-reporting regions is not known. However, the responsible USAID project officer for the water project estimated an overall twenty to thirty percent achievement of targets. Further, a recent evaluation of the Rural Water and Environmental Sanitation Project 221 (which is similar to 219) revealed that latrines were being used in only three out of fifteen communities visited. No regions reported on protection of water sources although data are available at the regional level.

The number of latrines installed as a result of project 219 is thus difficult to assess because complete data are not available at the central MOH. However, according to local and central MOH project staff and USAID project officers, implementation improved considerably during the last year as a result of active involvement of sanitary engineer staff in the planning and programming process of each region. Nevertheless, while the pace of project implementation has improved significantly, the regions are behind in reaching the targets set for themselves. The relationship of commitment of funds to disbursement has improved significantly, but the actual completion of activities at the local level appears quite low. The regions vary considerably in activity levels, and the ratio of latrines installed to those planned or constructed is still low. In addition, the recent evaluation of Project 221 concluded that the use of latrines was very low. Finally, in regions where both projects 219 and 221 are operative, project 221 appears to be taking precedence in implementation, because of its size and scope and easier procedures.

In sum, the physical aspect of latrine construction appears to have improved significantly due to more active involvement of regional sanitary engineers in planning and implementation. Both environmental sanitation projects have been more successful with construction than with distribution and installation of latrines. The problems in distribution and installation seem related to problems in logistics (gasoline, per diem) and to weak community education efforts. For example, health promoters do not appear to be active agents of community education in hygiene or in installation of latrines. However, it is impossible to assess the real level of their involvement since standardized data are not routinely collected for promoters. The low use rates indicate the need for stronger community involvement before the installation phase, and for reassessment of the acceptability to the community of the type of latrine proposed. While environmental sanitation activities have improved under the project, they still lag considerably for several reasons: 1) their relative smallness in relation to the other components of the health project; 2) their location administratively within the Directorate of Maternal and Child Health and Population rather than in the Directorate of Environmental Sanitation; and 3) the much larger scope of project 221. The team believes that much more emphasis should be given to environmental sanitation through other efforts or projects because of the enormous needs in environmental sanitation in Peru.

Recommendations - Environmental Sanitation

Recommendation 3.3-1 to consolidate environmental sanitation activities. Consolidate environmental sanitation activities by completing activities already initiated and reprogramming the remainder of 219 environmental sanitation funds into regions not covered by the larger sanitation project or into other project activities.

Recommendation 3.3-2 regarding study on the type of latrines. Conduct a study of the population's preferences regarding type of latrine to increase the use rate of latrines.

Recommendation 3.3-3 regarding USAID support. USAID should support new environmental sanitation and rural water supply projects.

3.4 Community Education*

The goal of community education efforts in primary care is to change negative health attitudes and practices. The MOH recently adopted a two pronged strategy called the "Plan de Alfabetización Sanitaria" (PLAS) to extend health education activities to the community level. The first component encompasses outreach activities to be undertaken by health centers, health posts, and community workers, especially health promoters. The second involves national mass media campaigns and local use of the mass media.

*A more detailed report of the status of community education efforts is available in the October 1984 PRITECH report, "A Disease Control Strategy Assessment."

Health regions are responsible for both local media efforts and for outreach activities. This includes training personnel in appropriate techniques for health education and preparing and producing health education materials. Health personnel are expected to carry out individual and group education activities.

USAID funds were intended to stimulate community education efforts through the provision of educational materials and equipment to health posts and auxiliaries in fifty areas. The total amount originally budgeted for community education under the project was $580,000 ($410,000 USAID and $170,000 counterpart). The original amount budgeted for community education was reduced from $410,000 to $150,000 because the money was not being spent by the regions.

Under Project 230, monies were provided for educational equipment such as slide projectors and other audio visual equipment and aids, and $500,000 was provided for the development of health and family planning educational materials. Some educational materials were to be purchased at the central level for distribution to the periphery.

At the central level, USAID support has assisted the MOH in contracting for a national mass media campaign which focuses on child health in general and on three specific themes: family planning, immunizations, and oral rehydration therapy. Television, radio spots, and printed posters are the media being used in the campaign. The mass media campaign was programmed to reach 7,000,000 people. Other donors also have actively supported both health education strategies of the MOH.

The team's visits revealed that community education activities at the local level varied greatly among regions and among facilities. There were a few sites that were quite active, but the majority had sporadic and weak community education activities. In the most active sites there were intensive outreach activities including house to house visits, assemblies, parades, active use of the local media, involvement of religious leaders, schools, political parties, and even dropping leaflets from airplanes. In other areas very little happens. An active program appeared to depend primarily on the presence of a knowledgeable, creative, and innovative health educator or other professional committed to health education; and secondarily on the availability of resources specifically committed to health education.

Some specific local community education efforts are occurring in certain regions. A radio program with national coverage called "Aula Abierta" has themes in sanitation, nutrition, care and prevention of childhood diarrhea, use of ORT, and respiratory diseases. The ENTEL-AID/AED Rural Communication Service Project initiated in 1979 in the San Martín region is an educational program serving rural communities used actively by the health personnel in San Martín.

Standardized data to evaluate the level of these activities do not exist on either a local or national basis. The MOH data and supervisory systems do not accurately document either the quantity or quality of health education activities. A recent study of educational necessities conducted by the MOH with PAHO support reveals several problems in health

education.* The study pointed out that health personnel did not know the health status of their communities, nor did they have adequate knowledge of the MOH primary health care strategy or of educational methods. Seventy-five percent of the health personnel interviewed did not participate in community development or education activities. The health study also pointed out major weaknesses in educational techniques and lack of educational aids at the community level.

At the local level the team observed both positive and negative features of the status of educational materials. Attractive posters with health and family planning messages in Spanish were displayed in MOH facilities visited by the team at all levels. Other educational materials and equipment, however, were rarely found at health centers and posts. This also has been documented in other related reports. For example, only one health center out of the eight visited by the evaluation team had a slide projector, and the staff of the center were unaware that a slide projector was available until the regional supervisor found it and showed it to them. One regional office out of nine visited had a projector, slides, cassette player, and cassettes. Nevertheless, many educational materials of good quality are available in Spanish in Lima.

For the most part, those educational materials found in centers and posts were locally produced. While the themes may have been more appropriate and adapted to local custom, however, the materials in general were of poor quality and unattractive. On the other hand, reports indicate that centrally produced materials frequently are not field tested and therefore may not be appropriate for certain regions of the country. Centrally produced materials often do not reach health centers, health posts, promoters, and TBAs in either sufficient quantities or consistency. An exception is the Ica region which has an adequate supply of attractive, locally produced materials.

In short, so far (November 1984) little appears to have been done with project funds in the provision/production of health education materials at the local or central levels. While individual regions have programmed for educational materials and training manuals, the amounts have been very small. With the exception of posters, few materials appear to be produced at the central level. Those that are produced centrally do not appear to be reaching the local levels in sufficient quantities. There is much anecdotal evidence that with a few exceptions, audio-visual and educational materials are in very short supply and that project funds for this component are not used in a very effective or efficient manner, despite the need for these materials.

On the national level, a mass media campaign began in late September, 1984 and is estimated to be reaching several million people. The campaign includes ten thirty-second spots for television, twenty spots for radio, fifteen one-minute spots, and billboard, posters, and information folders. All messages are in Spanish and focus on immunizations, ORT, and family planning. The campaign seems to be well designed and executed and might serve as a model for regional efforts. However, little of the strategy or methodology used at the national level has been imparted to the local level to date. Little financing is available for regional use of media. In fact,

*Ministerio de Salud Pública, "Capacitación de Recursos Humanos en el Primer Nivel," 1984.

local use of media, especially radio, would be of great potential benefit for reaching communities with health education messages. This is especially true given the known problems of distribution of educational materials and the low level of knowledge and use of good educational techniques by the majority of health professionals.

In sum, a short-term, nationally directed mass media campaign is presently underway and there are local groups of health professionals providing educational services. Clear efforts are being made in scattered instances to use the local media in an effective way and there are several interesting pilot projects. Nevertheless, the regions are facing several constraints: 1) inability to clearly define educational objectives, 2) no plan of action for specific educational activities or priorities for themes to be covered, and 3) limited resources for health education. With a clear strategy and coordinated support from the central level, much more could be done to improve the reach of health education messages to the community level.

Also, the twenty-four health educators who recently completed a one-year training program at the School of Public Health should strengthen community education activities at the local level.

Recommendations - Community Education

Recommendation 3.4-1 regarding health education materials. The MOH should make a commitment to purchase, produce, and distribute a sufficient quantity of health education materials to all levels of the PHC system. Instead of being available on a one-time or sporadic basis, Spanish education materials should be made available routinely to the area hospitals, health centers, health posts, and promoters.

Recommendation 3.4-2 to increase use of radio for health education. USAID should consider supporting development of regional radio campaigns in ORT, immunizations, prenatal care, and family planning; and also consider supporting planning for ongoing, regular, periodic radio spots and other types of radio programs in the different indigenous languages. The messages and tapes developed in the mass media compaign should be sent to the regions and funds should be made available to allow regions to program spots on local radio stations in local languages. Radios are available where health personnel will not reach in the near future. Radio is underused and appears to be a potentially very effective medium for health messages, as it is for messages in commerce, politics, and agriculture. The team suggests an assessment of the cost-effectiveness of television media campaigns versus frequent regular spots on radio in urban and rural areas for future programming.

(In March 1985 it was decided that the program for mass media will continue. An increase in the use of radio be will considered when there are evaluation results in July 1985. Tapes can be sent to the regions for local programming.)

Recommendation 3.4-3 to coordinate community education with delivery of services. Link and coordinate health education and media efforts in a timely fashion with the providers of related services and with the delivery of supplies (such as ORS and contraceptives).

4.0 PROJECT COMPONENTS TO IMPROVE PRIMARY HEALTH CARE

The six sections of Chapter Four correspond to outputs from projects 219/230: Project Management and Administrative Structure (section 4.1); Financial Systems (section 4.2); Logistics and Supplies (section 4.3); the Health Information System (section 4.4); the Supervision System (section 4.5); and Training (section 4.6).

4.1 Project Management and Administrative Structure

Section 4.1 is organized in the following sub-sections: (4.1.1) Introduction, (4.1.2) Management of Projects 219/230, (4.1.3) Planning, and (4.1.4) Administrative Organization.

4.1.1 Introduction

This section of the report analyzes and makes recommendations on the management of projects 219/230 at the Ministry of Health. Attention has been focused on the Directorate of Maternal and Child Health and Population (DSMIP) as the coordinating agent of projects 219/230, to the regional departments as implementing agents, to the General Administration Office (Oficina General de Administración - OGA) regarding finances and supply, and also to other Ministry offices to the extent that they are involved in these two projects. Attention was also focused on central and regional administrative relationships for a unified picture of any problems.

4.1.2 Management of Projects 219 and 230

Overall management of projects 219/230 is the responsibility of the Executive Director of the DSMIP. The Project Department is under his direction and handles many administrative activities including:

- The control and implementation of national and international purchase orders.
- The receipt and distribution of materials and equipment to health regions.
- The control of stocks in the regions, area hospitals, and health centers and posts.
- The formulation of the schedule of obligations.
- The programming and distribution of counterpart funds.

At the regional and area hospital levels a Coordinator is responsible for the implementation and control of project-related activities. Medical, supervisory, and training personnel usually supervise routine project activities.

Accounting and budget control are the responsibility of the regional and area hospital accounting departments. These departments handle all documentation related to expenditure reporting. At the central level, accounting and budget control are the responsibility of the Executive

Accounting Office (Oficina Ejecutiva de Contabilidad Presupuestaria y Financiera - OECPF) of the General Administration Office.

The logistics system for the projects will be examined in section 4.3, but we note that the Office of Supplies and Support Services of the General Administration Office is the support unit at the central level. This unit is responsible for customs procedures, storage, and regional distribution (and through the regions to the area hospitals) of all supplies and equipment for projects 219/230.

The Department of Projects can be improved by focusing on:

- Orienting central and regional management of routine operational activities to a clearer focus on results.
- Improving the efficiency and effectiveness of the information system that controls and evaluates operational activities.

It would also be appropriate to modify and reinforce routine management and control functions for projects 219/230 in the Project Department of the DSMIP. These projects are handled regionally by a Regional Coordinator who reports to the Regional Director. Coordinating tasks are normally done part-time and the Coordinator is responsible for other activities as well. In some health regions the head of the Department of Statistics and Programming is the Coordinator, while in other regions the Executive Director performs this function. The Coordinator could in principle achieve an acceptable performance level depending on the personal interest and time dedicated to individual tasks; in practice, however, time and interest are usually insufficient.

The evaluation team observed examples of good PHC project management in several regions including Ica, Callao, Piura, and Trujillo. These successes can serve as useful models to other regions and to the central level of the Ministry.

The regional director of Ica deserves special recognition for his innovative spirit and the organizational changes he has instituted. His continued work in this post for over three years has made possible the achievement of reforms. More important for applicability to other regions, he has organized a team of people with a highly motivating style.

The Director in Ica has succeeded in developing a team that effectively supports him in daily project management. He does not employ a coordinator in the administration of projects financed by international agencies, as this role was eliminated in the early stages of project 224 when problems occurred between the coordinators. Subordinate personnel also experienced difficulties with "having to report to two bosses." These two factors caused a situation characterized by poor supervision, low motivation, deficient personnel performance, and most likely a low level of efficiency.

The good habit of holding regular meetings with personnel from different levels of the regional health system has also been institutionalized. Personnel from health centers have meetings to share experiences and discuss common problems. These meetings have become an instrument for communication and coordination.

The Callao and Trujillo directors also have instituted the team management approach. As in Ica the evaluation team observed the coherent organization of work, highly motivated leaders, good supervision, and extensive knowledge about PHC. The evaluation team noted that when the Regional Director was informed of developments in projects 219/230, the Coordinator considered the projects to be important. When the Regional Director paid attention and required accountability on the part of the Coordinator, the results tended to be satisfactory. This was clearly demonstrated by the Sur Medio Project in Ica; the Regional Director showed interest in the activities and results of project 224 and in fact personally took the initiative in the management and control of the project.

The evaluators' observations suggest that different administrative and organizational arrangements can improve performance and efficiency in Peru's MOH, as they do in other parts of the world. Both effective and ineffective administrative practices should be monitored to learn from experience.

Recommendation 4.1-1 regarding a PHC management team for Peru's primary health care program. Reorganize present personnel with responsibility for overseeing PHC activities into a PHC management coordination and improvement team for PHC, including but not limited to projects 219/230 and 224. The team should include officials from the central Department of Projects (DSMIP) and the Regional Coordinators of all participating regions. The PHC team should improve PHC activities, including financial and logistics problems, work towards setting realistic performance targets, collect information to be analyzed to improve management, and work to improve reporting to the MOH and international agencies. The PHC team should avoid becoming a new obstacle to the efficient progress of plans and requests. The main thrust of the recommendations in other sections is to delegate greater responsibility to the regions. The PHC team should become a source of assistance to the regions, not a new layer of review and approval above the Regional Director.

People from the successful project teams from Ica, Piura, Trujillo, Callao, etc., should be included in the PHC team. This will ensure that some members of the team have had a successful experience as part of a PHC team.

Special training for the PHC team would be useful to strengthen their knowledge and skills and for "team building." The training might include a workshop on setting objectives, clarifying the PHC team role relative to other PHC organizations, setting realistic PHC performance targets, and mobilizing resources as necessary.

The Westinghouse advisers should participate in the training as trainers and/or as participants by accepting a collegial role on the team. They should be available as a resource to help accomplish a few high priority tasks requiring Westinghouse assistance. This kind of collegial dialogue should generate useful tasks for the Westinghouse team.

The training workshop might also develop better work distribution for the PHC team related to the coordination and management improvement work that the team should implement. This includes planning, control, and evaluation of PHC activities for problem identification, resolution and any required reprogramming.

(In March 1985 the evaluators were informed that seminars are being pushed now with Ica people coming to Callao, Callao to Ica, Piura, etc.)

The MOH has been so occupied with solving input-level problems that it needs a clearer orientation to outputs, i.e., the health services that the PHC system is intended to provide. Information about the services exists at the area hospital level but is not generally used there or at the central MOH or at USAID.

Recommendation 4.1-2 regarding "performance boards" A clear and relatively simple technique for reinforcing an "output orientation" is a "performance board" for DSMIP and for the Vice Minister as well as for the offices of USAID, Westinghouse, and other offices involved in PHC. A "performance board" is used to monitor the status of the project focusing attention on indicators of PHC services to the population in need of health care. Table 1 of this evaluation illustrates the kind of indicators- ORS packets distributed, prenatal and post natal consultations, new family planning acceptors (and active contraceptive users), children protected against polio, etc. Most of the data are available at the hospital level even though they are not widely used.

Similar "performance boards" for the regional, hospital, health center, and health post levels are both useful and feasible. One evaluator saw performance boards in Panama years ago displayed in the waiting room of health centers together with the budget for the health center; it made transparent to the patients the inputs and outputs of "their" health center.

The next level of sophistication in a "performance board" is to plot targets for each indicator, e.g., show last year's actual monthly average and monthly targets for the current year if data are collected monthly, so that performance can be easily compared to the targets.

The third level of sophistication, also well within the capabilities of Peru's MOH, is to estimate the size of the target population for each kind of service and monitor the "coverage" indicators. Some technical guidance may be needed to estimate the target population and procedures for estimating coverage correctly. It may be best to start out using coverage indicators only for management purposes at the higher levels in MOH and at USAID since very low coverage may be discouraging for field staff. Once there is positive momentum in several areas and coverage is improving, introduce the coverage indicators to give a sense of perspective about the magnitude of the task ofproviding adequate coverage to the massive population in need of PHC services.

This recommendation may be particularly interesting to a new government if it wants to move strongly with PHC. "Performance boards" can win political support by showing simply and clearly how much improvement is taking place. It fit the ideal of "grass roots democracy" which has deep roots in the USA and which should be well received by the new government.

Project Management at USAID

The PHC strategy of the Government of Peru provides the framework for USAID-assisted projects 219/230 as noted earlier. USAID is contributing to strengthening the Ministry of Health's logistical and information systems as well as its systems of control and evaluation. This is accomplished through the technical assistance of the Westinghouse advisers and by supporting training of technical and administrative personnel abroad. Financing medical equipment and supplies and training and supervisory activities permit the MOH to invest in physical infrastructure. Six advisers have recently been assigned to the regions.

USAID/Peru has made significant efforts and progress in resolving logistics problems regarding the flow of funds, materials, supplies to the regional and lower levels of the health system. Technical assistance in reviewing the financial systems and procedures was provided through a Westinghouse short-term National Consultant. Useful recommendations were made and most were implemented and resulted in significant improvements.

One staff person was added to USAID's Health and Nutrition Division who initially had to devote a great deal of time to tracking down documents and to learning the MOH logistics system. Another staff person was added to the Department of Projects of DSMIP to oversee offshore MOH shipments. The Contract Officer responsible for preparing PIO/C's for projects 219/230 and the USAID's Regional Contracting Officer have been very involved in processing purchase orders for offshore procurement. In Section 4.3 internal USAID procurement procedures are discussed.

USAID's internal process for reporting expenditures is somewhat meticulous as is the Ministry's--details of this process appear in section 4.2. Invoices and receipts attached to documentation are briefly reviewed by the Project Manager's Administrative Assistant and then reviewed in detail by the Office of the Controller, where accounting and financial control are performed. Supervisory and training reports are also reviewed to obtain data and information useful for control and evaluation.

Processing accounts takes about a month, depending on the volume and quantity of the documentation submitted. This time lapse could be reduced considerably while reinforcing the control and evaluation process by adding a person with experience in health services administration to the Health and Nutrition Division. This person would work under the direct authority of the Health and Nutrition Division's Project Director, helping to manage different components of USAID-assisted PHC projects and making recommendations to improve them. He or she also could help to develop and implement a simple management information system for supply and training activities.

Recommendation 4.1-3 related to adding one USAID officer for primary health care work. USAID should consider adding one officer to the Health and Nutrition Division to assist in PHC activities in the Health and Nutrition Division. An assistant to help with processing project documents (and with simplifications of procedures on the Peruvian side) should free the Project Manager to participate more in other aspects of the project and to promote and coordinate other PHC activities.

USAID needs to increase its orientation towards results and request more explicit targets from the Westinghouse consultants. A dialogue should begin now, before the end of projects 219/230, regarding output targets that should guide Westinghouse assistance in improving the PHC service delivery system. The MOH should be included in the discussions. The goal of the discussions should be to define mutual expectations from technical assistance during the remaining two years. Comments from some Westinghouse consultants indicate that such a dialogue would be useful. USAID's expectations may have been too ambitious and too vague for good management, and now is the time to rectify the situation.

Recommendation 4.1-4 regarding setting priorities and output targets for USAID contractors. Establish clear output targets for the Westinghouse contract resulting from a dialogue including USAID, Westinghouse, and the MOH. There is sufficient experience to identify potential targets, judge what is realistic, and set priorities. This process should orient the Westinghouse team toward some specific realistic output targets now while they have discretionary resources. Some suggestions regarding output targets for the Westinghouse advisers appear in Section 6.

USAID would benefit from "performance boards" in the office of the Project Manager and the Division Chief. See Recommendation 4.1-2 regarding "performance boards."

USAID Procedures

USAID procedures for future loans to support the PHC system may have to change. As the system develops, the volume of activities and expenditures away from the central level of MOH should increase substantially which will aggravate the current problems of centralized controls discussed in detail in Section 4.2. It appears that the Government of Peru will soon allow direct payments to the regional level. However, the USAID controller's office is concerned about the capacity of the Peruvian government to audit and control a decentralized PHC program. The controller's office considers it essential that USAID verify expenditures at least on a sampling basis, which would imply an increased workload if USAID auditors have to go to the regions. There is precedent in the Disaster Relief and Rehabilitation Project, but USAID is not set up for auditing at the regional level.

USAID procedures can make an important difference. For example, the procedures in project 221 for environmental sanitation were easier than procedures in 219 which led to a preference for project 221.

Recommendation 4.1-5 regarding financial controls in future health programs. In preparing the project paper for follow-up projects supporting PHC, USAID should analyze the need for and feasibility of modified financial procedures conducive to decentralized operations by MOH. For example, consideration might be given to using an auditing firm in Peru, working for USAID or working for GOP to go to the regions as necessary for financial management and control.

Project 219 Extension

Project 219 was scheduled to terminate in January 1985, but an extension was approved. There are some activities that are authorized in 219 but not in 230 which might require adjustments. Since projects 219/230 have been administered together, however, the basic issue is whether productive use of the remaining 219/230 funds can be made given the present project status.

The overall conclusions of this evaluation indicate that Peru is making important progress toward developing an integrated health and family planning system to deliver primary health care to its population. Important progress has been made, but much work remains to provide widespread and effective coverage to the many people in need of PHC. Some obstacles that have hampered the projects are analyzed in this evaluation, and many practical recommendations for improvement have emerged. If MOH makes changes in the financial and logistics systems to expedite the flow of money and goods and introduces the output-oriented management procedures recommended in this evaluation, the extension of time to use the 219 money should be worthwhile. (Project 219 had been extended by March 1985).

4.1.3 Planning

The Ministry of Health has been committed to a strategy of primary health care since the year 1978. This strategy includes the following four elements: the reorganization of the Ministry; the improvement of logistics, information, control, and evaluation systems; the extension of physical infrastructure; and the strengthening of intersectoral coordination.

This strategy is generally accepted and supported within the MOH. It receives economic and technical assistance from USAID and other international agencies to improve the health service systems, due to the great potential for extending health services to population segments that otherwise would not even receive minimal preventive and curative health care.

The implementation of the primary health care strategy stimulated important changes in the way the Ministry of Health operates. Chapter Three of this report describes the improvements in health services already achieved.

In brief, the strategy for the development of primary health care has already produced significant results in the operating activities of the MOH.

Planning for primary health care is complicated by the following factors:

1. Various international organizations provide assistance to implement a PHC strategy, but often have preconceived ideas about how such a strategy should be developed. These ideas reflect these organizations' different experiences in other countries and their own policies and priorities which may be unrealistic for Peru, or may not conform to the policies of the Ministry of Health. However, the Ministry of Health is unable to develop independently its own PHC strategy in accordance with the national health strategy, i.e., to develop projects and related activities to create the conditions necessary to achieve an effective PHC program. As a result more than 60 international aid projects exist, often developed with little or no coordination with the Ministry. These projects sometimes overlap and to a certain extent duplicate each other. For example, the training of promoters receives the support of USAID, the World Bank, and the German Agency for Technical Cooperation (GTZ). At the same time other important areas are neglected, such as the development of management skills through short courses and "in-service training" of administrative personnel.

2. The PHC strategy implies a conscious and systematic effort to identify "potential users." For example, the report of Giesecke, Caceres, and Wooton (1982) maintains that to meet the demand for PHC services the health system should change its traditional passivity, based on professional medical attitudes, to a more active perspective that responds to public health priorities.

3. PHC strategy requires that health personnel and other resources be distributed to facilities convenient to people in need of PHC services. However, the health service system has developed mostly in urban centers, is dominated by doctors, and is based chiefly in hospitals and health centers providing curative rather than preventive health services. In this area PHC strategy still has not achieved decisive change.

4. High turnover of regional and subregional management and professional personnel hampers PHC strategy. Jobs in the interior of Peru are less attractive than those in Lima and other important urban centers. The MOH's policies have not produced sufficient stability in management and operations personnel outside urban areas. In eight regions visited by the evaluation team, four regional directors had held their jobs less than a year, two between one and two years, and only two for three or more years.

5. The fourth component of PHC strategy recommends the use of non-MOH channels to extend health care services to those who cannot be served efficiently with MOH resources. Little has been done until now to involve other institutions in PHC and in the development of "intersectoral" health programs. For example, little progress has been made in developing environmental health programs with those governmental agencies responsible for housing programs and community development.

6. Planning for PHC implies experimenting with pilot projects and evaluating them to determine what works, implementing and diffusing

successful project results, and continuing support to ensure the projects' success after subsidies and international agreements end.

7. Plans, norms, and procedures are developed primarily at the central level by technically competent professionals, but these plans, norms and procedures often are considered by regional and subregional operating personnel to be inappropriate to local conditions due to the regional variations and diverse cultures of Peru. The perspectives and experience of regional operating personnel have not been integrated effectively and systematically into the process of developing plans, norms, and procedures with the central personnel.

There are many opportunities to improve the planning process. The general approach of planning and making improvements should include: the identification of which aspects of PHC are working well and which are not, systematic analysis of successful and unsuccessful aspects to improve the efficiency of regional and subregional services, and the timely reprogramming to improve performance. Active participation is needed from central, regional, and subregional Ministry management personnel to improve this process. It is important to ensure the participation of non-medical operations personnel for non-medical decisions. Technical assistance should be available from projects 219/230 for high priority tasks.

The General Planning Office (Oficina General de Planificación - OGP) is responsible for the development of national health plans. The regional and subregional levels participate in the planning process by providing data and information on the health situation. In preparing the annual expense budget, regions and subregions communicate their investment needs to improve and expand the service system. During interviews with professionals of the regional and subregional planning departments, however, the comment was heard that "we only prepare the reports that the central level requests."

The Westinghouse regional advisers could assist the regional and subregional management personnel to encourage more active involvement of regional planners.

Recommendation 4.1-6 regarding the participation of regional personnel in the planning process. Regional personnel should be more involved in planning. The OGP should review its procedures for requesting the opinions of professional personnel in regional Ministry offices to determine: a) to what extent these procedures contribute to plans that are considered unrealistic by operating personnel, and to the loss of motivation on the part of the regional personnel, and b) how to systematically obtain regional offices' opinions and perspectives to integrate them into OGP plans. The planning process will increase in importance if the MOH implements this evaluation's other recommendations on setting realistic performance goals and developing unit costs.

The scopes of work of the six regional Westinghouse consultants should give high priority to assisting health officials to develop data on costs, unit costs, and performance. The consultants also should help communicate clearly the situation to the OGP and relate current practices to regional health priorities, while respecting the established channels of MOH.

Coordination of international assistance projects is needed. These projects often are inadequately coordinated in terms of their objectives and actions to achieve them. Joint project planning and control is particularly appropriate when projects overlap geographically and have common objectives. For example, PAHO, USAID, the World Bank, and the GTZ all currently support training activities for auxiliary personnel, as described in section 4.6. Another area of overlap and gaps is the provision of office furniture and equipment by several international agencies, while regional offices lack basic equipment like calculators. Coordination of international programs currently is done with informal mechanisms, such as personal contact and communication, so it is probably inevitable that inconsistencies arise.

A Monitoring Committee was created recently at the top management level of the Ministry, presided over by the Vice-Minister of Health with the General Office of International Exchange (Oficina General de Intercambios Internacionales - OGII) as secretariat. This committee responds to the need to create an organizational unit to coordinate projects developed with international assistance.

The international donor agencies are expected to welcome the strengthening of the monitoring committee if it prevents the duplication of effort and the implementation of conflicting strategies and projects. The donors will also appreciate the committee's assistance in helping the Ministry's executing agencies to achieve project objectives.

An inventory is currently being taken of the 60 or more international projects in Peru. After completing and analyzing this inventory a manual data bank will be developed, to be converted into an electronic data bank once it is reviewed and modified. This electronic data bank is likely to constitute a valuable source of information to:

- Analyze current projects for complementarity, omissions, and duplication of effort to improve PHC.
- Define areas where international assistance could make a significant difference in quantity and quality of PHC services provided.
- Design a coherent program for international aid projects.
- Design an efficient system of administrative control to handle international aid projects based on objectives, regions of the country, types of inputs (personnel, materials, and supplies), and population categories served.
- Identify the health needs or specific population categories to which new projects should be directed, e.g., infant diarrhea.

In conclusion, a monitoring committee merits the full encouragement and support of USAID and the other international agencies to improve organizational coordination at the highest levels of the Ministry .

The evaluation team suggests some terms of reference for the Monitoring Committee that define in precise terms the objectives and the useful outcome of this activity. Clear and precise goals must be defined using the PHC strategy as a base, perhaps beginning with:

- o Promote international assistance to develop multi-sectoral projects.
- o Identify projects that are complementary to existing ones to expand services in specific geographic areas and attend to high priority PHC activities.
- o Monitor projects to facilitate problem solving.
- o Identify successful experiences to assure their continuity after international support ends and adapt them to other locations.
- o Establish a collaborative process with international agencies to to integrate their projects with other Peruvian health services.
- o Eliminate the duplication of efforts that often occurs when projects with common objectives are implemented.
- o Establish realistic targets to systematically evaluate project achievements and learn from experience for future reprogramming.

As the secretariat of the Monitoring Committee, the OGII should assign priority to specific activities including:

1. Take inventory of existing and proposed international projects and their most important characteristics.
2. Develop standard project monitoring procedures to make it easier for the Ministry and the international agencies to compare experiences, based on performance indicators and unit costs for PHC activities.
3. Respond in a timely fashion to the Monitoring Committee's and international agencies' requests for progress reports.
4. Prepare reporting procedures to improve compliance with international agencies' commitments.

In addition, the General Office of International Exchange would benefit from technical support in developing a data bank to plan and direct international projects successfully.

Another potential role for the Monitoring Committee is to promote support activities to strengthen PHC, including the following:

- o Encourage the extension of PHC programs.
- o Promote and sponsor private health care programs directed to the population not fully served by the MOH system.

- o Provide technical assistance to improve the administrative and operating quality of health programs.

- o Promote research and evaluation.

- o Promote economic assistance for personnel training abroad and the importation of supplies unavailable domestically.

Recommendation 4.1-7 regarding the Monitoring Committee. The Ministry of Health should continue to develop a Monitoring Committee and use the Office of International Exchange for the coordination of international projects. Formulate the objectives of PHC strategy, realistic specifications of expected results, and a specific plan of activities. The General Office of Organization and Methods should be encouraged to provide technical assistance needed in its area of specialization. USAID should provide support to the extent that outside technical assistance is needed from Westinghouse or elsewhere.

Annual Operational Plans are required from each region under the Project Agreements for Projects 219/230. The DSMIP Department of Projects has drawn up a document entitled "Guide to Programming Activities for Projects GOP/AID," which serves as a guide for preparing regional Operational Plans for the Extension of Primary Integrated Health Care Coverage (527-0219), and the Integrated Health and Family Planning (527-0230) projects. This guide provides the basic model for Operational Plans, providing standards for the detailed contents of the Operational Plans, chapters, and the forms and tables that should be used (a total of 19).

The Guide does not propose a schedule for the development of the Operational Plans. Consequently, the personnel at the Planning and Programming units at the regional and area hospital level do not have a clear concept of when to submit Operational Plans.

The Guide does not contain precise instructions covering the policies, restrictions, and priorities for expenses and new activities to be considered in 1984-1985. This means that each Planning and Programming unit applied its own criteria regarding these aspects.

The Operational Plans are formulated by the regional Planning and Programming departments. To do this the departments request data and information processed by the Planning and Programming units at the area hospital level. In some area hospitals the Planning and Programming unit prepares the portions of the Operational Plan dealing with training, supervision, and environmental sanitation. Nevertheless, the delays in creating plans and sending support material from the area hospitals frequently have resulted in plans' being written by only two or three regional people who are suddenly assigned the job.

Operational Plans are meticulously analyzed at the central level. Expense estimates are verified, estimates for training course materials are examined, and schedules for supervisory visits and activities are analyzed. All of this takes considerable time. Finally, the Operational Plans are reviewed and approved by USAID.

Delays in the development and approval process of Operational Plans are encountered because of the practice of returning plans from the central to the regional and sometimes area hospital level when there are mistakes. These mistakes include deficient preparation of plans according to the "Guide," omissions, and incorrect estimates of expenses. When errors do occur, the time needed to rectify the error and resubmit the plan to the central level is often excessive.

In conclusion, the process of formulating Operational Plans is cumbersome. Three levels of review and approval are involved: regional, central, and USAID. The plan is also formulated in such detail that meticulous review and revision is invited.

There are opportunities to simplify the planning process at the regional and area hospital operating units to make this process smoother and more flexible.

> Recommendation 4.1-8 regarding the use of Integrated Regional Health Plans instead of Project Operational Plans Integrating any future USAID and other foreign assistance projects into Regional Health Plans should be considered, since no additional operational plans will be drafted for projects 219/230. International organizations would benefit from this measure in various ways. A consolidated regional budget would facilitate determining project complementarity and calculating each project's overall contribution. A considerable reduction in the processing work for the preparation and execution of the regional plan could be expected since only one plan rather than several would be drafted, as is currently the case.

Other noteworthy observations were made about the planning process. First, easily accessible data on PHC activities and user characteristics are not exploited to determine the appropriateness of modifying PHC strategy and/or the best method of delivering services. Second, service statistics appear to be used to establish goals and program activities, but are not synthesized or analyzed to identify operating problems and make management decisions. In addition, all administrative levels gave low priority to analyzing variations in service delivery to increase productivity, i.e., identifying and evaluating good and poor performance to learn from experience.

Central, regional, and subregional statistical offices lack modern office equipment to perform their work. The statistics department of one of the area hospitals visited had only two calculators for eight people. When the department head was asked how he handled this situation, he responded, "some use the calculators, others do work that does not require them, and others are unproductive."

4.1.4 Administrative Organization

The current administrative organization of the MOH has important deficiencies that were recognized by the Government of Peru and were used as the basis for a planned reorganization of the MOH two years ago. Among the objectives of the reorganization were the following:

1. Achieve a more rational grouping of PHC-related components under the authority of a Ministry division.

2. Decentralize the authority and responsibilities for health services operational activities to the regional level.

3. Improve the capacity at the central level to control and evaluate regional and subregional operations.

The objectives of this proposed reorganization are still appropriate today, but none of the objectives has been fully achieved so far. Conflicts regarding the reorganization project among some of the directors prevented the establishment of a broad consensus for implementing the reorganization. The reorganization project thus has only been partially implemented.

The experience of two years ago is a warning that similar recommendations in this evaluation may also be controversial within the MOH. USAID can help with technical assistance to create a consensus-building process. Other factors will also be important, however, such as the personalities within the MOH or new government policies after the 1985 elections.

Organizational Structure

The Ministry's current organizational structure consists of eleven staff units, including the General Planning Office, Organization and Methods, International Exchange, Information, Statistics, and Administration; Figure 1 summarizes the structure in an organigram. There are four functional units: the Divisions of General Health, Pharmacy, Environment, and the General Office of Health Services. There are seventeen regional offices that should serve as line units, according to the proposed organizational design. Also included are the National Institute of Public Health and the School of Public Health.

Some obstacles the success of projects 219/230 appear to result from the organizational structure, when in reality they stem from other sources. Ministry officials interviewed indicated the problems mentioned below as hindrances to project implementation:

- Long delays in decision-making at the central, regional, and subregional levels.

- The lack of a clearly defined authority for administrative and supervisory posts at central, regional, and subregional levels.

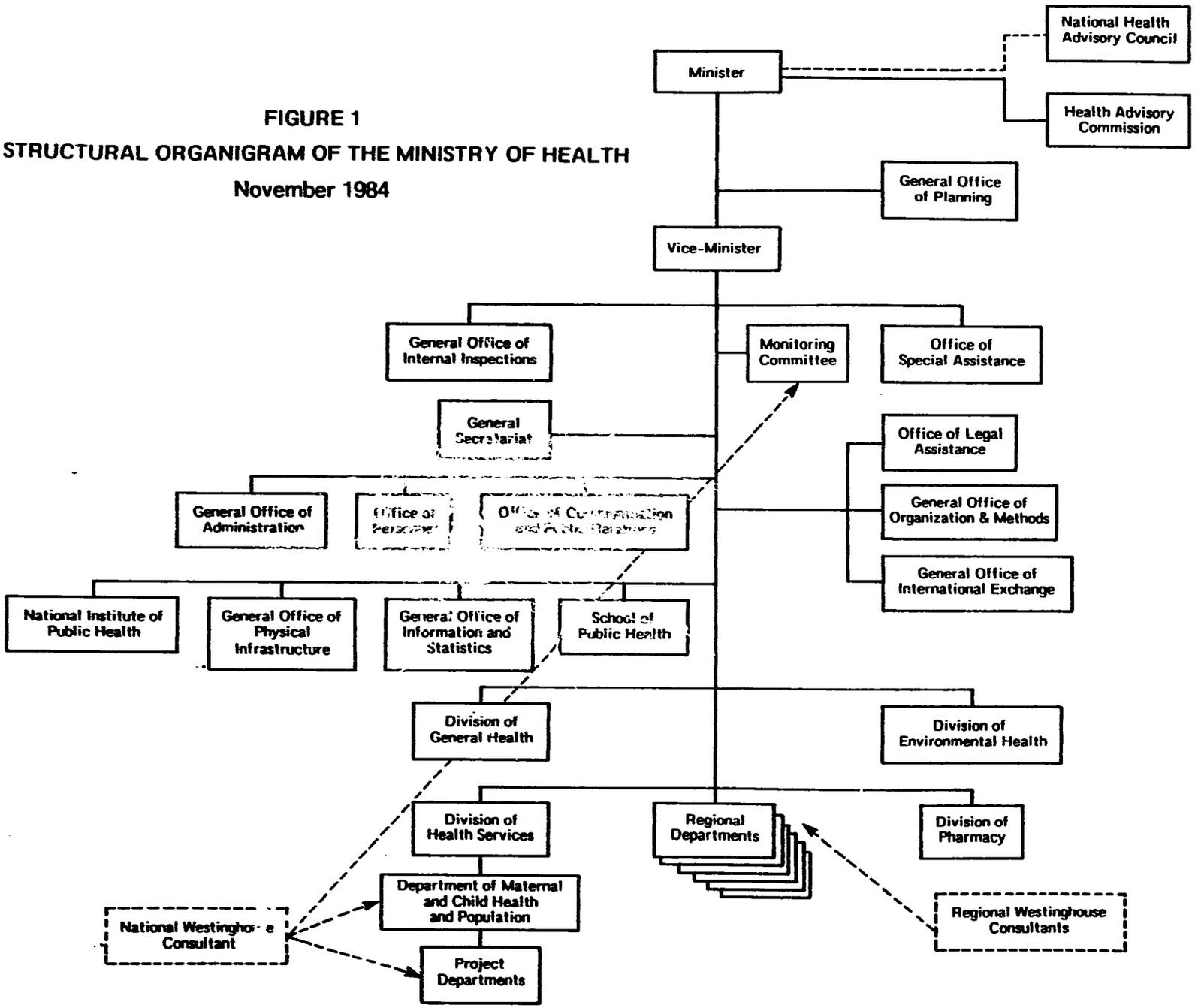
- Poor upward communication on the progress of health activities and the difficulties encountered in performing these activities.

- Inadequate procedures for evaluating performance.

FIGURE 1

STRUCTURAL ORGANIGRAM OF THE MINISTRY OF HEALTH

November 1984



These deficiencies that affect projects 219/230 are partly due to the lack of attention to a series of proposed changes to improve MOH's organization. Some of these changes have moderate potential, but together would have a significant impact. A strategy for major changes involving organizational reforms most likely will require greater reliance on internal resources, such as the General Office of Organization and Methods. This Office needs to be reinforced and expanded if it is expected to carry out the professional quality of work required by the Ministry.

The staff of central level functional units of the MOH try to exercise the close supervision and control appropriate to a "line unit," while the staff functions often are not well done. These staff units take the role of closely managing the PHC program away from regional operating units, and thus these operating units do not perform their roles as they should. The professional and technical staff of the General Office of Organization and Methods, for example, are not very active as internal consultants of organization and methods. The Personnel Office focuses on controlling and documenting of personnel movements, and does not provide the technical assistance required to design training and human resource evaluation programs. The Directorate of Maternal and Child Health and Population pays closer attention to the detailed control of operations than to providing assistance to the regional divisions to formulate techniques required for health service delivery.

The regional divisions in turn do not fully exercise their authority as line units. They usually wait for specific guidelines and approval from the central level regarding everything concerning the handling of health services. Combined with the high turnover of central and regional managerial personnel, this causes obvious administrative problems.

In summary, the Directorate of Maternal and Child Health and Population and other Ministry divisions act as if they were the line units with authority and responsibility for detailed operating decisions. This leads to excessive concentration of administrative processes at the central level, and the disintegration of these processes at the regional and subregional levels. In almost all of the interviews, central and regional officials commented on the harmful effects of this centralization.

Some problems mentioned in interviews that adversely affect health services from projects 219/230 seem to result from excessive central concentration of authority. The considerable number of reviews required for processing funds requests from regional and subregional levels is one example. The same observation applies to the review of Operational Plans, which can take up to six months for final approval.

> Recommendation 4.1-9 regarding delegation. The Ministry of Health should analyze the feasibility and desirability of delegating responsibility for day-to-day operations from the central to the regional and subregional levels. The Office for Organization and Methods could analyze specific situations with outside technical assistance as needed. The analysis should include interviews with regional as well as central MOH directors. In analyzing which functions can be done better from the regional level and how much

delegating should be done, the study should consider the recommendations in other sections of this report, especially 4.2 regarding financial systems, and 4.3 regarding logistics. There are already regions, such as Ica, that have good experience managing more autonomously.

The results of the analysis should be circulated to the central and regional level offices and should be the subject of a workshop for regional directors. The participation of outside technical advisers, such as consultants from ESAN and University of the Pacific, may be helpful to manage the discussions in a constructive and collaborative manner. A useful approach would be the "Organizational Development" style of collegial discussions of a management issue of common interest. Health service providers and non-physician manager-administrators should be included in the interviews and workshop. If the national level workshop produces useful results, similar sessions should be held regionally.

Control and Evaluation Processes for the MOH

MOH processes for control and evaluation of PHC services are hampered by delays of up to two months in the consolidation of service statistics at the area hospital level.

According to some of those interviewed, the current problems of administrative control and evaluation are the following:

- Too much detailed control by the central level.
- Difficulties in implementing various technical norms developed at the central level due to their inappropriateness to the specific conditions of some area hospitals.
- Effective performance evaluations are not done.
- Service statistics are not used to improve health activities at the operating units level.
- Considerable delays occur in the collection and compilation of service statistics.

It is difficult for the Project Department staff to determine if results and objectives are being achieved. A variety of technical norms exist regarding procedures for operational activities, but there are few predetermined standards to evaluate performance, such as whether services are being delivered. Some technical norms are considered impractical by operations personnel even when they appear technically sound. For example, supervisory norms require an excessive number of supervisory visits to health centers, health posts and community health workers, and training norms require the use of teaching material too advanced for many trainees. (See sections 4.5 and 4.6 for further discussion of supervision and training.)

Potentially useful data are not being properly analyzed. Daily records have many data which are not analyzed for management improvements. Data gathered at health posts, health centers, and area hospital and regional

levels are not analyzed by the respective Statistical Units or the Planning and Programming Unit for administrative control purposes.

The relevant statistics regarding PHC services do not reach the personnel with specific responsibility to coordinate projects 219/230 at the Directorate of Maternal and Child Health and Population. These statistics go directly from the health regions to the General Office of Information and Statistics to be compiled later at the sectoral level. At no time are these data analyzed with administrative criteria to identify problems, omissions, and opportunities to improve the efficiency and effectiveness of operational activities. More effective corrective measures could be taken with statistics on primary health care with the appropriate administrative control criteria.

These problems with data make it difficult to stay informed of the progress of projects and prepare the periodic reports required by the Executive Director of the DSMIP, other Ministry personnel, and the Project Manager at USAID.

To facilitate useful feedback in project monitoring, four fundamental requirements have to be met as follows:

- Set realistic performance targets and define simple performance evaluation indicators.
- Design and implement good methods of collecting and analyzing data for administration purposes.
- Send the data to the staff responsible for interpreting the information and solving the problem, as well as to the people who prepare the reports.
- Develop a process for promptly analyzing problems and motivating operating personnel to resolve them quickly.

Recommendation 4.1-10 related to control and evaluation. Examine the control methods currently used in projects 219/230 to ensure that they contain the essential elements of a good feedback and administrative control system. These are: realistic performance targets with simple indicators that are easy to monitor, a process for collecting and interpreting information to improve the situation, and a process for taking corrective measures. The Head of the Project Department should develop a plan of action for creating this monitoring system, with technical assistance as necessary. USAID should promote the development of this feedback/replanning system.

Periodic reports are useful if they are concise and focus on critical information on problems and opportunities to improve the efficiency of specific PHC components. Report content normally should not remain unchanged from one period to the next. A mix of achievement reporting and exception reporting is normally appropriate. For projects 219/230, the report content should be classified by project component, each with a target showing expected achievement in terms of quantity and time. Reports comparing actual and planned

performance should be prepared, and operating personnel should be offered the chance to report on problems and be given the opportunity to call for help from the central level.

Existing evaluations and studies at the central level often are not used. Even when the recommendations are considered useful and interesting, little has been done to implement them. An important exception is Robert Moore's recommendations on the financial system which have been implemented for the most part.

In Recommendation 4.1-1 we recommend that a PHC management team be formed. This would be an appropriate group to manage the PHC feedback/replanning process.

Policies and Procedures

The MOH uses written norms to communicate policies to operating units on many technical and administrative issues. The norms are usually prepared and distributed in the Ministry's central offices by technical specialists without significant involvement of the operating units. The norms provide standard procedures for diverse situations, which prove difficult to use in many situations.

The evaluation team heard two kinds of remarks about the norms: 1) some norms are unrealistic, so the operating units cannot follow them in practice; and 2) in some cases the norms permit flexibility, but other administrative obstacles have constrained their actual implementation.

MOH personnel at regional and area hospital levels complained of a proliferation of norms and that many were unrealistic. Specific problems noted include:

- Supervisory visits to the periphery cannot be made as frequently as prescribed. In section 4.5 we discuss the supervision situation in more detail.

- Per diems are governed by rigid, uniform procedures that provide inadequate reimbursement for field visits in many situations, and involve long delays to collect. In practice there are great differences in the costs for transportation, lodging, the distance to sites, the availability of receipts, etc.

- Operational Plans require so much detail and review that they are not completed and approved in time to serve their intended function of orienting the operating units' programs.

- Expenditure reporting procedures are intended to help operating units provide health services at a reasonable cost, but attention is often focused on detailed cost reviews with little or no consideration to results. Section 4.2 comments in more detail on financial systems.

Rigid administrative procedures that defeat the purpose of norms that were satisfactory were discussed in section 3.2, on family planning services.

The policy is to facilitate the massive and rapid extension of family planning services using auxiliary personnel whenever a physician is not essential; in practice, however, new acceptors often are turned away when a physician is not available. Distribution of oral contraceptives is cut off in many places where there is no physician, and permission to provide private sector contraceptive services is delayed for long periods.

Few policies and procedures are developed at regional and area hospital levels to adjust to local conditions for projects 219/230. An important exception is Ica, where project 224 (Sur Medio Pilot Project) has led to local variations that have proven very fruitful. The Ica experience suggests that regional offices are capable of making adaptations to improve both productivity and morale.

The PHC strategy makes it important to consider the diverse problems confronting operating units in regions away from Lima. Changes have not been incorporated into MOH processes for establishing and communicating its policies and procedures. The "Guide for Programming GOP/AID Projects" was prepared centrally without extensive involvement of regional and area hospital level personnel, so the same problems are directly pertinent to projects 219/230. The PHC strategy contains important changes in the roles of physicians and non-physicians in the health delivery system, so it is not surprising to find important "slippages" in the transition that involves physicians yielding some of their traditional functions to others.

> Recommendation 4.1-11 regarding the preparation of norms. Change the MOH approach of using norms to communicate policy; place more emphasis on providing practical guidance to the operating units. This would entail more participation from operating units in norm preparation and review. Innovations could be tested selectively to provide realistic and flexible guidelines. Norms should be output oriented, instructing the operating units on objectives and should allow more discretion to respond to unusual situations with these objectives in mind.
>
> National norms could provide principles, but give the regions flexibility to set specifics in cases like per diems. Recommendation 4.2-7 deals more specifically with travel expenses.

Systems and Procedures

The main observation about MOH systems and procedures is that delays appear to be typical rather than exceptional for many MOH procedures.

Specific factors causing these delays include:

- The management style requires several people's intervention at various levels of review and approval for any transaction, such as for the approval of Operational Plans and budgetary expenses.
- Personnel lack the capacity in methods of analysis and data processing to evaluate and make decisions. Please note that we make specific recommendations in section 4.4 on the information system.

- o Adequate criteria are lacking for unusual situations. During field visits by the evaluation team, members heard several comments from management and operations personnel that there are no specific guidelines from the central level on designing Operational Plans.

- o Regional and subregional management personnel tend to rely excessively on technical subordinates. One regional adviser suggested that delays in decision-making and action were due to frequent consultations made with technical staff on strictly administrative matters.

- o The MOH has a centralist management style with the idea that the consent of the superior is always necessary to make things work.

- o The Peruvian law is strict. Violations that might be overlooked in other countries can lead to a scandal, a criminal trial and imprisonment in Peru.

This centralist style of management results in an inefficient organization of work which requires the constant intervention of the superior to make the system function. In these instances even good systems and procedures would not ensure timely decision-making and action.

The General Office of Organization and Methods (Oficina General de Racionalización - OGR) has not had sufficient resources to improve systems and procedures for implementing PHC strategy. The OGR currently has a staff of four professionals, even though its personnel budget provides for 43 professionals and technical assistants. To fulfill its role as "internal consultant" in organization and methods, the OGR must maintain efficient supervision, get systematic evaluation of results, and it must receive recognition for jobs well done to motivate the professional and technical personnel. The OGR should seek work among its "potential clients": the Directors General, the Executive Directors, and other subordinate Ministry personnel. The OGR also needs clearer objectives regarding its internal consulting activities.

Recommendation 4.1-12 regarding improved systems and procedures. The MOH should analyze systems and procedures and make recommendations to eliminate delays that hamper operating personnel. The General Office of Organization and Methods (OGR) will need help fulfilling its role as internal consultant for MOH systems and procedures. Starting points should be the changes in the Financial and Logistics Systems recommended in sections 4.2 and 4.3. Detailed analysis of needs and implementation of changes should be supported by outside advisors from Westinghouse or elsewhere, but the OGR should participate actively both to contribute and to improve the OGR's capacity for independent analysis.

Personnel

Systems and procedures are efficient when trained personnel are available, but the MOH lacks a comprehensive training policy. Standard

procedure has been to leave training for implementing or modifying procedures almost completely to individual initiative. This practice costs a considerable number of administrative errors and omissions every day.

For example, the accounting personnel from an area hospital were unsure if they should account for USAID funds only, or also for Counterpart and Public Treasury funds. Frequent omissions in documents require them to be returned from the central to regional and subregional levels for corrections. This example shows the potential value of continuous personnel training in new procedures.

> Recommendation 4.1-13 regarding in-service training for management and administration skills. MOH personnel need more in-service training to perform their management and administrative responsibilities efficiently. Section 4.6 regarding training indicates that a great deal of foreign money is available for training PHC personnel at the periphery, and that PHC training funds should be more carefully rationed. Some of these funds should be redirected to training in basic management and administration skills, such as the development of output targets, unit costs, and using feedback to solve problems. The MOH would benefit from much additional training, but it should not come from projects 219/230 in view of the PHC priorities of these projects. Other agencies with different priorities may be interested in filling this gap.

Training courses for administrative and management personnel should not last more than one or two weeks and build upon each other. Three sequential two week courses with sufficient time in between sessions to internalize concepts, principles and skills, are better than a six week course. Courses are more effective when designed around actual problems that the participants encounter in their work situations. Cases, simulations and role playing are preferable to lectures and conferences. The courses would be more effective if the teaching staff acted as resource persons and were experienced in the application of the techniques of group dynamics.

An efficient strategy for continuous training should accomplish the following:

1. Develop management's and supervisory personnel's ability and motivation to identify subordinate personnel training needs together with technical personnel of the General Office of Personnel.

2. Improve procedures for analyzing training needs at all MOH levels, especially of PHC personnel.

3. Design training programs jointly with supervisory personnel.

4. Identify training opportunities in Peru and abroad.

5. Implement training programs and evaluate the results to designing new training programs.

High turnover of management and professional personnel at all levels has been a serious obstacle to PHC service programs. The evaluation team noticed a difference in the efficiency, effectiveness, and motivation in the personnel between regions whose director had held the job over three years and those where he had held the job less than one year.

Recommendation 4.1-14 regarding increased continuity of regional health leadership and use of "teams". The MOH needs to analyze the problem of high regional turnover with outside technical assistance from Westinghouse or elsewhere. The analysis should evaluate the impact of leadership continuity on the PHC program and what factors influence the most effective leaders in their decisions to stay or leave a regional post. These factors might include financial and non-financial incentives, opportunities for advancement, and other elements of job satisfaction.

One suggestion is to hire a Deputy Director for each region for a three year term to provide regional continuity even if the Director is moved more frequently. The Deputy Director position would be reserved for a person with the management and administrative skills to run the region in case the Director is a physician lacking good management skills. The MOH could thus make physicians Directors without forfeiting good administration. Some physicians do have appropriate management skills or can develop them with management training. In these cases the Deputy Director position can be a stepping stone to becoming Regional Director.

It is important to consider experimenting with different monetary and non-monetary incentives and to adopt a policy of encouraging productive field personnel to continue in their jobs. Non-monetary incentives may be experimented with, ranging from public recognition to transfering management and professional personnel from a less attractive region to a more attractive one as a reward for good performance.

Building a good team is another approach to providing continuity at the regional level. A good team can help motivate team members to work hard, achieve useful results, and derive more satisfaction from their jobs. Please note related comments on team management preceding Recommendation 4.1-1.

Professional development opportunities constitute an important non-monetary incentive for management, technical and supervisory personnel. Training programs based on systematic needs identification have proven effective in developing skills and in indirectly increasing motivation. It is important to direct training to specific development needs of PHC personnel. For example, in designing administrative training programs, consideration should be given to typical problems in supplies handling, fund management, selection and assignment of extension personnel, and the provision of services to patients. Professional and technical personnel also should receive frequent training in their specializations to improve productivity.

Recommendation 4.1-15 on providing specific training to management, administrative, and professional personnel. Provide specific training for management, administrative, and professional personnel based on the training needs identification in their areas of responsibility. Training should be periodic, progressive, and directed to resolving problems impeding the achievement of expected results in PHC services.

4.2 Financial Systems

4.2.1 Introduction

The financial systems involved in projects 219/230 were identified as the highest priority concern of USAID and also of the MOH personnel involved in the project. Numerous individuals interviewed by the evaluation team said that the flow of funds was the single most important problem to be addressed. Consequently, financial systems were given intensive attention in the evaluation.

Financial systems are control mechanisms for the proper utilization of funds and other resources of an organization and for the preservation of its assets. Financial systems also constitute tools to facilitate the efficient delivery of quality services. This function of financial systems is recognized and has been adopted as a guide by the Ministry of Health of Peru in its 1984 publication entitled "Curso del sistema del tesorería." It establishes as "an objective of the Treasury Office (Oficina de Tesorería) to expedite management of public funds at all administrative levels by the simplification of payment procedures so as to reduce costs of goods and services" (Chapter I, par. one, page one).

It may be logically inferred that this approach of expediting the management of public funds will also bring about an active, efficient, and effective health services delivery system. Inherent in the concept of "efficiency" are the concepts of "productivity" and "cost-effectiveness." Moreover, the implementation of this approach will contribute to the creation of an organizational environment that motivates the providers of health services and employees.

This section of the report has as its objective the evaluation of the MOH's financial systems to identify areas of potential improvement with particular attention to the primary health care program and projects 219/230. Due consideration is given to the dual role of the financial systems as control tools and as facilitators of the delivery of health services. The evaluation recommends specific improvements in the financial systems.

4.2.2 Evaluation Methodology regarding Financial Systems

The foundation for this section of the evaluation consists primarily of several official documents listed in the Bibliography of the report, supplemented by interviews in Peru. Some of these documents provide the legal and policy framework for the financial systems, while others define specific procedures for financial management. Still others define contractual obligations between the MOH and other agencies that provide financial support to the health programs, such as USAID. Other documents reviewed include work plans, budgets, and performance reports.

The principal parameters or conceptual guidelines for the evaluation of financial systems have been the following:

- o Generally accepted government accounting and financial management principles and procedures.

- o Concepts and methods of work simplification.

- o Management theories applicable to the area of finance, such as delegation of authority and responsibilities, participative management, communication, motivation, and others.

- o The concepts of efficiency, productivity, effectiveness, and quality, generally recognized as elements of a good health system.

The evaluation is oriented towards two areas of major concern: the conceptual design of the financial systems and the actual application and functioning of the systems. The conceptual design is determined by laws, decrees, resolutions, budgeting and accounting manuals, agreements between the MOH and other agencies such as USAID, and letters establishing norms and procedures for the execution of agreements. The practical application and functioning of the financial systems is determined by formal and informal organizational structure, the communication system, the training of the personnel, and their level of motivation.

The evaluation has tried to establish the degree of consistency between the conceptual design of the financial systems (the specific norms and procedures) and the policies regarding finances, and between the conceptual design of the financial systems and its actual application in terms of the parameters and conceptual guidelines mentioned above. The evaluation gives special attention to projects 219 and 230; however, they are viewed and analyzed within the macro-financial system of the MOH because of the interdependence and reciprocal impact between the mini-system and the macro-system.

The evaluation has taken as a point of departure the reports prepared by Mr. Robert C. Moore of the Westinghouse technical assistance team. They are excellent reports and have been very valuable for the present evaluation. Also, a considerable amount of additional data was kindly prepared and provided by the Executive Accounting Office (Oficina Ejecutiva de Contabilidad Presupuestaria y Financiera - OECPF) of the General Administration Office (Oficina General de Administración - OGA) of the MOH. These data were obtained from official accounting records of the MOH, covering such aspects as financial statements for projects 219/230 during 1983 and 1984 (as of November 29, 1984); budgetary evaluation for 1980 through 1984; evaluation of targets for same period; personnel employed by occupational group for the same period; and actual expenditures for the same period. This information is available as a bound document entitled, Proyecto AID 527-U-0230-073 "Servicios Integrados de Salud y Planificación Familiar 1983/1984." This document is referred to hereinafter as the "Special Financial Report." The content of the document is broader than what the title may suggest; the title corresponds only to the

first set of data included in the document. (The original of this document has been given to USAID.)

The methodology had contemplated the interview of five physicians of the MOH who are studying at the Medical Sciences Campus of the University of Puerto Rico for their Master's degree in Public Health. One of those physicians, Dr. Jesús Toledo, was contacted by the financial specialist before leaving for Peru. A meeting with all five physicians was arranged through Dr. Toledo for November 2, 1984, but none of them attended the scheduled meeting. Further efforts were made to contact them with no positive results, mainly due to an academic recess of one week, November 5 through November 11. The financial specialist left for Peru the 10th of November.

As part of the data-gathering phase, the financial specialist visited the Callao and San Martín health regions. The persons interviewed at those regions are indicated in Annex 1 of the report, "List of Persons Interviewed." The financial specialist also reviewed information from the other members of the evaluation team who visited other regions: Arequipa, Chiclayo, Lima, Piura, Trujillo, Ica, and Puno. Visits of the financial specialist to the Ica and Ancash regions were programmed, but they were cancelled or postponed at least twice in each case for reasons beyond his control. After that there was no time left for field visits without adversely affecting the analysis of the data already gathered and the preparation of the report.

The findings and conclusions on financial aspects are believed to be representive of all the regions. The financial situation appears similar in all of them, according to the data and information obtained from the following sources:

- The information directly obtained by the financial specialist through his field visits.
- The input provided by the other members of the evaluation team who visited other regions.
- The evaluation reports of the regions contained in their Operational Plans for 1983-84. All those reports were analyzed and selections from them are quoted in this section.
- The Special Financial Report prepared for the financial specialist by the OECPF.
- The information provided and observations made by the technical personnel who participated in the preparation of the Special Financial Report, particularly the person in charge of the contracts section of the OECPF.

4.2.3 Findings and Recommendations regarding Financial Policies

The principal policies that orient (or are expected to orient) both the conceptual design of the financial systems and their application and functioning are the following:

- The Head of each Budgetary Unit has the responsibility for the administration of his unit and the accomplishment of results in accordance with the established targets (emphasis provided) (Article 5, par. b, Budget Statute for 1984).

This policy places emphasis on the accomplishment of results and targets as a means and measure of management and financial control.

- A similar policy is established for the Heads of Programs (Budget Statute, op. cit., Art. 5, par. c).

- The Heads of Budgetary Units may delegate their authority to lower levels of the organization (Ibid, Art. 6).

It may reasonably be inferred that this policy is intended to expedite the health delivery system, to provide for its flexible operation, to simplify the decision network, and to improve the channels of communication.

- The budget performance shall be evaluated (semi-annually) in terms of income, the accomplishment of targets, and resource utilization (emphasis provided) (Budget Statute, op. cit., Art. 58).

Again, emphasis is placed on management and financial control based on results and targets.

- Budget performance is that phase of the budgetary process during which the administrative structure operates to accomplish the established targets (emphasis provided) ("Curso de Contabilidad Gubernamental Integrada," Ministerio de Salud del Perú, 1984, p. 31).

Again, emphasis is placed on achieving targets and results as the means and measure for management and financial control.

- The objectives of the methodology for budget performance are to simplify the information flow to the maximum degree possible, eliminating unnecessary duplications and reiteration (emphasis provided) (Ibid, p. 34).

This policy or norm is a recognition of the need for and convenience of simplifying the financial procedures.

- The quality and timeliness of the information required for the periodic reports on budgetary performance (about 13 reports) constitute the philosophical base of the Budget Directives (emphasis provided) ("Curso de Contabilidad Gubernamental Integrada", op. cit., p. 36).

The quality and timeliness of the information depends on the simplification of the financial procedures and on the responsiveness of the whole system.

- The philosophy of the budget system is based on the need for increased participation of all levels of the administrative structure in the process of the budget preparation; through such participation, people will propose their own priorities with reasonable limits (emphasis provided) ("Directivas para la Formulación del Presupuesto 1985," Ministerio de Salud, p. 1).

  Inherent to this philosophy is the concept of "participative management," aimed at the maximum utilization of employees' abilities and at creating a motivating environment.

- The payment procedures established in the Decrees Number 19350 and 19463 are designed to:

  a) Facilitate the financial decision process so as to maximize productivity (emphasis provided) ("Curso del Sistema de Tesorería," Ministerio de Salud del Perú, 1984, Chap. 1, par. 9).

  b) Activate the management of funds at all levels of the Public Sector by means of the simplification of the payment mechanisms (emphasis provided) (Ibid, Chap. 1, par. 9).

- Once more, the Ministry of Health recognizes the need to "quicken the management process at the operational and service delivery levels..." in its National Development Plan for 1984-1985 (Plan Operativo Sectorial, 1984, p. 54, par. 9).

Recommendation 4.2-1 regarding a plan to improve financial management. OGA, with the support of Westinghouse consultants and/or outside consultants, should develop a plan for the effective implementation of the policies described above. This evaluation report and the specific recommendations made in the pages that follow should constitute the basis for such a plan.

4.2.4 Budget Preparation

The Annual Budget Statute of the Public Sector establishes the procedural framework for the approval, execution, and evaluation of the budget. The law states that the Central Government Budget, including the MOH budget, shall be prepared in accordance with the "Directivas de Ejecución y Control del Presupuesto." The approval of the budget shall be formalized by means of a resolution issued by the head of the respective department (i.e., MOH) (Art. 8 of the Budget Statute).

The "Directivas de Ejecución y Control del Presupuesto" provide that "In the determination of expenses, each Budgetary Unit may utilize the most convenient level of detail. However, the budget proposals to be submitted to the central government level shall be by major items of expenditure (asignaciones genéricas)" (emphasis provided) (p. 6 of the Directivas).

There are 12 major items of expenditure of which only five correspond to operational or current expenditures:

01	-	Personnel
02	-	Supplies and materials
03	-	Services
04	-	Current transfers
05	-	Pensions

The remaining seven major items of expenditures correspond primarily to investments.

Budget control based on major items of expenditure provides great flexibility in the budget execution. However, at the operational level the budget execution is controlled on the basis of numerous specific items of expenditure into which the major items are broken. The plan of accounts provides more than 60 specific line items. Transfers between specific line items must be approved by the central level of the MOH, even if they are within the same major item of expenditure. This reduces considerably the flexibility of the budget execution. It also limits considerably the discretion of the persons responsible for the budget execution. In the analysis of the budget execution phase this situation is discussed in more detail. (When funds are available from various donors, the funds cannot be co-mingled, e.g., a desk costing 400,000 soles might not be purchasable even with one million soles available in four accounts if no single account had the entire 400,000 soles.)

Organizations, like human beings, are moved by objectives, purposes, and goals. To the extent that the objectives are accomplished, the organizations will have been effective, and if the costs were reasonable, they will have been efficient, too. Therefore, the analysis and evaluation of the operations of the MOH and projects 219/230 concentrate on achievements first and then on the means to attain them efficiently.

It should be presumed that the persons given the responsibility of accomplishing the organizational objectives and goals are competent. Based on the assumption of competence, they should be given sufficient and adequate discretion in the selection and handling of the means to accomplish the objectives and goals. If they do not prove competent, then they should be trained or replaced. Rigid control over the means does not contribute at all to the accomplishment of objectives and goals of the organization. On the contrary, rigid control constitutes a source of insecurity and dissatisfaction and creates a poorly motivating environment, according to motivation theories that have been empirically tested.

The need for and convenience of output-oriented controls are implied in the policies of the government of Peru and the MOH, enumerated in section 4.2.3 above. However, the design of some of the financial procedures and the actual implementation of the procedures are not consistent with said policies. Specifically, despite the recognized need for output-oriented controls, the Directivas para la Formulación del Presupuesto do not provide the mechanisms for directly relating resources requested with proposed performance targets. The reference to targets is very sketchy.

The MOH organizational structure does not facilitate the linking of resource (inputs) and performance targets in the administrative process of planning, budgeting, implementation, and evaluation; both input and output measures are needed to judge efficiency. For example, there is no adequate coordination between the unit in charge of sectoral planning and the unit in charge of budget preparation at the top level of the MOH. (Note that the difficulty of integrating planning and budget functions is universal, despite their close interdependence.)

The "Plan Nacional de Desarrollo para 1984-1985--Plan Operativo Sectorial del Ministerio de Salud" is an excellent document. It shows the great effort and achievement that have been made by the MOH to identify and quantify health targets. However, these targets are not analyzed on the basis of past experience and resources available. Consequently the document fails to demonstrate the realism of the goals. As a minimum the proposed targets should be compared to the targets achieved in previous years. As a matter of fact, the Special Financial Report shows that although the targets accomplished during 1984 compare favorably with those of 1983, the level of accomplishment is below fifty percent of the projected level.

At the General Administration Offices (OGA), the organizational units deal with accounting and budget control exclusively in terms of resources budgeted, flow of funds, and expenses incurred. No reference is made to results accomplished (outputs) in relation to funds and resources used (inputs). That is the situation, for example, in the "Area de Contabilidad Presupuestal," the "Area de Convenios," and the "Unidad de Calendarización" of the OECPF.

At the level of the General Directorate of Health Services (Direccion General de Servicios de Salud - DGSS) there is relatively limited integration and coordination between the units that deal with planning, budgeting, and program evaluation. As a result, there is a need for integrated focusing on resources and results accomplished (input/output).

At a regional level the same process takes place. The budget, accounting, and treasury offices, or the equivalent units, deal exclusively with funds appropriated, the flow of funds, and expenses incurred, with no reference to goals. The units that deal with the planning, programming and evaluation of programs and services do not relate goals to resources.

The level of consciousness about efficiency and productivity is low at all levels of the MOH. That is, there is a limited consciousness about the need to use resources efficiently to achieve performance targets.

The situation is more or less the same with respect to projects financed partly by agencies such as USAID. USAID requirements concerning the accomplishment of pre-specified targets are not sufficiently rigorous to induce the MOH to establish mechanisms that promote efficiency and productivity and offer feedback to confirm the performance.

The timetable for the preparation of the budget is not realistic for synchronization with budget implementation. The "Directivas para la Formulación del Presupuesto" (p. 10) require that by May 14, the Budgetary Units shall have prepared preliminary budget proposals. By July 23, the proposals shall have been prepared in final form and by August 28, they shall have been submitted to Congress.

The "Planes Operativos" of the health regions are their work plan and budget with respect to projects 219 and 230. Therefore, they are part of the overall work plan and budget of the MOH. However, the "Planes Operativos" for 1984 were still pending approval by the USAID in November 1984, with barely one month remaining in the fiscal year that ended on December 31, 1984. There have been delays in the preparation, review, and approval of the "Planes Operativos" at all levels. These deviations from the budget timetable also occur in its execution. There are multiple causes for these delays:

- The preparation of the "Planes Operativos" is a new methodology, so it requires training and adjustments in management style and techniques.
- Communication barriers have made difficult the implementation of the new methodology.
- The "Planes Operativos" are extremely detailed, thus complicating their preparation, analysis, and use.

(Westinghouse commented in March 1985 that all but four regions had completed their plans and budgets and the remaining four were expected during March of 1985.)

Please note that no more Operational Plans are required during the remainder of projects 219/230 and a different methodology will be adopted for future projects.

The following two recommendations, as well as those that follow, will help to close the gap between the policies that orient the design of the financial systems and their actual use. These recommendations will also contribute to better sychronization of the phases of the calendar for budget execution.

Recommendation 4.2-2 regarding budget preparation to include performance targets and estimated unit costs. In the budget preparation and presentation, data on performance targets should be integrated with resources needed to accomplish them through the establishment of unit costs. The budget should then be focused on achieving goals at reasonable costs.

(The Director of OGA commented that the use of performance targets and other "program budgeting" methods make a lot of sense, but are not possible now. The Ministry of Finance has discarded program budgeting in favor of a set of "ceilings" and negative controls to reduce government expenditures.

Recommendation 4.2-3 regarding a Budgeting and Planning Committee. Developing useful estimates of unit costs will require a closer integration and coordination between the organizational units that presently deal separately with the projection and evaluation of programmatic goals and the resources needed to achieve these goals. The integration and coordination may be accomplished by means of a Budget and Planning Committee in which the following units are represented. A similar structure should be established at the regional level:

- Executive Office of Accounting (OECPF):
  - Budget Accounting Section
    (Area de Contabilidad Presupuestaria)
  - Scheduling Section
    (Area de Calendarización)
  - Accounting Information Section
    (Area de Información Contable)
- General Directorate of Health Services (DGSS)
- Directorate of Programming and Evaluation (DPE)
- Directorate of Maternal and Child Health and Population (DSMIP)
- General Planning Office (OGP)

(The Director of OGA commented that the recommendation was a good idea, but that the Planning Office should be responsible and should involve the other offices.)

4.2.5 Budget Execution Procedures

The procedures for the execution of the MOH budget are described schematically in Figure 2, "Central Government Payment Procedures: by the General Administration Office" and in Figure 3, "General Government Payment Procedures: by Regional Office of the Ministry." These figures were obtained from the official document "Curso de Tesorería del Ministerio de Salud del Perú," op. cit. The detailed procedures are contained in that document and in the official document, "Contabilidad Gubernamental Integrada del Ministerio de Salud, 1984," op. cit. These procedures apply to both treasury and counterpart funds.

The procedures for the budget execution of projects 219 and 230 that concern the funds provided by USAID are presented schematically in Table 5 "Approval of Operational Plans," Table 6 "Request for Funds," and Table 7 "Remittance of Funds to the Regions," and are described below. These tables were taken from the official document "Procedimientos y Contabilización de los Convenios Interacionales con AID, Ministerio del Perú" where the detailed procedures appear.

Calendar of Obligations ("Calendario de Compromisos")

The budget is executed on the basis of a monthly obligations calendar. The calendar of obligations is the stage at which the funds needed to meet the projected expenditures for the month are reviewed and authorized. The corresponding amount of appropriated funds is committed to meet the projected obligations.

The "Calendarios de Compromisos" are developed at the Budgeting Unit level, i.e., the health regions and the MOH central level. The OGA coordinates and consolidates them. The "Calendarios" must then be approved by the General Budget Office (Dirección General del Presupuesto Público) in coordination with the Public Treasury Office (DGTP).

The payment of the obligations incurred as per the "Calendario" must conform to the Request for Funds and the Disbursement Authorization. The budget execution ("ejecución del gasto") and the expenditures statement ("rendición de cuentas") must be supported by the following documents:

- Payroll ("Planilla unica de pagos por remuneraciones y pensiones")
- Invoices ("Factura de compra de bienes y servicios")
- Voucher ("Comprobante de gastos")
- Appraisal of capital improvements ("Valorización de obras")

Request for Funds ("Solicitud de Giro")

The request for funds is the stage which follows the approval of the

"Calendario de Compromisos" and at which government agencies like the MOH request the funds they need. The requests must be approved by the Treasury Office (Dirección General del Tesoro Público - DGTP), which gives authorization for the issuing of the funds requested. The unexpended funds of any authorization are available for subsequent periods; however, they must be requested and justified again. The regions channel their requests for funds to the Treasury Office through OGA. The request must be accompanied by the report of funds expended from the previous disbursement authorization.

Disbursement of Funds ("Giro y Pago de Obligaciones")

This stage consists of the issuance of checks to the OGA and to the regions for payment of expenses incurred. The check must be supported by documents evidencing the expenditure.

The following schedule must be followed by the Budgetary Units:

Schedule of Obligations ("Calendario de Compromisos")

Presentation to the Dirección General del Presupuesto Público (DGPP) (Figures 2 and 3: stage A, steps 1 and 2) 15 days prior to the beginning of the month covered by the "Calendario."

Approval by the DGPP (Figure 2: stage A, step 1; Figure 3: stage A, step 2) 10 days before the monthly Calendario is to become effective.

Approval by the MOH (Figure 2: stage A, step 3) within 10 days following approval by the DGTP.

Request for Payment ("Solicitud de Giro y Pago")

Presentation of the request to the DGTP (Figures 2 and 3: stage A, step 1) not later than the 20th day of each month.

Approval by the DGTP (Figure 2: stage A, steps 1, 2, and 3; Figure 3: stage A, steps 2,3,4, and 5) three working days after its presentation.

The payment authorization ("Autorización de Giro") will be in force for the period beginning the day the request for payment is approved by the DGTP and of its publication in the official daily "El Peruano" and ending the next to last day of each month.

The "Calendario de Compromisos" requires very close synchronization of the different organizational levels and units that participate in its preparation, review, and approval. At the regional level there are at least four levels participating in the process in each of the seventeen regions. At the central level of the MOH at least four levels participate in the process. Also, USAID participates to the extent that projects 219 and 230 are concerned. It is very difficult to accomplish the required synchronization of the "Calendario de Compromisos" processing, month after month, due to the shortness of the cycle and the many organizational levels and units involved.

FIGURE 2

CENTRAL GOVERNMENT PAYMENT PROCEDURES: BY THE GENERAL ADMINISTRATION OFFICE OF THE MINISTRY

(PUBLIC TREASURY AND COUNTERPART FUNDS) Source: Westinghouse Health Systems

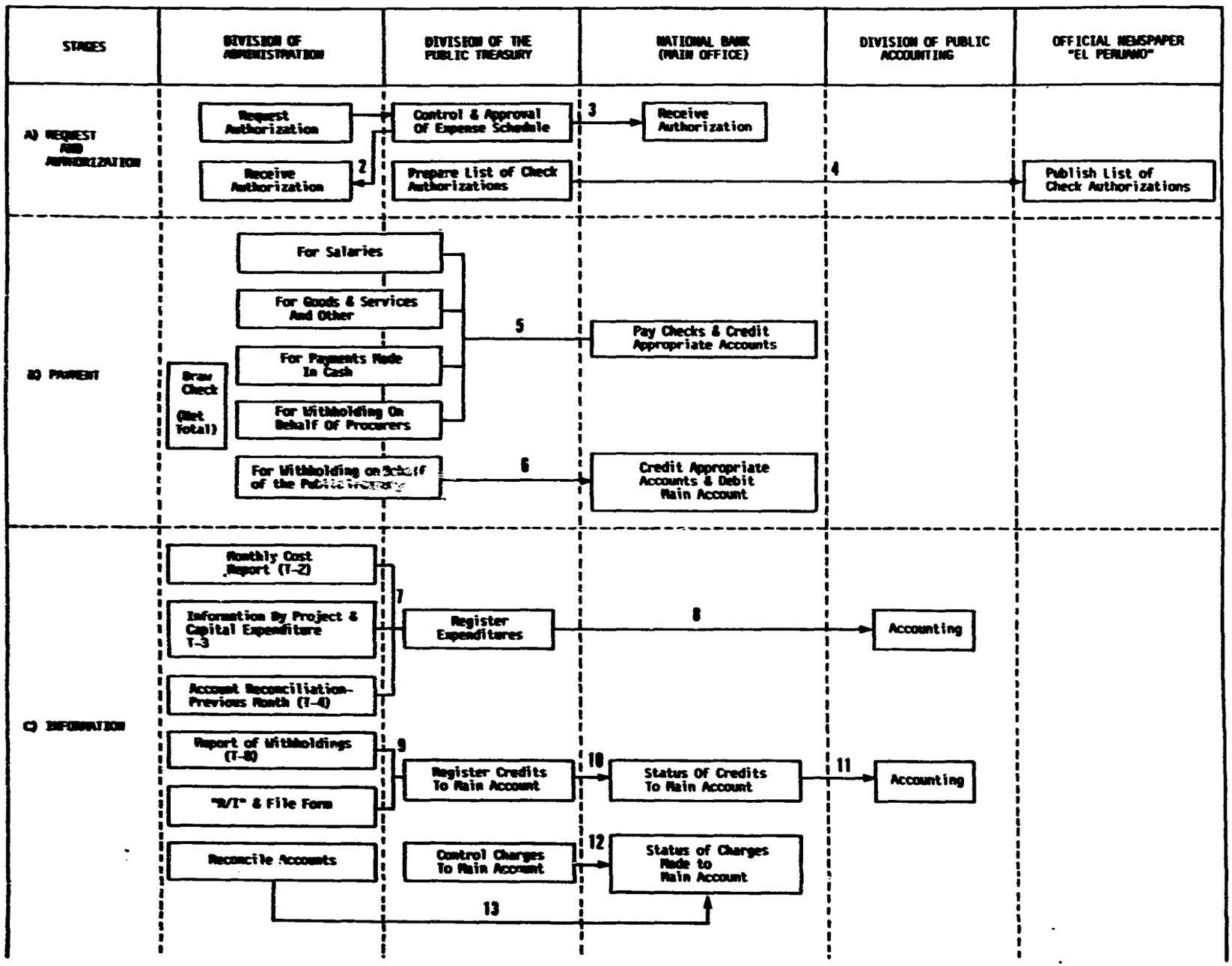
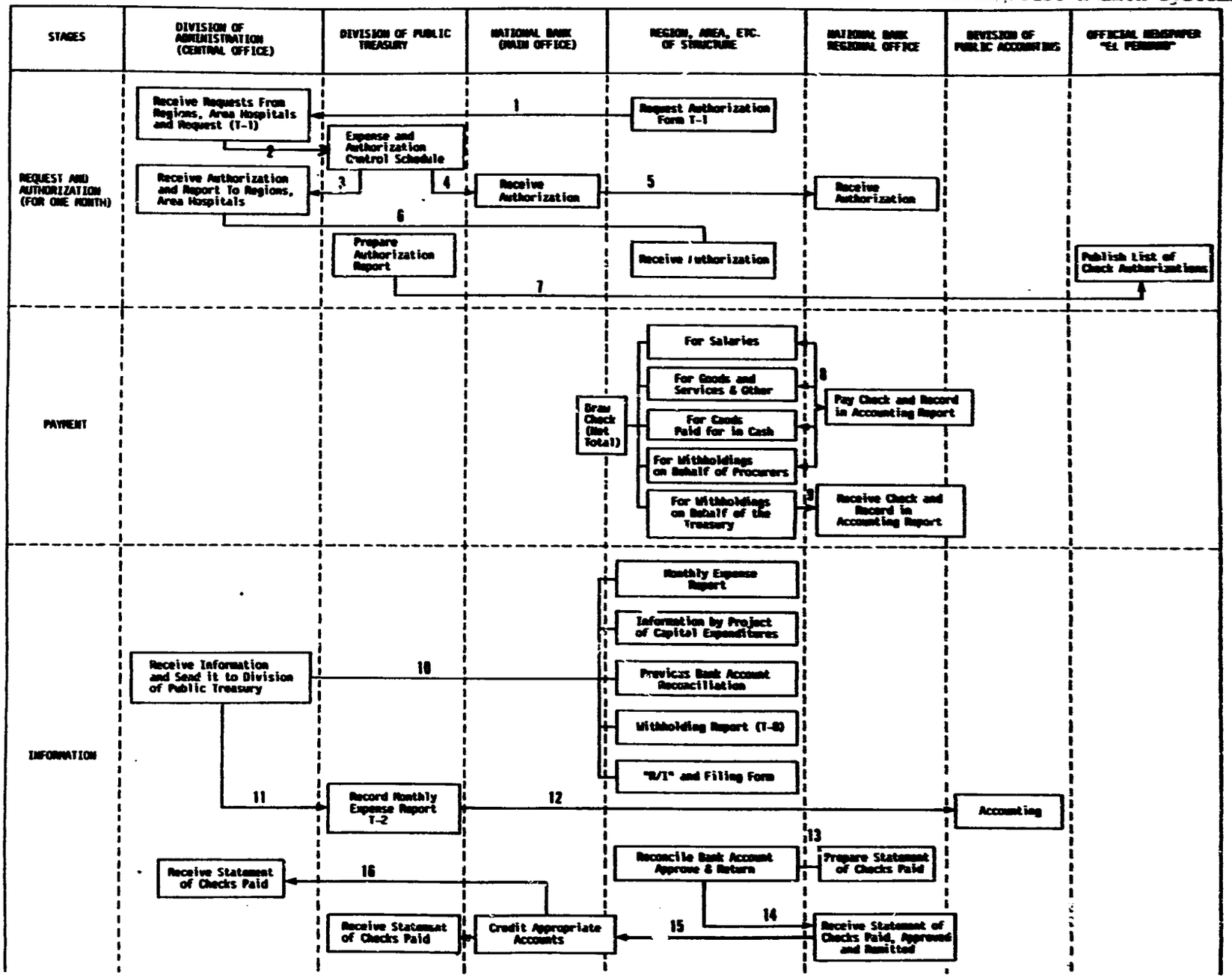


FIGURE 3

CENTRAL GOVERNMENT PAYMENT PROCEDURES: BY REGIONAL OFFICES OF THE MINISTRY

(PUBLIC TREASURY AND COUNTERPART FUNDS)

Source: Westinghouse Health Systems



Other facts and circumstances described in the paragraphs that follow aggravate the synchronization problem.

The request for payment must be accompanied by information contained in the following forms:

- o T-2 Monthly Expenditure Report ("Informe Mensual de Gasto"); one for each source of financing, by major and by specific items of expenditure.
- o T-3 Capital Investment Report ("Informe por Projectos de los Gastos de Capital"), by projects.
- o T-4 Conciliation of the Flow of Funds by Sub-accounts ("Conciliación del Movimento de Fondos de Sub-cuentas").
- o T-8 Statement of Witholdings ("Relación de Retenciones").

The preparation of the monthly expenditure report takes a considerable amount of time because it is detailed by specific items of expenditure, which are numerous. The control of the budget execution and of expenditures by such numerous specific items of expenditure makes it difficult to meet unforeseen needs if a transfer of funds between specific items of expenditure is required. The authorization process for such transfers is slow and cumbersome, particularly considering the short, one month cycle of the "Calendario de Compromisos".

For example, in the Callao region the distribution and installation of latrines was held up by a transfer of funds between specific items of expenditure. The specific item of expenditure for transportation services was short of funds, even though there were sufficient funds in other specific items within the same major budget item.

Another example is in the San Martín region where three outboard motors were ordered for the boats which are used to transport promoters, public health inspectors, and supervisors. By the time the order was placed, prices had increased considerably so there were only sufficient funds for two motors in the appropriation item. It was decided to buy the two motors rather than wait for the authorization of a transfer of funds. The result appeared as an under-expenditure in the monthly expenditure report when compared to the "Calendario de Compromisos," since the two motors cost less than the funds programmed for three. Situations like those described above are important, not because they result in under-expenditures, but because they reduce the health services delivered and cause employee dissatisfaction.

The payment of per diem ("viáticos") presents a similar situation in all the regions visited by the evaluation team. The persons interviewed at the regional level claim that it is very difficult to obtain receipts to substantiate the expenses incurred, particularly in the remote rural areas. For taxi expenses the difficulty is present in urban areas as well. A sworn statement is permitted in lieu of invoices and receipts in these circumstances. However, this mechanism has been rejected for unknown reasons;

it may be due in part to a communications problem.

Communication barriers are evident at all levels of the MOH, both vertically and horizontally. For example, the central level of the MOH substantially reprogrammed expenditures for the San Martín region without consulting the region and then notified the region late in October, only two months before the end of the fiscal year.

This situation reflects not only a communication problem, but also failure to delegate sufficient authority to the region to carry out the heavy responsibility given to a health region. The close and detailed control of the budget execution from the central level of the MOH is a manifestation of the inadequate delegation of authority to the regions. One of the regional directors commented that decisions which affect the day-to-day operation of the regions should be taken by the regional level. He added that decisions of broader scope that must be taken by the central level of the MOH should be made after consultation with the regions.

The problem of synchronizing the execution of the budget as well as its preparation applies to projects 219/230. Government offices such as the MOH that use resources other than public treasury funds and those of the "Fondo de Inversión y Contrapartida" (FIC) must submit monthly expenditure and capital investment reports on these projects to the DGTP.

The delay at central level is due in part to the delay of the regions in submitting their monthly expenditure reports ("rendición mensual de cuentas"). The regions cannot request an advance for the coming quarter until 66 percent or more of the advances of the previous quarter have been spent. The reports are very detailed and must be accompanied by the corresponding invoices and receipts supporting the expenditures incurred. These documents are examined at various levels of the MOH and at USAID.

Preparing and reviewing the report of monthly expenditures is a very detailed, meticulous, and consequently slow process. The close control by specific items of expenditure causes errors in the classification of expenditures which would not be so frequent if the control were by a smaller number of major items of expenditure. These errors force the Agreements Section (Area de Convenios) of the MOH to reject a significant number of items included in the expenditure reports. Additional rejections are made at USAID. Another reason for the rejection of the expenditure reports is the insufficiency of the supporting documents, particularly with regard to traveling expenses as previously indicated. The reimbursement of expenses is delayed for a long time, discouraging field visits by promoters, public health inspectors, and supervisors. The negative impact on services is direct and immediate.

The MOH recognizes some of the difficulties mentioned above in its "Plan Nacional de Desarrollo para 1984-1985, Plan Operativo Sectorial":

> "Late approval of the 'Calendarios de Compromisos' by the Ministry of Economy, Finance, and Commerce. Also, the approval of the Requests for Funds is incomplete and late."

"The execution of the budget entrusted to the regions to implement important health programs has been deficient....Also, the presentation of expenditure reports by the regions is very slow, creating serious problems for liquidating the budget at the MOH central level" (p. 38).

Table 8, "Status of Financial Situation of Projects 219 and 230," illustrates the situation of expenditures reported as of November 28, 1984 (see the Special Financial Report prepared by the OECPF). As of that date, with 91.7 percent of the fiscal year having elapsed, the regions had not yet reported on the use of 57.6 percent of the funds for the year (i.e., 871,906,662 Soles). The performance of the leading regions in terms of their slowness in presenting expenditures is shown in Table 9.

With respect to international technical and financial assistance, the MOH states that "the administrative support is slow in the payment of funds and the reimbursement of expenditures; delays in the delivery of supplies and the rigid control of project funds limit the development of health activities in other programs" ("Plan Nacional Desarrollo, 1984-1985," op. cit., page 43).

The slow delivery of supplies through USAID is due in part to causes beyond its control, as confirmed by the present evaluation. However, the close and detailed review of invoices and receipts which accompany the expenditure reports is a potential source of delay in the payment process. (See section 4.3 of this report regarding the Logistics System).

The difficulties identified during the present evaluation generally correspond with those identified in the workshop, "Proposal of Specific Technical Administrative Measures for Coordination of Health Programs Supported by International Cooperation Projects." The workshop was held in Santa Clara, April 25-27, 1984. Among the conclusions arrived at during the workshop on the topic "Administrative Support for Health Programs" were the following:

- There is inefficient and ineffective coordination between the Ministry of Economy, Finance, and Commerce and the Ministry of Health concerning the counterpart appropriation and the Congressional Budget Commission.

- There has been non-compliance with the budget appropriation of national counterpart funds.

- The organization and functioning of the administrative structure do not provide adequate support for the development of projects.

- Administrative personnel are not adequately trained and thus do not assume full responsibility for their functions and duties.

- There is inadequate horizontal coordination among the different organizational units and sections of the General Administration Office.

TABLE 5

APPROVAL OF OPERATING PLANS

(AID Funds)

Source: Westinghouse Health Systems

DIVISION OF GENERAL HEALTH SERVICES	USAID	GEN OFF. OF ADMIN/ OFF. OF BUD., ACC., FIN. & TREASURY	ACCOUNTING SECTION CENTRAL ADMINISTRATION AGREEMENT SECTION
1) Receives Operating Plans from the regions with projections of need by type of project and activity to be performed during a certain time period. 2) Reviews and approves them, then sends them as well as the central level plans for their respective approvals. 4) Receives the approved documentation from AID and sends it to the General Office of Administration. 5) Prepares an official letter to AID, acknowledging receipt of the approved Operating Plans. 7) Informs the regions by official letter of AID's approval and attaches copy of the approved Plans.	3) The Office of Health, Nutrition, and Education receives the Operating Plans and reviews them with the help of the Office of the Controller and the Office of Resource Development. Later, AID prepares a Project Implementation Letter informing the Ministry of their approval of the Plans. The letter also indicates: a) The type of project, source of financing, codification, and corresponding denomination. b) The duration of the project. c) The regions that will execute the project and the dollar value by category or activity in expenditures both local and abroad. 6) Receives the letter from DGHS mentioned in No. 5.	8) DGHS sends the approved Plans to the General Office of Administration. The plans are sent to the Executive Office of Budgetary Accounting and Finance, to be routed to the Central Administrative Accounting Section, to be sent finally to the Agreement Section.	9) Receives the documentation and records it on Standard Control Sheets for the approval of the Executive Offices, i.e., by the regions and central level as follows: a) Type of project. b) By source of financing: Loan, grant; by expenditure, both local and abroad. c) Dollar value. At the end of the process, the approved Operating Plan is filed for future reference.

TABLE 6

REQUEST FOR FUNDS

(AID Funds)

Source: Westinghouse Health Systems

REGIONS	DIVISION OF GENERAL HEALTH SERVICES	GENERAL OFFICE OF ADMINISTRATION; OFFICE OF BUDGETARY ACCOUNTING, FINANCE AND TREASURY	OFFICE OF BUD. ACC., FIN & TREASURY; CENTRAL OFFICE OF ACCOUNTING ADMINISTRATION AGREEMENTS	GENERAL OFFICE OF INTERNATIONAL EXCHANGE	AID
1) Submits to DGHS the Request for Funds by type of project, source of financing (loan/grant) for a period of 90 days in accordance with the designated amount in the Operating Plan. The following AID documents are attached: BEGINNING: Remittance Form No. 3 quarterly payment plan for remittance in local currency. Remittance Form No. 4 Report on the status of advanced funds.	2) Receives documentation from the regions and submit it to GOA, attaching the Request for Funds to cover costs at the central level. 6) Receives Remittance Forms No's 1 and 2 prepared by the Agreement Section. Obtains Director's signature. The Forms are returned to the Agreement Section.	3) OGA receives the documentation from DGHS and routes it to OBAFT to be sent in turn to the Central Accounting Administration Unit of the Agreement Section. 8) Receives documentation and sends it by official letter to the General Office of International Exchange.	4) After receiving the documentation, this Section consolidates Remittance Forms No.'s 3 and 4. These forms should be signed by the Section Chief. Remittance Form 1 (SF-1034) and Remittance Form 2, Advancement of Funds Certification, are filled out right away. 5) Remittance Forms 1 and 2 are sent to DGHS for the signature of the authorized official. 7) Once all the documentation is signed it is routed to GOA.	9) Receives the documentation from GOA and sends it to AID.	10) The documentation is received by the Office of Health, Nutrition, and Education to be reviewed. 11) After being reviewed and approved, the Office of the Controller is requested to write a check for the designated amount. 12) The Office of the Controller reviews the documentation and makes an entry of the transaction in the AID Accounting Books.

TABLE 6 (CONT.)

REQUEST FOR FUNDS

(AID Funds)

REGIONS	DIVISION OF GENERAL HEALTH SERVICES	GENERAL OFFICE OF ADMINISTRATION; OFFICE OF BUDGETARY ACCOUNTING, FINANCE AND TREASURY	OFFICE OF BUD. ACC., FIN & TREASURY; CENTRAL OFFICE OF ACCOUNTING ADMINISTRATION AGREEMENTS	GENERAL OFFICE OF INTERNATIONAL EXCHANGE
13) The Office of the Controller processes the Payment Voucher, and proceeds with the preparation of a check.	14) Receives check and copy of the Remittance Form (SF-1034) which specifies the dollar amount and the exchange rate and sends them by official letter to GOA.	15) Receives documentation from DGHS and sends it to OBAFT with a copy of the letter from DGHS. OBAFT sends it to the Treasury.	16) Receives the documentation from OBAFT, and prepares the following: a) Notice of receipt of funds. b) Confirmation of the receipt of loan funds to be remitted to the Public Credit. 17) The check is deposited in a separate account of AID for projects 219 and 230. 18) Copies of the following documents are sent to the Agreement Section: a) Payment Voucher b) Letter from DGHS c) Notice of Receipt of Funds d) Checking account deposit slip In addition, copies of the Notices of Receipt of Funds are sent to the Budget and Accounting Office to be registered to the account. 21) Receives the Remittance Distribution Table from the Agreement Section.	19 Receives the documentation processed by the Treasury and registers remittances received from AID in soles and dollars on control sheets. 20) A Remittance Distribution Table is prepared in soles and dollars, classified by service activity and items of expenditure. It is then routed to the Treasury for the attachment of checks to be sent to the regions.

TABLE 7

REMITTANCE OF FUNDS TO REGIONS

(Funds provided by AID)

Source: Westinghouse Health Systems

CENTRAL LEVEL				REGIONAL LEVEL	
OBAFT-TREASURY	OBAFT	ACCOUNTING SECTION CENTRAL ADMINISTRATION AGREEMENTS	OFFICE OF THE REGIONAL DIRECTOR AND PROGRAM COORDINATOR	TREASURY	ACCOUNTING SECTION
1) Prepares the following documentation: a) Proof of Payment b) Checks for each region c) Letter Remittance of Funds to Operating Units 2) Sends the documents listed in No. 1 to OBAFT, including the Remittance Distribution Table. 4) Sends check and appropriate documentation to regions. 5) Sends a copy of the Proofs of Payment, letter, and Remittance Distribution Tables to the Agreement Section.	2) Receives documentation from the Treasury, signs the official letter and check and returns all documentation to the Treasury to be sent in turn to the regions.	6) The Section Chief receives from the Treasury copies of the Proofs of Payment and Remittance Distribution Tables sent to the regions, and consolidates them onto Standard Auxiliary Forms that he uses for control. The documentation is distributed to his employees to be properly registered to the subsidiary accounts of each region.	7) Receives documentation sent by the Treasury such as checks and Proofs of Payment to be used in controlling the funds used for programmed activities. The coordinator reviews these documents and remits them to the Regional Office of the Treasury.	8) Receives documentation from Program Coordinator and prepares the following: a) Receipt for the Receipt of Funds b) Deposit slip for the checks in separate AID accounts. 9) Makes bank deposits. 10) Sends to Accounting Department copies of the documents listed in No. 8 above and the Remittance Distribution Table. 11) Records the prepared documents.	12) Receives the documentation from the Treasury and and records it in book of funds received. All of this documentation is given to the Agreement Program Accountant. 13) Establishes auxiliary control of funds received for the activities to be carried out.

Other difficulties identified by the evaluation team generally correspond with those which had been previously identified by the regional directors and supervisors. Following are some of these difficulties which have been mentioned in one or more of eight reports submitted by the regions (Cajamarca, Tacna, Huanuco, Ancash, San Martín, Piura, Trujillo, and Lima):

- o Lack of motivation and orientation of personnel at different levels.
- o Few incentives for personnel at the primary level of health care delivery.
- o Lack of stable and clear coordination at the regional and central levels for management of the project.
- o Lack of flexibility in budget control resulting in the return of funds to the central level.
- o Lack of understanding and consistent communication of the objectives, goals, and targets of the projects.
- o Inadequate knowledge about the Operational Plan among chiefs and personnel responsible for its execution.
- o Limited training of personnel that direct and carry out the projects.
- o Personnel contracted for the projects have not been fully used.
- o Lack of understanding about some aspects of the accounting system has impeded use of funds appropriated the previous year.
- o Delays in submitting expenditure reports by the hospital areas and regions.
- o Lack of systematic supervision from the control level.
- o Lack of guidelines for the correct utilization of funds.
- o Lack of a rational distribution of equipment and materials for primary health care from the regions to the different areas.
- o Delays in the remittance of USAID funds by the MOH central level.
- o Reports of expenditures to USAID are channelled through the central level of the MOH, resulting in further delay.
- o The delay in reporting expenditures to USAID detains subsequent disbursements.
- o The programming of activities was very optimistic in some aspects.

TABLE 8
Status of Financial Situation
Projects 219 and 230
As of November 28, 1984
(in thousands of soles)

Year and Type of Financing	Collection and Remittance of Funds			Rendering of Accounts			Balance to be Accounted For			
	219	230	TOTAL	219	230	TOTAL	219	230	TOTAL	%
1983										
Grant	36,876	8,359	45,235	31,115	3,443	34,558	5,761	4,915	10,676	23.6
Loan	522,231	375,451	897,682	435,425	331,975	767,400	86,805	43,475	130,281	14.5
TOTAL - 1983	559,108	383,810	942,918	466,540	335,418	801,958	92,566	48,390	140,958	14.9
1984										
Grant	126,568	142,992	269,561	62,886	44,075	106,961	63,682	98,917	162,599	60.3
Loan	1,033,889	209,649	1,243,538	420,146	114,085	534,231	613,742	95,564	709,306	57.0
TOTAL 1984	1,160,457	352,642	1,513,100	483,032	158,160	641,192	677,424	194,481	871,906	57.6
1983 and 1984 Combined										
Grant	163,445	151,352	314,797	94,001	47,518	141,520	69,443	103,833	173,276	55.0
Loan	1,556,120	585,100	2,141,221	855,572	446,060	1,301,632	700,548	139,040	839,588	39.2
COMBINED TOTAL	1,719,565	736,452	2,456,018	949,574	493,578	1,443,152	769,991	242,873	1,012,864	41.2

Source: Special Financial Report

Table 9

Unreported Funds as a Percentage of
Total 1984 Funds

(as of November 28, 1984)

	Project 219		Project 230	
	Type of Funds			
Region	Loan	Grant	Loan	Grant
Lima	100		62	
Ayacucho		62	50	
Tacna	87	98	95	
Huanuco	66	54	93	
Piura			98	61
La Libertad	100	100		49
Cajamarca	50			95
San Martín	59			

Source: Special Financial Report.

- o Delays in the processing of the customs clearance ("Resolución de Exoneración Aduanera") impede the timely withdrawal of supplies from the Customs House.

- o Delays in the provision of funds and supplies have impeded the accomplishment of programmed targets.

- o Lack of adequate support from the regional administrative units.

- o The complexity of the accounting system causes delays in the reporting of expenditures and consequently in the remittance of additional payments.

Seven of the eight regions (88%) identify among the main difficulties the lack of stable and clear coordination at the regional and central levels. Three of the regions point to inflexibility in the budget control. Five of the regions (63%) identify as a principal obstacle inadequate understanding and communication of the objectives, goals, and targets of the projects.

The difficulties identified above may be summarized in five major categories: 1) inadequate coordination of programs and projects at all levels; 2) inflexible budget control; 3) inadequate communication, vertically and horizontally; 4) inadequate training and orientation of personnel; and 5) inadequate motivation of personnel caused by the above difficulties. Implied in these problems is the limited operational flexibility of the MOH and, consequently, its limited efficiency and effectiveness. The MOH recognizes the need to "expedite the administration process at all levels," as one of its principal objectives in the "Plan Nacional de Desarrollo 1984-1985," op. cit, item 9, page 54.

The limited flexibility of the MOH is due to three major causes:

(a) The organizational structure of the MOH is not clearly defined. The horizontal relations between organizational units whose functions and activities have reciprocal impact are unclear. That is the case, for example, for the units responsible for planning and budgeting.

(b) The decision-making process is highly centralized. This is reflected in, among other things, the close and detailed control over the budget execution exercised by the central level of the MOH, using specific items of expenditure and the detailed prior control of financial transactions instead of greater reliance on financial accounting and post auditing.

(c) The budget execution process is very long with many unncessary and inconvenient steps and interventions. This had been pointed out already by Mr. Robert Moore, Westinghouse consultant, in his financial reports.

Norms and Procedures for the Disbursement of Funds by USAID

The norms and procedures for the assignment and disbursement of USAID

funds for projects 219/230 vary somewhat from the procedures for the disbursement of treasury and MOH counterpart funds. The disbursement of USAID funds is subject to an Operational Plan prepared by the regions covering one year and to Quarterly Disbursement Plans. On the basis of these two plans, USAID advances funds to the regions quarterly. Treasury and MOH counterpart funds are authorized and issued on a monthly basis.

The regions must spend at least 66 percent of the funds received before requesting a new advance. The regions must submit to USAID monthly expenditure reports ("rendiciones de cuenta") and a list of specific disbursements. These documents must be accompanied by the original invoices and receipts as supporting documents for the expenditures.

The procedures described above show the great effort that has been made to systematize and institutionalize the budget execution process. It facilitates the training of personnel in this area and the consistent application of the procedures. Some phases of the procedures, however, present certain difficulties which affect the efficiency and effectiveness of the operational level and which discourage the personnel. These difficulties are discussed below, following the sequence of the procedural steps schematically presented and described in Figures 2 and 3 and Tables 5 through 7.

USAID procedures for the allocation and disbursement of funds to the regions for projects 219/230 are much simpler than those of the MOH (see Tables 5 through 7). Disbursements are made by USAID on the basis of a quarterly plan. This longer cycle provides more flexibility for the reprogramming of expenditures. The unexpended funds at the end of any quarter can transfered to the next quarter and from one fiscal year to the next. USAID controls the budget execution using six to ten major or generic items of expenditure. Specifically, the Implementation Letter 17 for Project 230 specifies the following six "project components": I. Equipment, Vehicles, and Maintenance; II. Medicines and Contraceptives; III. Training; IV. Logistics System and Administrative Support; V. Information and Education; and VI. Supervision (Request Format 3). The Implementation Letter 21 for Project 219 specifies the following ten "components" or "line items": 1) Medicines, 2) Medical Equipment and Supplies (Medical equipment - offshore procurement), 3) Transportation, 4) Community Education, 5) Sanitary Activities, 6) Training, 7) Supervision, 8) Technical Assistance, 9) Information System, and 10) Evaluation and Research (Liquidation Format 3).

The USAID procedures do present certain difficulties. As previously indicated, the preparation, review, and approval of the budgets for projects 219 and 230 are not well synchronized with the overall budgetary process of the MOH. The inadequate synchronization is present also in the execution of the budget. For example, the first operational plan for the year 1984 arrived for approval USAID on the 20th of September. To speed up approval, personnel from MOH worked at USAID the second half of November and December, and a USAID staff member processed the plans for USAID's approval at the same time. These plans were finally approved as corresponding to the period 1985-1986. The problem is due in part to the extreme complexity of the Operational Plan. It is extremely detailed, slowing down its preparation, analysis and management at all levels of the MOH and USAID. In section 4.1 of this report this problem is discussed in some detail.

4.2.6 Specific Recommendations to Simplify Financial Procedures

Results-oriented control requires the design and implementation of an effective, trustworthy budgetary information system. Despite its defects and limitations, the present information system provides a more rational basis for budgetary control than does the current control based on specific items of expenditures. After all, the budget is a management tool, a means to achieving an objective or target. Therefore the attention and control should be concentrated on the objectives and goals, and not only on the means, i.e., the specific items of expenditure incurred to achieve the goals.

Results-oriented control also requires an effective but simple cost accounting system. Some efforts are being made already to determine the cost of services. With a little additional effort it should be possible to produce a simple cost accounting system that is good enough for the initial stage.

The administration and operation of the MOH health delivery system is a very complex task because of the highly technical nature of health services; the great social relevance of services; the diversity of professionals, technicians, and specialists that participate in the delivery of services; the geographical dispersion of health facilities; the distances that separate many of the facilities from the central MOH; and the physical and human limitations of the means of transportation and communication.

It is almost impossible to manage efficiently and effectively such a large, complex, and dispersed enterprise from the MOH central level. A reasonable delegation of authority to levels where the services are actually provided is necessary to permit the regions and the areas to carry out their enormous responsibilities in service delivery.

> Recommendation 4.2-4 regarding delegation of authority. Delegate greater authority to the Regional Directors concerning the budget management and execution. Initially, the regional level should be delegated control of the budget execution for specific line items of expenditure. The central level of the MOH should limit its control to the major or generic items of expenditure, even though it continues to receive expenditure reports by specific line items for information purposes to MEF. Simultaneously, efforts should be made to establish a system of budgetary controls based on results, goals, and resources, as is contemplated in the MOH policies.
>
> (The Director of OGA commented that the delegation can be done; training would be required. The recommendation to report by specific line items is only to allow MOH to comply with MEF requirements. The USAID Controller's office expressed concern if MOH central level only reviews generic items: "Central MOH has established internal control units which should not be bypassed if USAID is to accept financial reports as a basis for reviewing project expenditures.")
>
> Recommendation 4.2-5 regarding reporting of expenditures. Reporting of expenditures by major items of expenditures is recommended. Accordingly, the expenditure report should be controlled at the central level only by generic items. The invoices and receipts

supporting the expenditures incurred should be sent to the central level for controlling the budgetary ceiling on expenditures only. In due time the regions will have to account for the allowability of the expenditures. This is the function of post-audit accounting which is the current usual practice in public and private enterprises. The post completion audit should be done by an organization independent of the MOH.

(The USAID Controller's office commented that original invoices and receipts need not be sent to USAID, but in view of the effective internal control system in place at the central level of MOH, regions should continue sending original invoices and receipts to central MOH. The original recommendation was to keep the invoices and receipts at the regional level using post-audit accounting. As PHC expands the level of operations in the field (after projects 219/230 have ended) this further delegation should be considered again with changes in USAID procedures, if necessary, such as sending Peruvian auditors to the regions as has been done in the Disaster Relief Project.)

Recommendation 4.2-6 regarding lengthening the budget and reporting period to a quarterly cycle. Extend the calendar of obligations cycle to three months. A period of three months allows reasonable time for an objective analysis of the budget execution and for taking appropriate and timely measures to adjust the expenditures to the projected costs in the calendar of obligations.

(After the November 1984 evaluation work, the calendar process was modified to allow spending up to the middle of the following month, which ameliorates the problem of a monthly cycle. There is precedent for a quarterly cycle as used for the Peruvian armed forces; however, changing the cycle is beyond the authority of MOH (See Recommendation 4.2-16). The Ministry of Finance must be involved.

Recommendation 4.2-7 regarding per diem. The control of per diem and travel expenses (viáticos) merits special attention because of its direct and immediate impact on health services and personnel. It is recommended that the payment or reimbursement of per diem and travel expenses be made on the basis of a certification made by the two most immediate levels of supervision above the employee claiming the payment. The certification would be as to the date, time, place, and purpose of the field visit made by the employee. Payment would be made on the basis of pre-determined fixed rates. The rate structure would consider such variables as day and time of departure and arrival, type of transportation used, and distance traveled.

(The Director of OGA commented in March 1985 that a better process for per diem and travel expenses (viáticos) had just been approved.)

Recommendation 4.2-8 regarding reprogramming of disbursement schedules. As a general rule, the regional level should initiate any reprogramming of the "Calendarios de Compromiso" and disbursement plans. If the central level of the MOH detects a need to reprogram before the regional does, the central level should inform the latter

and advise regarding the need for reprogramming. These cases should be exceptional. If they were not exceptional, the solution should not be substituting the central for the regional level doing the reprogramming.

(The Director of OGA commented that only the Minister can reprogram disbursements and only under strictly controlled circumstances.)

Recommendation 4.2-9 regarding program and project coordination. The MOH should experiment with different coordination mechanisms and strategies such as:

- Regularly scheduled meetings between units with a significant functional interdependence and shared objectives. These meetings should follow a predetermined agenda, structured so as to foster an integrated approach in the definition of goals, evaluation of the accomplishment of goals, analysis of factors that contribute to or hinder their accomplishment, and the actions required to correct deviations from the targets.

- Interchange of work plans and reports about tasks completed.

- Occasional seminars and workshops.

- "Living" workshops for the employees to share perceptions and concerns which often constitute communication barriers and interfere with communications.

A great part of the communication barriers will be eliminated with the implementation of the above recommendations.

(The Director of OGA commented that "if MOH can do it, so can the regions.")

Recommendation 4.2-10 regarding motivation. Making major improvements in motivation requires more analysis and goes far beyond what can be done in this evaluation. The implementation of the above recommendations should contribute to the creation of a more motivating environment. All the above recommendations will, directly or indirectly, satisfy human needs. According to behavioral science theories, people seek self-fulfillment; they want to assume responsibilities commensurate with their competence; they want to be considered part of the organization and to contribute to the accomplishment of its goals; and they want to feel needed by the organization.

The effective implementation of the recommendations concerning coordination, communication, and motivation will depend on an appropriate mix of types of leadership and management styles. It will depend also on the professional competence of the leaders. These factors should be studied carefully in developing plans for improving motivation and performance.Other areas which should be considered in an in-depth evaluation of motivation and personnel performance are the following: salary scales; non-monetary incentives; management style; the competence of physicians as administrators

(given the lack of a formal training in Health Administration for persons occupying key administrative positions); and the leadership abilities required to complement management skills.

Financial Procedures

Financial procedures should change to fit together with the previous recommendations regarding the delegation of authority (4.2-4), the reporting of expenditures (4.2-5), and the use of a quarterly cycle (4.2-6). Other recommendations on financial procedures follow which are similar to those made by Mr. Robert C. Moore of Westinghouse, in his report covering the periods of September 19, 1983 - December 16, 1983, and July 17, 1984 - October 12, 1984. Some of his recommendations are developed here in more detail, others are added, and all are linked to the whole financial system of the MOH. Limiting the recommendations to projects 219/230 would limit the level of flexibility that could otherwise be obtained by addressing the MOH financial system as a whole because of the inherent reciprocal relationship of its components.

Recommendation 4.2-11 regarding Operational Plans ("Planes Operativos"). (No more Operational Plans will be submitted for projects 219/230, but the recommendations of the evaluator are presented for their relevance to streamlining the financial procedures for future projects in Peru.) The review of the Operational Plans (see Table 5, step 2) should have the benefit of the advice of the Executive Accounting Office (OECPF) to make sure that they are compatible with the overall MOH budget. Similar participation may be given to the General Office of Planning to make sure that the "Planes Operativos" are compatible with the "Plan Nacional de Desarrollo-Plan Operativo Sectorial del Ministerio de Salud." In addition, the "Planes Operativos" could be simplified considerably. This would facilitate their preparation, analysis, review, approval, and implementation. Three copies of the implementation letter ("carta de implementación", or PIL that USAID sends to the DGSS (step 3) could be sent directly and simultaneously to the OGA (one copy) and to the OECPF (two copies) (steps 4 and 8). The OECPF could send directly and simultaneously one copy of the PIL to the "Unidad de Contabilidad - Administración Central" and the second copy to the "Area de Convenios" (step 8).

Recommendation 4.2-12 concerning the request for funds. The requests for USAID funds that originate at both the regional and central MOH levels (Forms 1 and 2) could be appropriately consolidated by the DGSS (Forms 3 and 4) (Table 7, steps 1, 2, 3, 4, and 5). The DGSS should reconcile the requests for USAID funds in coordination with the "Area de Contabilidad Presupuestaria" and the "Unidad de Calendarios y Control de la Ejecución del Presupuesto" of the OCEPF to assure their compatibility with the requests for funds from other sources. The DGSS could send all this documentation directly to "Area de Convenios" of the OECPF. All documentation concerning the requests for USAID funds could be sent directly to USAID by theDirector General of OGA with an information copy to the Director General of the "Oficina General de Intercambios Internacionales" (OGII) (steps 8 and 9).

The requests for Public Treasury and Counterpart funds (Form T-1) (Figure 3, stage A, steps 1 and 2) could follow the same modified procedures, with the following variations:

- The participation of the "Area de Convenios" would be limited to reconciling the requests of funds from all sources.

- USAID involvement at this step would be eliminated because USAID does not participate directly in the review of requests for Public Treasury and counterpart funds.

Recommendation 4.2-13 regarding receipt of funds. USAID funds should be sent directly to the regions. USAID would send simultaneously a copy of the corresponding Remittance Form (SF 1034) and a photocopy of the check to the DGSS. The DGSS would make three copies of those documents and would distribute them directly and simultaneously to the Director General of the OGA, the Director of the OECPF, and the Office of the Treasury (steps 14 and 15).

(USAID payment directly to the regions was approved in principle by OGA in September 1984.)

Recommendation 4.2-14 regarding reporting of expenditures. The documents concerning the liquidation of funds should be sent by the OGA directly to USAID. An information copy would be sent to the OGII. The Report of Expenditures should be limited to the major or generic items of expenditures. Finally, the review of the invoices and receipts that support the disbursement of funds and the certification of their allowability should be delegated to the Regional Directors. Both USAID and the MOH central level could verify the allowability of the expenditures and the supporting documentation by means of financial audits at the end of each fiscal year.

(The Director of OGA commented favorably on sending OGII an information copy as recommended (see related recommendations 4.2-4 and 4.2-5.)

Legal Considerations regarding the Recommendations

The only recommendation that may possibly require Congressional action is related to the retention of the supporting invoices and receipts at the regional level instead of sending them to the central level and to USAID. The Budget Statute provides for the submission of invoices as supporting document for goods and services purchased (Chapter III, Articles 41 and 42). However, the statute does not specify the highest organizational level to which such documents shall be sent. On the other hand, Chapter I, Article 6 of the statute provides that: "The heads of the Budgetary Units may delegate their corresponding authority by means of a Resolution or Agreement, as the case may be. The delegation of authority for budget administration at lowerprogram levels may be made by a Resolution from the head of the Budgetary Units."

As it concerns the transfer of funds between items of expenditure, Chapter III, Article 48 of the Budget Statute provides for the following:

> "Budget modifications of transfers between line items will be approved subject to the following:
>
> At the level of divisions of the Central Government:
>
> a. Within the same Budgetary Unit, by Resolution of the Head of the Division [e.g., the MOH] when the transfer corresponds to specific items of expenditure within the same major or generic item of expenditure for goods and services. In any other case the transfer shall be authorized by Resolution of the General Directorate of the Public Budget.
>
> b. Within the same Project, by Resolution of the Head of the Budgetary Unit.
>
> c. Between Projects, by Resolution of the Ministry of Economy, Finance, and Commerce when favorably recommended by the General Directorate of the Public Budget."

On the other hand, the "Guidelines for the Preparation of the Budget" provide that the budget be prepared and presented by major or generic items of expenditures, twelve in total (p. 6). Of these twelve items, only five correspond to operating or current expenditures. Thus both the Budget Statute and the "Guidelines" for budget preparation allow ample discretion to the MOH to determine the degree of control it should exercise over the budget execution at different levels.

4.2.7 Availability and Utilization of Resources for Primary Health Care

The great limitation of the resources available to the MOH is generally known. Therefore, no further analysis is required than the relevant parts of the MOH analyses quoted below from the "Plan Nacional de Desarrollo para 1984-1985--Plan Operativo Sectorial":

> "3.7 Financial Resources"
>
> "It appears from the 1983 Budget that the reduction of financial resources assigned to the Sector continues. In [Table 10] it is shown that the participation [of the MOH] in the total central Government Budget has declined every year during the last three years, indicating that the priority granted to the Sector is only rhetorical because it is not followed with Budget appropriations. As a result, the quantity and quality of health activities are affected by the reduction of financial resources and of the purchasing power for medicines, supplies, medical equipment, etc., necessary for the proper implementation of those activities" (page 36).

"The increase in the appropriation for the generic items 02-goods, 03-services, and 04-current transfers has been rigidly and insufficiently estimated (40 percent). This has resulted in multiple problems in the delivery of services in the various facilities of the Sector and has been insufficient, considering that the inflation rate for 1983 was around 130 percent; the seriousness of the situation is obvious. As a result, suppliers have cancelled the MOH credit almost completely" (page 37).

"Very frequently the funds are not fully appropriated to the MOH in accordance with the Budget Preparation Guidelines, as has occurred with the Counterpart funds needed to meet contractual obligations with other countries and international agencies. The limited increase in the appropriation has greatly affected the development of priority programs, thus affecting the health of the community" (pp. 37-38).

"Considering the estimated figures for the final 1983 Budget, there was an increase of 66.7 percent over the initial figures, which signified increases of 61.5 percent for current expenditures and 120.4 percent for capital expenditures. Clearly, that increase does not satisfy the Sector's expectations. The magnitude of the problem is greater because the increase in the appropriations for supplies and materials (02), services (03), and current transfers (04) has been limited to 30.4 percent, 17.9 percent and 32.0 percent, respectively, far below the inflation rate and hampering the operation of the health facilities, which cannot obtain sufficient amounts of food, uniforms, medicines, etc. This situation undoubtedly has affected the services provided to the community" (page 39).

With respect to the conditions and adequacy of the health facilities, the following statement is made in the "Plan Nacional de Desarrollo":

"A high percentage of health facilities are inadequate due to age, deterioration, limited capacity, and scarce, obsolete, and poorly maintained equipment. As a result, productivity is low" (page 35).

4.2.8 Counterpart Funds

Compliance regarding the authorization and remittance of counterpart funds has improved since July 1984, according to key officials of the Accounting Office (OECPF) of the OGA. This improvement is shown in Tables 11 and 12. The improvement is due to USAID financing the counterpart cash flow for projects 219 and 230.

4.2.9 Use of Resources

The MOH has made efforts to improve the use of the resources available to it. In 1984, for example, funds appropriated for the healthregions (Budgetary Unit 06--Atención Integral de la Salud) were equivalent to 62 percent of the total MOH Budget. In 1983 the budget share of the regions was only 41 percent, and in 1980 it was 49 percent.

Funds appropriated in 1984 for programs of direct health and medical care (Budgetary Units 04, 05, 06, 07, and 08) were equivalent to 81 percent of the total MOH Budget. The share of the physical infrastructure was 10 percent and that of Central Direction and Administration was only seven percent. That distribution seems to be reasonable on the basis of generally accepted standards. (Data obtained from the Special Financial Report.)

On the other hand, funds appropriated for salary expenses have increased significantly during the last three years (1982 through 1984), while funds for the purchase of goods have been reduced (see Table 13, "Budget Execution - Ministry of Health"). The increase in funds for salary expenses occurs despite a decrease in the number personnel appointed. In the year 1981 there was an increase in appointments of 65 percent, and the MOH Budget was almost doubled. In 1982 and 1983 there was a reduction in appointments despite a significant increase in the MOH Budget (see Table 14, "Personnel Appointments").

The efficient use of resources and productivity could be significantly improved to the extent that recommendations made in this report are implemented. This would help to efficiently achieve the objectives and targets of the Ministry of Health, both quantitatively and qualitatively.

4.2.10 Technical Assistance regarding Financial Systems

As previously indicated, the financial reports of Mr. Robert Moore were the point of departure for the present analysis and report. His professional contribution has been very valuable.

At present and in the foreseeable future technical assistance will be required in the financial area of the MOH with a more sustained and broader scope.

> Recommendation 4.2-15 regarding technical assistance in financial systems. The General Office of Organization and Methods should contract a full-time systems analyst to provide technical assistance to the MOH. The analyst should have adequate preparation and competence in "Systems Analysis" so as to approach the financial systems from a broad and integrated prespective. This includes understanding the components of a financial system (financial accounting, cost accounting, budgeting, cash flow, capital investment) and the relationship of the financial system to the administrative structure and other systems, including the information system. The Systems Analyst should develop and implement a work plan to gradually make the necessary modifications to the financial systems and procedures that would expedite the work of the health delivery system and make its functioning conform to existing policies. This will require a process of consciousness-raising and training of everyone served by the financial system. The basic modifications required have been recommended in this section of the evaluation. (The Director of OGA commented that technical assistance in financial systems was a good idea and he welcomed it. Westinghouse concurred. USAID plans to provide more TA in financial systems.)

The financial problems of projects 219/230 are partly the results of government-wide problems that require attention at the Ministry of Finance (MEF). During the "consensus building" process in Lima in March 1985, the MOH agreed with the objectives of simplification and on the need for an output-oriented financial management system. The MOH is familiar with program budgeting since it used that system for years. The Director of OGA understands and would prefer a system based on the expenditures "para que" (for what purpose) rather than "en que" (for what items). However, recently MEF changed the budgeting system as part of an austerity program to control public expenditures. MOH perceives the new system as a set of expenditure ceilings and negative controls that preclude the financial management improvements recommended in the evaluation. Discussions with the USAID/Peru financial analyst suggest that the evaluation recommendations regarding the financial system are feasible even now. He concurred that a great deal can be done to improve the performance of the PHC system within the existing MEF approved system, even though the emphasis of MEF is on control of expenditures at this moment.

The evaluators suspect that it was not the intention of MEF nor of MAC (the company advising MEF on these matters) to hamstring the effective and efficient operation of the other Ministries in their efforts to slow expenditures. Consequently, the actions based on this evaluation probably should include discussions between USAID and the Ministry of Finance about the broader problems of public expenditures management which go beyond projects 219/230. The evaluators do not know to what extent similar problems exist in other Ministries. They also do not know the level of awareness at MEF of the extent of the delays and costs and negative effects on performance that are resulting from the new system of expenditure controls.

USAID may wish to discuss with Peru's Ministry of Finance the broader issues of managing public expenditures (while limiting expenditures since that is the policy) using systems that lead to government programs effectively delivering valuable services to the public (e.g., PHC services). The reduced performance of the operating Ministries, in the form of poor PHC services for example, will inevitably undermine public support for democratic government and popular political support. Emphasizing "performance" is a typical USAID theme and a useful one; performance is important and government agencies should strive to perform valuable services. Focusing on "performance" as an objective also provides a sound basis for designing practical USAID-supported projects to improve "performance."

> Recommendation 4.2-16 regarding USAID's offering assistance in Public Expenditures Management. USAID should discuss with the Ministry of Finance the negative effects on "performance" of the operating ministries that result from the system's being used to restrain public expenditures. The negative effects of poor performance in PHC services and other public services on the legitimacy of government and popular political support should be noted. USAID should offer assistance to the newly elected government of Peru in Public Expenditures Management as one option available to the new government, if this kind of assistance fits the priorities of the new government.

Table 10

Comparison of the MOH Budget
with the Budget of the Central Goverment

1981, 1982 and 1983

(in thousands of Soles)

Year	Ministry of Health	Central Government Budget	MOH Budget as a Percentage of Central Budget
1981	104,705	1,359,820	5.6
1982	141,908	3,071,847	4.6
1983	211,835	5,166,508	4.1

Source: Annual Budget Statute of the Public Sector for 1981, 1982, and 1983.

TABLE 11

FLOW OF PUBLIC TREASURY AND COUNTERPART FUNDS - PROJECT 527-0219

UP-08 - PRIMARY HEALTH CARE
EEP-103 - INTEGRATED PRIMARY HEALTH CARE AID-0219
1984

	Requested Schedule	Approved Schedule	Check Authorization	Obligated Funds
FIC (Counterpart)				
January	----	136,000	136,000	---
February	170,000	140,000	---	3,500
March	170,000	125,000	125,000	---
April	105,000	80,000	80,000	30,000
May	80,000	80,000	80,000	5,000
June	48,000	30,000	48,000	14,000
July	610,000	580,000	580,000	455,000
August	555,000	555,000	555,000	407,000
September	442,000	442,000	442,000	312,000
October	330,000	330,000	330,000	320,100
November	327,000	327,000	327,000	18,700
December	715,000	---	---	---
November Total:	2,837,000	2,825,000	2,703,000	1,565,300
Public Treasury				
January	---	---	---	---
February	---	---	---	---
March	---	---	---	---
April	---	---	---	---
May	---	---	---	---
June	---	---	---	---
July	---	30,000	---	30,000
August	394,000	394,000	394,000	353,000
September	497,000	497,000	497,000	496,000
October	70,000	70,000	70,000	---
November	11,000	11,000	---	---
December	81,000	---	---	---
November Total:	972,000	1,002,000	961,000	879,000

TABLE 12

FLOW OF PUBLIC TREASURY AND COUNTERPART FUNDS - PROJECT 527-0230

UP-08 - PRIMARY HEALTH CARE
EEP-102 - INTEGRATED SERVICES AND FAMILY PLANNING AID-0230
1984

	Requested Schedule	Approved Schedule	Check Authorization	Obligated Funds
FIC (Counterpart)				
January	---	50,000	50,000	---
February	50,000	40,000	---	---
March	50,000	35,000	35,000	---
April	93,000	50,000	50,000	24,308
May	90,000	90,000	90,000	500
June	70,000	70,000	70,000	---
July	548,000	318,000	318,000	293,815
August	72,000	72,000	72,000	64,852
September	---	---	---	---
October	217,000	217,000	217,000	216,300
November	---	---	---	---
December	---	---	---	---
October Total:	1,190,000	942,000	902,000	599,775
Public Treasury				
January	---	---	---	---
February	---	---	---	---
March	---	---	---	---
April	---	---	---	---
May	---	---	---	---
June	---	---	---	---
July	---	230,000	---	158,000
August	856,000	856,000	856,000	549,500
September	793,000	793,000	793,000	488,400
October	427,000	427,000	427,000	369,000
November	389,000	389,000	389,000	35,100
December	628,000	---	---	---
November Total:	3,093,000	2,695,000	2,465,000	1,700,000

TABLE 13

BUDGET EXECUTION - MINISTERIAL LEVEL

MINISTRY OF HEALTH OF PERU

(from all sources of financing)

(in thousands of soles)

LINE ITEM	1980 SOLES	%	1981 SOLES	%	1982 SOLES	%	1983 SOLES	%	1984 SOLES	%
FINAL AUTHORIZATION AMOUNT										
TOTAL	53,849,243	(100.0)	102,370,036	(100.0)	176,824,010	(100.0)	352,180,075	(100.0)	472,273,002	(100.0)
Salaries	21,804,912	(41.1)	40,488,351	(39.6)	104,902,468	(59.3)	211,981,000	(60.2)	266,949,000	(56.5)
Goods	11,142,782	(21.0)	25,119,753	(24.5)	37,127,042	(21.0)	63,107,925	(17.9)	79,274,000	(16.8)
Other	20,101,549	(37.9)	36,761,932	(35.9)	34,794,500	(19.7)	77,091,150	(21.9)	126,050,000	(26.7)
EXECUTED										
TOTAL	45,845,265	(100.0)	83,200,811	(100.0)	166,316,709	(100.0)	341,528,988	(100.0)	312,503,954	(100.0)*
Salaries	21,039,329	(45.9)	40,462,202	(48.6)	105,966,308	(63.7)	226,740,820	(66.4)	189,094,526	(60.5)
Goods	9,395,003	(20.5)	19,361,172	(23.3)	32,091,214	(19.3)	58,241,017	(17.1)	61,627,517**	
Other	15,410,933	(33.6)	23,377,437	(28.1)	28,259,187	(17.0)	56,547,151	(16.5)	60,338,758**	
VARIATION FROM PREVIOUS YEAR										
Authorized		———		+ 93.0%		+ 72.7%		+ 99.2%		+ 34.1%
Executed		———		+ 81.5%		+ 99.9%		+105.3%		

*Includes: From the Public Treasury Funds and Ministry Funds -- 311,060,801 (SOLES)
From Project 219 and 230 (Years 1983 and 1984) -- 1,443,153 (SOLES)
TOTAL 312,503,954 (SOLES)

For Public Treasury and Ministry Funds the end of the reporting period is August 31.
For Funds for Projects 219 and 230 the end of the reporting period is November 28.

** Does not include attachment corresponding to projects 219 and 230. Information not available.
Data obtained from special financial report.

Table 14

Personnel Appointments
Ministry of Health

Year	Professionals	Technicians	Auxiliaries	TOTAL
1980	9,345	1,497	22,633	33,475
1981	19,062	3,707	32,480	55,429
1982	13,730	13,478	25,613	52,821
1983	14,450	23,019	13,723	51,192

Source: Special Financial Report.

4.3 Logistics and Supplies

4.3.1 Introduction and Methodology

A good logistics and supply system represents a crucial and necessary factor in the efficient and effective delivery of primary health care services to populations in need. This system is even more important in view of the limited funds and geographical obstacles which affect the health system of Peru.

The objective of the evaluation of the logistical and supply system of the MOH is to determine the status of the current system, with emphasis on projects 219/230, and to formulate recommendations leading to the improvement of the system.

To achieve this objective, documents relating to logistics and supplies listed in the Bibliography of the report have been used as sources of information. In addition, personal interviews and meetings with key officials and employees of USAID and the MOH were held. On-site inspections were also carried out in seven health regions which included four Hospital Areas, seven health centers, and four health posts. The total number of people interviewed or consulted was between 85 and 100. Meetings were also held with the Westinghouse Health Systems Technical Adviser in Logistics and Supply, Mr. Jack Wolff.

In March 1985, the MOH formed a working group to review the evaluation's recommendations in the draft of Section 4.3. The first session was attended by the evaluators and comments are noted where appropriate.

4.3.2. Procurement Procedures in the Projects

The investigation made at the central level of the MOH and in several health regions, including the study of the laws and procedures that govern purchasing, showed that the requirements for logistics systems closely follow the established requirements for the projects and are therefore acceptable. The purchases made by the Mission are within the procurement system established by USAID regulations adjusted over time to meet MOH norms and practices and to facilitate logistics procedures. Purchasing activities were carried out according to established requirements. The logistics and supply procedures have remained practically unchanged throughout the life of the projects.

Major Obstacles

1) Direct offshore purchases were made beginning in August 1983 through the USAID Regional Contracting Office. However, the difficulties experienced in obtaining responsible bids for purchasing medicines, vitamins and vehicles led to the decision to go to the GSA Services and Commodities.

GSA procedures have worked well for the purchase of vehicles. They have been adequate for coping with problems regarding incorrect billing, partial deliveries and insurance claims. Purchases of medical equipment and pharmaceuticals, however, have not been as easy as vehicles. A purchase order is required for each item to be shipped from the USA.

As a result of an evaluation study recommendation, materials and supplies for promotors and midwives were purchased locally after October 1982 to stimulate their wide distribution and use. Materials and supplies purchased in the U.S. remained stored in local warehouses rather than being distributed to promotors and midwives.

2) At the Ministry of Health, where local purchases and the procedures for removal from customs, storage, and distribution of goods are carried out, the principal obstacles are the operational procudures that delay the paperwork and the different stages of the purchasing process, which lengthens the purchasing cycle to the point of adversely affecting the date of delivery and distribution of supplies. An example of this complex procedure is the document, "Requisition and Delivery Voucher" ("Pedido-Comprobante de Salida" or PECOSA). This document takes about three days to get from where it is generated to the Procurement Unit, where it then suffers a series of delays until the publication of the solicitation. The entire cycle can last from thirty to forty-five days.

3) Another very significant problem is the lack of sufficient funds to absorb the cost of removing goods from customs, storage, and transportation of merchandise received from abroad. For various reasons, including the delay in obtaining required documentation for customs, goods are warehoused subject to charges for this service, which is inevitably prolonged by the lack of funds. The lack of funds affected payment for private transportation by land or air for sending supplies to health regions outside of Lima. The availability of counterpart funds since August 1984, however, has facilitated significantly the delivery of supplies and equipment to the regions by private transportation. There have been some incidents of theft, but the processing of insurance claims by the MOH has been relatively troublefree.

4) The previous problem is aggravated by the limited number of cargo vehicles of the Executive Office of Supply and Support Services ("Oficina Ejecutiva de Abastecimiento y Servicios Auxiliares"), which frequently forces them to use heavy vehicles from the private sector both for bringing cargo to the Central Warehouse and for distributing the goods to the regions accessible by land.

5) The MOH's warehouse is located in three places, far removed from the main building of the Ministry. These facilities need improvements to ensure better security and control if the different warehouses cannot be integrated into a single location or a building adjacent to the MOH. They also lack mechanical equipment to move the cargo. This work is currently done manually, even for the heavy cargo. A request for support from USAID to purchase equipment for the central land warehouse is presently under study. At the regional level, project 219 grant funds have been made available to repair warehouses.

6) A source of great concern at the Ministry of Health is the time taken for purchases by USAID offices in the United States. The purchasing cycle takes an average of three months to the date of delivery of the goods to the unloading dock.

7) There is no adequate purchasing plan by which the Ministry of Health submits purchase orders in a timely way. Generally, the specifications for the equipment or materials are sent incomplete and the process of correcting them at the Purchasing Office of USAID takes time, which unnecessarily prolongs the transmittal of the order to the United States or affects the local purchasing of supplies by the Mission.

4.3.3 Procurement Procedures Used by USAID for Foreign Purchases

Policies and Organization

The purchases made by USAID adhere to the purchasing regulations established for the Missions. Local purchases closely follow federal systems of competitive procurements, where at least three potential local or foreign (U.S.) bidders are invited to participate. Awards are made to the lowest bidders as long as the articles quoted are within the required specifications and terms, also taking into consideration the date of delivery. Purchases in the United States are handled by the GSA Services and Commodities/AID division, Washington, D.C., as well as the Procurement Division of USAID/Peru. The purchase orders or PIO/C (Project Implementation Order for Commodities) are sent to AID/Washington to be forwarded to GSA Services and Commodities. For direct purchases the purchase order is sent directly to suppliers.

The Procurement Division of USAID/Peru is the authorized agent in Peru to make local and foreign purchases. The Office is composed of the Chief of Procurement, two Purchasing Agents, and one Contracting Assistant. In special cases or in situations of high volume operations, temporary personnel are used to speed up purchasing activities.

The Chief of Purchasing directs and supervises the personnel assigned to his office, oversees and gives instructions related to purchasing activities, and controls and follows up activities at all stages of the purchasing cycle. The Purchasing Agents are responsible for verifying and revising the specifications for equipment and supplies. They also prepare the requests for proposals, select potential bidders, and supervise the evaluation process for the proposals. The Contracting Assistant is responsible for preparing and reviewing the purchase orders (PIO/C) and the service contracts resulting from purchasing activity.

USAID Procurement System

The sequence in the purchasing cycle has the following steps, in the case of purchases made with project loan funds:

1. MOH requests by letter that the Mission make foreign purchases in accordance with the Operational Plans.

2. The specifications are corrected, if necessary.

3. In cases where the total amount of purchases does not exceed $100,000, the competitive purchasing system is activated by means of informal bids.

4. Purchases exceeding $100,000 are handled by the Regional Contracting Officer.

5. In the latter instance an Evaluation Commission is needed, which in addition to evaluating the proposals received is also responsible for making the award. The corresponding purchase order is then issued.

6. For purchases in the United States, GSA Services and Commodities receives the purchase documents through AID/Washington.

7. Existing federal contracts with suppliers or manufacturers in the U.S. are used or purchases are made in compliance with federal purchasing regulations.

8. The ordered merchandise is requested for delivery air freight to the port of departure, or for shipment to a selected airline.

9. In the case of shipping, the bill of lading and other documents are sent by mail. Generally, the original is sent to the Mission and a copy to MOH.

10. In the case of air transportation, airway bills are sent together with the merchandise.

11. When the MOH receives the original documents, or when USAID receives the shipping documents, the Mission proceeds to prepare an Arrival Notification Letter, to which shipping documents are attached, for each individual case.

13. From the previous step on, the handling of customs clearing, receiving, and storage of the merchandise is the responsibility of MOH.

Analysis of Current Practices

1. In general terms USAID's procurement system is carried out satisfactorily, in accordance with the applicable regulations and conforming to the administrative-technical requirements of the agreements or projects.

2. Delivery of local purchases transacted by USAID depends on the availability of the supplies requested. AID's internal processing of documents is far less bureaucratic than at MOH and is thus faster.

3. Nevertheless, purchases made in the U.S. via USAID/Washington take an average of three months from the initial request until the merchandise is delivered to the dock or air cargo terminal.

4. The apparent scarcity of personnel at the Mission affects the procurement system, making the rapid completion of the process difficult.

5. The FAR procurement procedures will change again on April 1, 1985. Virtually all important procurements for 219/230 will be completed before that time so the implications of the new procedures have not been analyzed.

Recommendations - USAID Procurement Procedures

Recommendation 4.3-1 regarding USAID procurement. Require the Directorate of Maternal and Child Health (DSMIP) to draw up equipment specifications and descriptions of materials as completely as possible to facilitate and simplify procurement at USAID. In the case of equipment purchases, it would be appropriate to receive the technical guidance of the personnel originating the request for preparing the specifications. If possible, the source of the information about the kind of item desired should also be provided, e.g., the catalogue and page number, catalogue or factory illustrations, or photocopies of the illustrations with the purchase order are highly recommended.

Recommendation 4.3-2 regarding training/orientation for personnel involved in procurement. Arrange training or orientation seminars for USAID and the MOH to discuss concerns and resolve doubts regarding procurement systems common to both, resolve problems, and improve the professional training of the personnel assigned to these tasks.

Recommendation 4.3-3 regarding analysis of the USAID purchasing office. Consider an analysis in greater depth than was possible in this evaluation of the procedures for USAID purchasing, particularly to determine to what extent the program's operating personnel can provide better guidelines to the USAID purchasing office for preparing specifications for equipment and pharmaceutical purchases.

Recommendation 4.3-4 regarding purchasing handled in Washington. Investigate the feasibility of shortening even more the purchasing cycle for purchasing in the USA, by taking advantage of every opportunity that presents itself.

4.3.4 Procurement Procedures at the MOH Central Level

Policies

Purchasing, storage, and supply systems at the central level of the MOH follow the respective laws that regulate logistical activities. Among these laws are the following:

- Law No. 22056 - Law of Creation of the Supply System;
- Law No. 22867 - Law of Administrative Decentralization;
- Supreme Decree No. 025-78-VC - Approval of the Administrative Regulation of Fiscal Property;
- Annual Budget Statute - regarding budgets, salaries, administration, and other items;
- Course on Administration of Supply;
- Ministerial Resolution - regarding accounting and supply procedures for the International Agreements between USAID and the MOH;
- Manual of Organization and Functions of the General Administrative Office (1983).

At the MOH, as in all the ministries and decentralized offices, the procedures of the Projects are followed in full compliance with the government's procurement system.

Organization at the Central Level

The Procurement Office of the Directorate of Supplies and Support Services (Dirección de Abastecimiento y Servicios Auxiliares or DASA) is currently composed of six Procurement Specialists, fifteen Supply Technicians and five clerical employees, for a total of twenty-six employees. This information was supplied by the Executive Director of Supply, Lic. Julio J. Herrera Fernández and by Lic. Edwar I. Melgarejo Jaimes, Director of Administrative System I.

Among the operational, technical, and control offices of DASA are the following: Executive Office, Record Unit, Cataloguing Office, Section of Suppliers, Planning Unit, Policy Section, Statistics Section, Procurement Section, Section of Purchased Goods, Purchasing Section, Solicitation Section, Verification Section, Analysis Section, Control Section, Import Unit, and some five other units and seventeen sections.

The total number of employees assigned to DASA is 534, of which 107 are classified as Supply Specialists I, II, III and IV, who perform various direct or support activities in logistics and supplies. The staff of DASA who are specifically involved in technical or operational aspects related to procurement belong to a group of five units, twelve sections and four warehouses. These employees perform the technical functions of purchasing, document analysis, verification, statistics, customs clearing, receiving, storage, and distribution of goods.

The administrative structure of DASA is highly complex and very bureaucratic.

Procurement at the Central Level

The central procurement system is regulated by the rules and regulations established in the laws and documents previously indicated. The procurement process at the MOH is basically very similar to public procurement systems of other countries of Central and South America, and of those in the U.S. and Puerto Rico. Purchases must follow the normal system of public competition, with exceptions authorized by law such as the treatment of sole source suppliers.

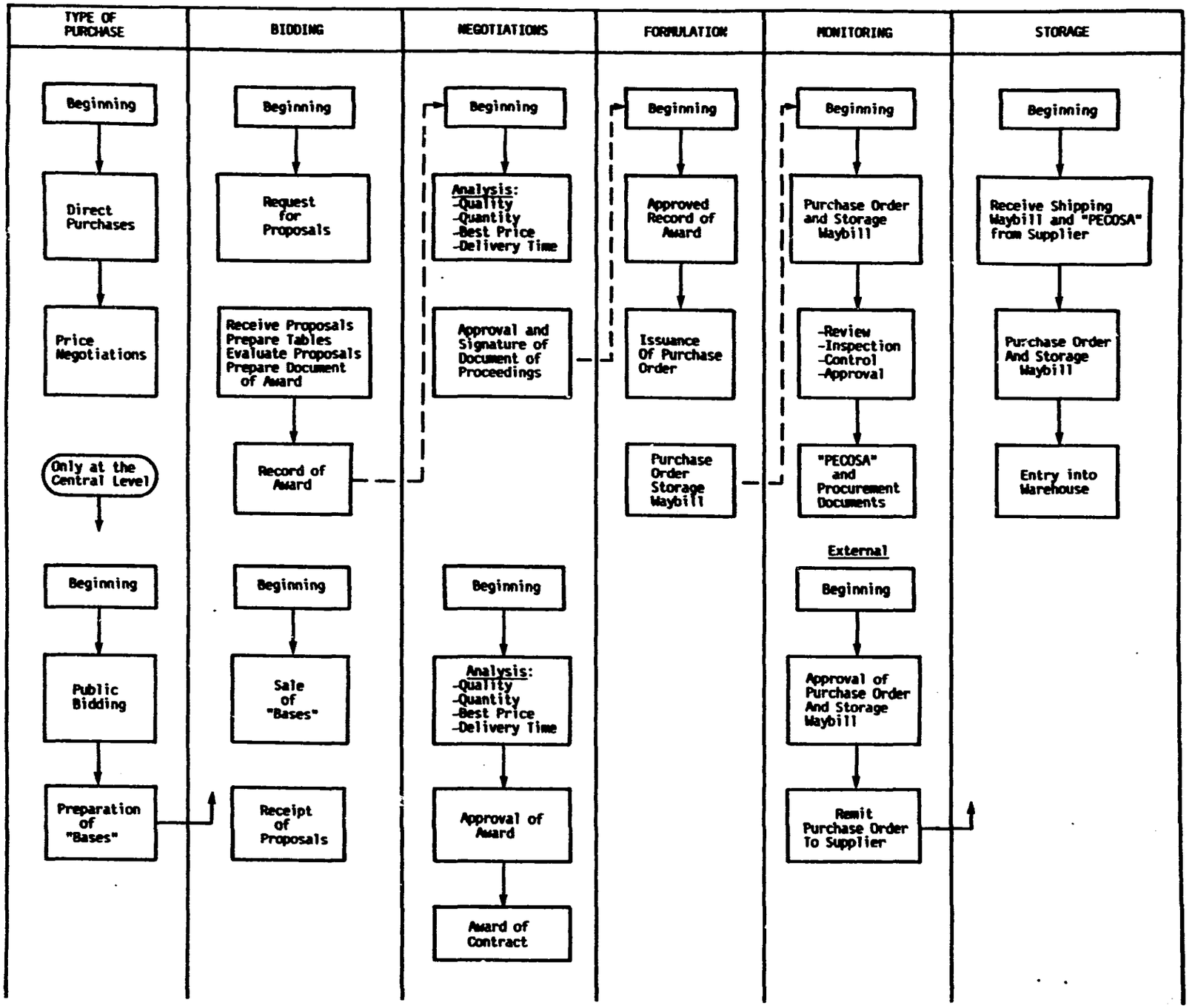
The procurement procedures of the MOH at the Central and Regional Levels are summarized graphically in the flowchart in Figure 4.

The Budget Statute has established new limits to determine the procurement method which must be followed:

a. Competitive Procurement - If the total unit cost or value exceeds

Figure 4

FLOWCHART OF PROCUREMENT PROCEDURES
REGIONAL AND CENTRAL LEVELS



the Minimum Annual Subsistence Salary (Sueldos Mínimos Vitales Anuales or SMVA) for Metropolitan Lima.*

b. Public Price Competition - If the total unit cost or value is between fifteen and fifty times the SMVA.

c. Direct Award - If the total unit cost or value is less than fifteen times the SMVA.

The MOH makes local purchases using the project loan funds. If the merchandise is not available in the Peruvian market, local representatives of foreign firms (U.S.) are contacted or U.S. suppliers are contacted directly.

The turnaround time for a competitive procurement is approximately 30-45 days once the documentation circulates through the various MOH offices responsible for controlling the process. For domestic purchases, the bidders are generally allowed two weeks to submit their secret bids. These competitions are publicized in the official daily, "El Peruano," and in other private sector periodicals.

Analysis of Current Practices - Central Level

1. The purchasing system of Central MOH is extremely cumbersome and slow, due principally to the large number of officials who either check the purchasing documents or simply endorse them without any other apparent impact on the substance of the procurement.

For example, a Request and Delivery Voucher (PECOSA) that is sent from the Directorate of Maternal and Child Health and Population takes an average of three days to arrive at the office of the Executive Director of DASA. The Executive Director endorses it and sends it on to the Planning Unit if it is a Direct Award. The Planning Unit issues a Procurement Description and determines if funds are available. If there are no funds available, the document is returned to its point of origin to be corrected and is rerouted through the same offices. Finally the document returns to the Procurement Unit to proceed with the purchase of the goods. This entire process for a simple purchase can take 30 days or more.

2. The brief study of the procurement system used by the MOH shows that the mechanics of the procurement process follow the rules and mode of operation of public purchases. We understand that the system also results from compliance with the regulations contained in the projects and agreements between USAID and the GOP.

*The SMVA is equal to 135,000 Peruvian soles monthly x 12 months = 1,620,000 soles annually, equivalent to approximately $325.00 annually at the November 1984 exchange rate of S/5.000 per U.S. dollar. As a result, the points of separation between procurement methods roughly US$16,300 (50 SMVAs) and US$4,860 (15 SMVAs).

(In March 1985 the Westinghouse Logistics advisor provided the team a five page analysis that should be considered in plans to improve procurement and logistics: "Análisis del Trámite de Documentos de Embarque y Mercadería de los Proyectos MOH/AID 219 y 230", Jack Wolff, 31 de enero de 1985.)

Recommendations - Procurement at the Central Level

Recommendation 4.3-5 regarding procurement at the MOH central level. The procurement system of the MOH merits an exhaustive evaluative study followed by technical assistance to modernize it and make it more efficient. To achieve this goal it probably will be necessary to change the laws and decrees that currently govern the procurement system. A better inventory control system with maximum and minimum inventory levels should be considered in the study.

(The Logistics Group commented that conflicts between international agreements and Peruvian law cause major problems, but not in this project. The international agreement should prevail, but there are differences of interpretation. Some projects have less trouble. The "Ley de Presupuesto" (page 12) Articles 25-28 creates the conflicts. The group concluded the problem was important enough to justify OGA and an adviser studying the problem to identify long term solutions.)

Recommendation 4.3-6 regarding training in procurement for MOH staff. Arrange for refresher courses and other training opportunities for the technical procurement staff regarding modern procurement practices in Peru and abroad. Training abroad is appropriate for two officials of DASA such as the current Executive Director, Lic. Julio V. Herrera-Fernández, and one other well known employee who is deeply involved in procurement work. They will benefit from meeting other procurement specialists and the work of their units will benefit. Continuity among the key employees of DASA, especially at the Executive Director level and the headquarters of the technical procurement office, is important for sustained improvement by generating ideas, testing new approaches, and carrying the successful innovations into the daily work of the unit.

(MOH commented that training abroad may not be appropriate because Peru's laws for procurement are very strict, rigid, and conservative,making it hard to learn anywhere outside Peru. The training is needed but the people who are trained abroad are likely to go to another job. The Department of Personnel could do something about it but turnover is a general problem.)

Recommendation 4.3-7 regarding avoiding mail rooms. Study the possibility of eliminating some of the intermediate steps and transactions by using fewer mail stations (at each Division for internal mail and for the transmittal of documents) so that, for example, the documentation or purchase orders go directly to the Executive Supply Office from the person requesting them at an Executive Office. This change could save time and would facilitate the delivery and distribution of merchandise. The alternative of handling mail and documents through one central mail station should be considered.

(MOH commented that eliminating the mail rooms entirely was not possible, but a review of the process involved to eliminate bottlenecks would be appropriate. In "Abastecimientos" they saved one to two days by consolidating two mailrooms. It was agreed that OGR would do an analysis with assistance from Jack Wolff and make recommendations.)

Recommendation 4.3-8 regarding notifying DASA of purchase transactions initiated. A copy of all purchase orders forwarded to USAID by MOH offices like DSMIP should be sent to DASA for information purposes.

(The Logistics Group agreed with the recommendation.)

Recommendation 4.3-9 regarding introduction of computers in procurement at MOH. The analysis of the MOH procurement system contemplated in 4.3-5 should consider the use of computers in the key functions. Computers could improve the effectiveness and efficiency of purchasing and storage control. The computers could also facilitate operations while supplying valuable statistical data necessary for the modernization of the procurement system and possibly installing CRTs (terminals with a cathode ray tube screen) in the health region offices. In addition to analyzing the potential impact on procurement and supplies, the analysis should also consider the impact on employment and the ability of MOH to maintain and support the system and pay for the on-going expenses.

(MOH commented that computers are much desired and USAID assistance is requested. In the current inflationary environment, good management dictates buying early to get as many goods as possible with a given budget in soles and maintain higher inventories. However, it is essential to have a good inventory control system to know when to reorder to avoid overflowing the facilities, to control theft and spoilage, etc. Computer based systems are desired as is "operations research." DSMIP and OGA want computers. It would facilitate dispatching goods directly from Callao to the regions without the delay at Central MOH. Westinghouse will study DSMIP needs. No decision was made on analyzing OGA needs.)

Recommendation 4.3-10 regarding long term supply contracts. One system that has proven efficient in other countries involves purchasing through long term supply contracts (i.e., six to twelve months) for supplies at prices agreed upon through public bidding for those articles, equipment, and products used daily or more often.

Even though the impact of inflation makes it difficult to implement this recommendation, it may be applied selectively at this time to identify responsible and capable suppliers who are willing to take into account the effects of inflation when submitting their bids.

In some other countries with serious inflation, purchase prices have a built-in indexing tied to the dollar, the cost of living, or an index of construction costs, etc. (Jack Wolff considers long term contracts infeasible until inflation is under control.)

Recommendation 4.3-11 regarding continued use of USAID procurement. It will continue to be appropriate for USAID to make direct purchases and assign the responsibility to the MOH for articles or products that are hard to procure and for products where there is likely to be an important advantage regarding price, quality, delivery capabilities, and the origin of the manufacturer. Nevertheless, the MOH should participate, at the central level as well as at the health region level, in a study to determine which articles or products which are difficult to procure and consequently should continue to be procured directly by USAID, which purchases should be assigned to the MOH for purchasing, and which merchandise should be procured directly by the health regions. Naturally, the final determinations for equipment purchases should take into account guarantees and the availability of replacements as well as maintenance and repair considerations. The progress of DASA should be taken into consideration in the allocation of responsibilities to be taken over immediately.

4.3.5 Procurement at the Regional Level

Policies and Organization

The procurement policy used in the health regions, where purchases are made on a smaller scale, is similar to that used by the MOH central level. The regions receive donated and loan project funds sent by USAID through the Ministry in accordance with the Operational Plans approved by the MOH and USAID. These funds are used for local purchases, or if the region deems it necessary, suppliers in other regions or cities are given the opportunity to bid. Purchases for Piura, for example, are sometimes made in Trujillo and Lima. The regions are authorized to process purchases through either the system of price negotiations or direct award, following the established regulations in the Annual Budget Statute (see Figure 4). Purchases that fall under the classification of competitive procurement are processed through the central level of the MOH.

The organization of the purchasing units in the regions is similar in all locations, with a Chief of Supply and the necessary additional personnel.There is a Chief of Storage and Personnel assigned to make deliveries to area hospitals, health centers, and health posts. In some places, the peripheral facilities needing supplies seek them directly from the supply installations. The supply unit is responsible for processing and transmitting purchase orders to the regional and central levels. The personnel receive assistance from the technical advisers regarding questions of procurement and storage.

Procurement at the Regional Level

The procurement process for the regions was presented graphically in the preceding subsection in Figure 4.

If the procurements are made with donated and loan funds, the Chief of Supply programs the purchases in the preparation of the Operational Plan and is responsible for making purchases for all the health facilities in the

region. The Chief of Supply also processes purchases made with national and counterpart funds to try to maintain a continuous and reasonable flow of supplies, both in initial supplying and resupplying.

Purchases are generally made according to the established competitive system, except for authorized purchases from sole source suppliers or in cases of emergencies due to disasters and other cases authorized by law.

Analysis of Current Practices - Regional Level

1. For the purpose of this evaluation, several health regions, including hospital areas, health centers, and health posts were visited in different areas of the country, as follows: regions: Lima, Callao, Piura, Lambayeque, Amazonas, Puno, Trujillo, and Arequipa; hospital areas: Rimac (A.H. No. 17), Piura (A.H. No. 3), Sullana (A.H. No. 2), and Las Mercedes; health centers: Huascar 2, Canto Grande, Bajo Piura, Querecotillo, Pitipo, Ferrenafe, and Belén (hospital & health center); and health posts: Luis Enrique XI, Simbila, Salitral, and Morrope.

2. The activities carried out by the different regions visited are very similar and follow an administrative system with very few variations.

3. The established norm is that the health regions receive all of the operational funds for the institutions under their jurisdiction. These funds are remitted by the MOH central level from the different funding sources: donations, loan funds, and counterpart funds. All supplies and merchandise are also received at the regional warehouse and are distributed proportionally to the hospital areas.

4. The hospital area distributes the supplies to the health centers in its area, and they in turn distribute them to the health posts, from which midwives and health promoters are resupplied.

5. This distribution chain is not completely uniform. Since it depends on the individual circumstances of the zone, the region sometimes distributes merchandise directly to the area hospitals, health centers, and health posts, such as in the case of the Lambayeque-Amazonas region under the jurisdiction of Chiclayo.

6. Many health regions have difficulty obtaining local supplies to cover emergencies or urgent needs, and this affects the medical attention given to patients since they have to wait several days, weeks, and sometimes months to receive supplies.

7. On occasion orders are made to Lima. Frequently the manufacturers or suppliers are out of the goods, mostly because demand exceeds supply, which depends on imports of raw material from abroad.

8. Preparation of the Operational Plans of the health regions begins very late and takes up considerable time. Frequently three months elapse of the year during which the plan is supposed to be in effect before the plan is completed. Experience has shown that there is also a delay in the approval of the plan by the MOH central level. For example, the Operational Plans for 1984 still had not been approved by the MOH during the month of November 1984, and were therefore submitted late to USAID for final approval. In the

meantime the health regions were forced to work with consignments of counterpart funds and funds from the Operational Plan from 1983. They also used their imagination and ingenuity to convince the community to cover the most urgent necessities for medical services through donations in kind.

9. The process of reporting expenditures, which begins at the lower levels of information and ends at the regional level, is extremely difficult and slow. For this reason, very few regions meet the expenditure criterion of 66% of the initial funds to qualify and receive additional project funds. This directly affects purchasing since sufficient funds for efficient and satisfactory administration cannot be depended upon at the different health establishments.

10. The situation of operational deficiency found at the health regions is due primarily to insufficient funds at the MOH, secondarily to the delay in reporting expenditures, and lastly to the lack of direct and continuous supervision and ongoing training in all service areas.

11. Expanding on the above, in many places we observed a lack of office equipment (typewriters, calculators, etc.) to facilitate accounting, information systems, the summary of statistical data, and other functions.

12. The procurement of various supplies by the health regions is being carried out in an acceptable manner and as expeditiously as possible, given the financial constraints on the health regions and hospitals of the MOH.

13. Regarding latrine building, this activity is being carried out with relatively limited effort and progress. In some regions the personnel and workers are available, but there is a shortage of materials. In other areas the latrines are built but there is no personnel to install them. For example, at the Bajo Piura Health Center, 92 latrines have been constructed and only 4 have been installed. At the Salitral Health Center, by September 1984 only 28 units had been installed out of an annual goal of 6600 latrines, representing a scant 8.33 percent. In the Trujillo region, which serves the hospital areas of Huamachuco, Chepen, and Trujillo, 100 latrines were built for Huamachuco in 1983, of which 50 percent were installed. In 1984, another 600 latrines have been built which will beinstalled using general treasury funds. In addition to these, 260 additional latrines are being installed with USAID grant and loan funds from the Agua-Sierra agreement.

Recommendations - Procurement at the Regional Level

Recommendation 4.3-12 regarding improvement of procurement at the regional level through better planning and supervision. Better planning and supervision are probably more important than money in the short run, since some important items are purchased with donated and loan funds and are available in Peru for the PHC system, e.g., oral rehydration salts, contraceptives, and essential drugs. Improving the financial situation and the financial systems will be important for the longer term for the MOH purchasing and distribution process.

Better planning and supervision can improve the distribution of supplies to locations that presently do not get adequate supplies.

The long delay in getting approval for Operational Plans, with approval at the very end of the fiscal year, has hindered the transfer of funds to the MOH and to the health regions. No more Operational Plans will be prepared for 219/230, but new procedures will be needed for the growing PHC distribution system. A study is needed of the evolving pattern of PHC services to estimate the total supply requirements and the distribution of the supplies needed by region, hospital area, health center, and health post to achieve the PHC service delivery targets projected for those establishments. The study should take into consideration actual experience and reasonable projections of service levels and need for supplies. (MOH agreed with this recommendation. Jack Wolff of Westinghouse Health Systems was asked to prepare a workplan to modify procedures.)

Recommendation 4.3-13 regarding an inventory of latrine construction and installations. Carry out a complete inventory of the latrine construction and installation project to determine the status of the program and provide a basis for making realistic estimates of which regions are working effectively and where the program is paralyzed.

Recommendation 4.3-14 regarding management and motivation. The general recommendations of sections 4.1 and 4.2 are applicable to the procurement and supplies function, i.e., attention is needed to motivate the people involved, to set performance targets at all levels, and to measure performance compared to the targets to analyze where there are important opportunities for improved effectiveness and efficiency.

4.3.6 Storage and Distribution

Adequacy of Supplies

Supplies such as equipment, medicine, and other goods used in the hospitals, health centers, and health posts are insufficient. The demand for medical services at many health establishments is greater than the capacity ofexisting facilities to offer medical care of a quality acceptable to the community. For example, at the Belén Hospital/Health Center in the Lambayeque-Amazonas region, they did not have sheets, surgical gloves, certain surgical supplies, etc. to supply the operating rooms. At many health centers there was a shortage of medical instruments such as stethoscopes, sphygmomanometers to measure blood pressure, instruments for the insertion of IUDs, etc.

A variety of medicines, principally life-saving pharmaceuticals, is markedly absent. In many places, including the health centers and especially the health posts, there is a pronounced scarcity of antibiotics or there simply are none at all. In other places there is only a limited amount of ampicillin in capsules or liquid. In other locations we found insufficient quantities of erythromycin and clindamycin.

We observed the apparent inequality in distribution from the hospital areas downward. We were informed that the hospital areas retain up to 70 percent of the supplies, and the remainder is sent to the health centers and, to a very limited extent, to the health posts.

Nevertheless, at almost all levels we observed normal quantities of oral rehydration salts, iron pills, and adequate quantities of contraceptives from the Family Planning Program, especially condoms and copper T's. At the majority of the health posts, the full range of contraceptive products was not available, including birth control pills, creams, and in some places, condoms.

All the regions have problems with the scarcity and inadequacy of vehicles. There is a shortage of ambulances or vehicles that can transport patients and vehicles to transport personnel and cargo. The possibility of exercising greater direct and effective supervision from the central level should be studied, encompassing all of the vehicles assigned to the regions, and using records of their usage, fuel consumption, frequency of repairs, mileage, and tire replacement. As far as possible vehicles of the same make and model should be purchased to make uniform supplies available for their repair, and in extreme cases, to repair one vehicle with the parts of others. The problem of the lack of transportation directly affects the entire supply and logistics system.

> Recommendation 4.3-15 regarding transportation and vehicle maintenance and storage. Analyze in greater depth the extent of the transportation problem, making a study of all the vehicles available, their operating condition, the availability of maintenance and actual use. The study should consider the feasibility and desirability of contracting out transportation work where the costs are higher and the service is less satisfactory from the MOH than from an outside contractor. The second study of storage should be kept separate.
>
> (The Logistics Group agreed that studying transportation and doing a separate study of storage were sensible. Jack Wolff recommended a study for one region earlier regarding cannibalizing, but it was not done. DASA should do the studies with TA from Westinghouse.)

Customs Procedures

The procedures for removing goods from customs are also extremely awkward and slow, resulting in a bottleneck which delays the subsequent storage. These customs delays are partially caused by a series of steps, many of which are unproductive or simply entail the endorsement of documents, through which the letter of removal is prepared. This occurs with purchases made with national as well as loan or donated funds.

Donated merchandise does not incur taxes, storage or handling charges, but it can be delayed over 30 days after which it becomes legally unclaimed and is subject to be sold by auction unless an extension is requested for their removal from customs. For example, at the time of the evaluation (November 1984), there were seven vehicles being held in Customs Storage that were received in July 1984, which for various reasons had still not been received in spite of the various requests for extensions. (In March 1985 the vehicles were released.)

If the merchandise is ordered from abroad with national or loan funds, the storage is paid if there is a delay, i.e., after 10 days after its receipt by Customs. After 30 days, the merchandise becomes legally unclaimed

in this case also. If the merchandise is received by air, storage charges are always incurred even if the merchandise is donated or purchased with national or loan funds. If the purchases are made with loan funds, the storage must be paid on all goods in accordance with pertinent laws. Storage costs are never incurred on donations.

For merchandise that is received at the General Division of Customs (Division General de Aduanas - DGA), which is based in San Isidro and has ports and air terminals in Callao, a request must be made to DGA for exemption from customs duties. At this point a serious bottleneck occurs that can cause delays of 15 to 120 days. We were informed that there is currently a case that has been waiting for 4 months for the approval of customs exemption.

The situation described above could easily be due to the possibility that private goods are attended to more quickly than public ones. Consequently, the customs activities of the Ministry of Health are delayed indefinitely, for no apparent reason.

Delays also occur at the Customs House in Callao when documents are presented for the calculation of the cost of the goods, storage, etc. It is possible that due to the fact that the MOH is a public institution the bureaucratic process takes more time than is normally necessary, with possible delays of more than 10 days at this stage. After this step, the goods are paid for and the documentation is presented for processing and delivery of the merchandise. These activities take another 7 days.

The goods then enter the jurisdiction of the MOH, and the DGA either delivers the merchandise or the Import Unit prepares the letter to request funds from the Budget. There is usually another delay of 15 days during which time the availability of funds is evaluated. If the goods are donations, the Import Unit issues a request for exemption from customs duties which goesthrough the mail room until finally arriving at the desk of the Vice-Minister, returning after another 10 to 15 days to the Import Unit to continue with the process.

We have been informed that at the Import Unit there is an extreme scarcity of personnel. There are only two dispatchers - one for each Customs House (sea and air). Delays also occur in this area whenever it is necessary to issue checks for petty cash funds.

When merchandise is received for a combination of various projects, or if the documentation arrives incomplete, the packing is deficient, there is damage to the merchandise, or if the insurance certificates are received late, there may be additional delays in the customs process.

Another detail that merits closer attention is that the insurance that covers imports is valid for 60 days only if the shipments are from the U.S., and usually for 30 days if the shipments are from Europe. If there are customs delays beyond the expiration date of the insurance, the opportunity to make claims is lost. For this reason it should be required that the expiration date be written on all insurance documents to help complete the customs processes on time.

When a local supplier imports merchandise on behalf of the Ministry of Health, a Certificate of Competence is requested for the supplier which is issued by the Ministry of Industry, Tourism, and Integration. This could be another cause of delay.

Recommendation 4.3-16 regarding customs brokers. Analyze the feasibility of using the services of customs brokers for the handling of customs dealings, putting these professionals in charge of all processes related to customs as soon as the donated or ordered merchandise are received, or as soon as the bills of lading arrive at the MOH. Customs brokers are used successfully in other countries, and the functions and responsibilities of these agents are duly regulated by the respective governments. Specialists in their fields, these brokers may be able to speed up bureaucratic processes and facilitate the customs process at a reasonable or reduced cost for projects 219/230 in particular and for the broader PHC program of the MOH as a whole. Customs brokers do not charge for storage in their warehouses.

(The Logistics Group agreed that a study was worthwhile, especially considering that brokers do not charge for storage in their warehouses. PAHO uses customs agents and is pleased with them. The Westinghouse agent got personal effects in three days with an agent, while USAID people may wait three months. However, there was disagreement about the potential for important improvements through agents due to problems internal to customs that will not be affected. New complications are also developing. New import regulations require the importer to pay the import duties (i.e., AID) but the Ministry is being charged currently, so conflicting legal interpretations are likely. Also, LUSA has challenged the imports of ORS (oral rehydration salts) so the packets were delayed in customs in March 1985.)

Storage Procedures

The procedures followed for the storage of supplies and equipment at the MOH central and regional levels are shown in the flowchart in Figure 5.

At the Central Level of the MOH

The storage system at the central level of the MOH is governed by norms that regulate this particularly important activity of the Ministry. The Central Warehouse is located in three different areas, far apart from each other and divided into 4 section: materials, foreign cargo, replacement parts, and biologicals.

The four warehouses maintain a manual inventory system (kardex files). Merchandise enters the warehouse in two ways: by means of a purchase order, if the procurement is made through bidding or through a local purchase, or by means of a "Note of Delivery to the Warehouse" if the merchandise is a donation.

Among the factors and problems that affect warehouse activities, we have noted the following:

- There is a lack of sufficient funds to pay customs duties or tariffs.

- Charges are frequently paid for delays in customs warehouses when the goods are not removed on time.

- There are problems with the monthly calendars of payment obligations. These are approved for amounts that are much less than those originally requested and the funds do not arrive in a timely fashion.

- The warehouses do not have appropriate or sufficient heavy transport trucks and therefore must use other private means of transportation.

- They do not have mechanical equipment, such as fork-lift trucks, to allow for easy and efficient handling of cargo. Pallets are not used to facilitate vertical storage.

- The almost constant lack of funds directly affects the existing inventory of supplies and makes the system of maximum and minimum levels inoperative, principally at the Materials Warehouse, which uses a kardex system. Supply levels frequently fall to absolute minimum levels or to nothing.

- Merchandise that is received at the other Warehouses is generally delivered in its entirety, or in accordance with the distribution instructions received from DGSS.

- We were told that the employees of the warehouses lack accident insurance, appropriate uniforms, safety shoes, helmets for low temperatures, etc.

- The vast and rugged geography of Peru coupled with limited air and land transportation inhibits timely deliveries to their destinations, to the detriment of services to the patient.

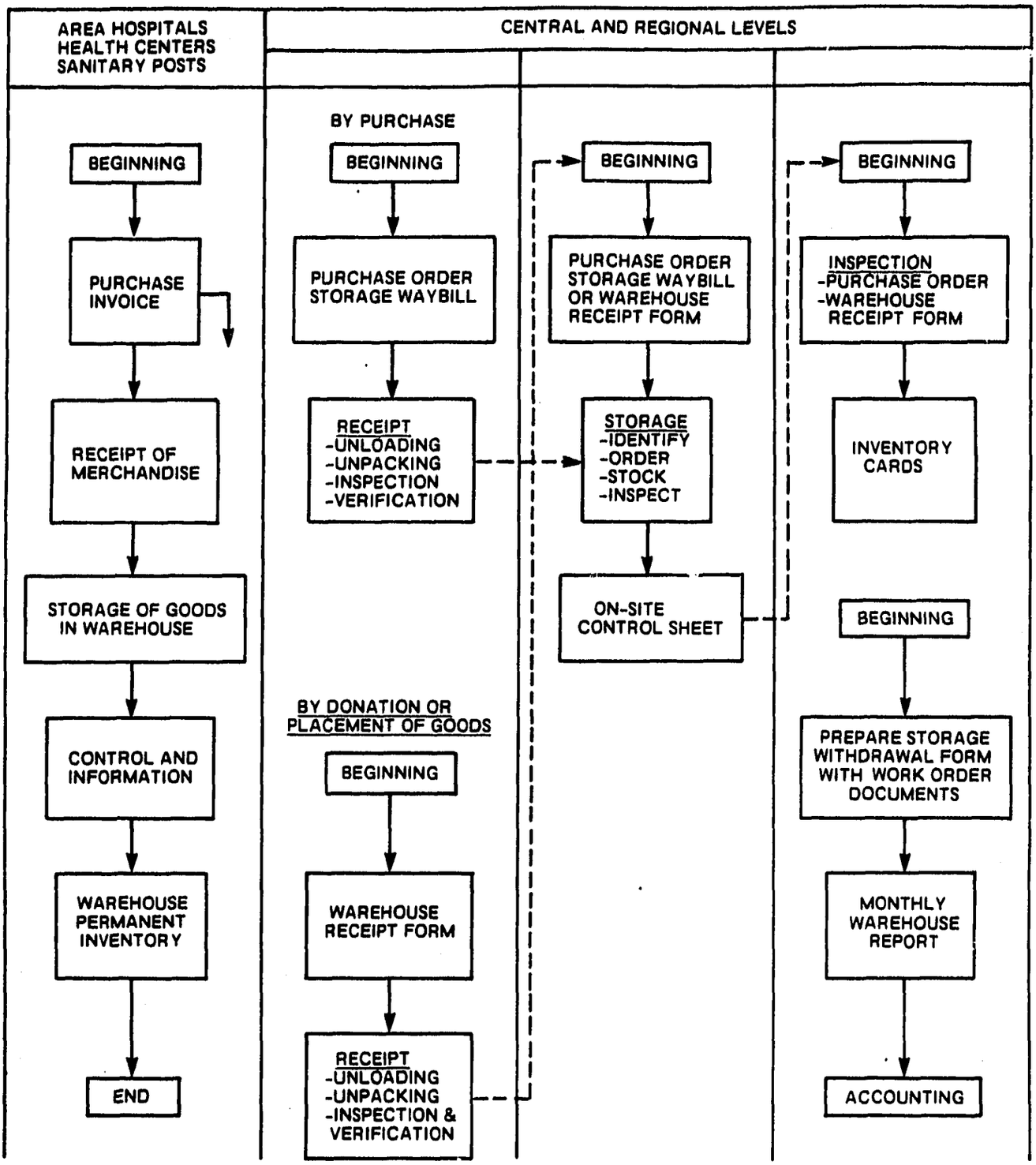
In the Health Regions

The health regions maintain their own warehouses following a similar pattern, but on a lesser scale than the Materials Warehouse at the central level. With rare exceptions the physical facilities are inadequate, with little space, poor ventilation, and excessive dust in the air. In the Piura Regional Warehouse, the concentration of dust in the air makes it unbreathable, and a layer of dust covers all of the equipment, articles, and materials in storage.

At the majority of health facilities, the warehouses are organized satisfactorily. The small amount of merchandise received and delivered is recorded in a simple manner on cards. At many warehouses a monthly fiscal inventory is carried out to communicate supply levels to the health regions, in hopes of receiving more supplies in accordance with what the region is able to send.

Figure 5

FLOWCHART OF STORAGE PROCEDURES



Distribution and Monitoring of Deliveries

At the Central Warehouse of the MOH in Lima, the delivery and distribution of merchandise is done chronologically according to the arrival of the Requisition and Delivery Vouchers (PECOSA), which are subjected to standard document routing through all of the mail rooms and offices of the MOH that must either approve or endorse the document. These Purchase Requisitions also serve to supervise the handling and control of deliveries made by the Warehouse.

If deliveries are made of merchandise procured with donated funds, the Warehouse receives distribution lists from the Directorate of Maternal and Child Health and Population related to projects 219/230 and proceeds with the deliveries, making them directly to the health regions.

Problems and Recommendations

The obstacles and problems that have been pointed out throughout this report, apart from the money component, are mostly of a bureaucratic nature and permeate nearly all of the procurement and supply operations of the Ministry of Health. Among the most serious impediments that make it impossible to reach a level of excellence with procurement and supply activities is the cumbersome nature of the administrative mechanisms. This has been recognized by both the USAID/Peru Project Manager and high level personnel of MOH. (In March 1985 the evaluators were told that definite actions had been taken to resolve these problems and overcome these obstacles.)

The lack of funds to minimize and correct many of the major problems that could be helped through financial means is another general problem affecting the logistics system. This lack of funding affects to a lesser extent procurements made with donated funds, including those made with loan funds from projects 219/230.

Turning to the subject of recommendations, improvements which can be adopted and put into practice have already been indicated in each section of the report. If the problems are considered seriously and in a positive light, we have no doubts that this precarious situation--affecting primary health care services to needy Peruvians, especially in rural areas--can be resolved or at least partially alleviated.

4.3.7 Participation of Technical and Regional Advisers

The technical and regional advisers have actively participated in the different stages of the logistics cycle, especially the procurement of goods through USAID using project grant funds. The Technical Adviser has worked closely with the officials of the DSMIP, and the merchandise received has practically been completely distributed in the designated areas.

Regional Advisers

Technical assistance in supply and procurement is provided by the regional advisers to the different health facilities under the jurisdiction of each health region. These advisers give support, cooperation, and advice on

procurement, storage, distribution, utilization, and maintenance. Such activities are considered to be very important, necessary, and effective, and have been well received by the beneficiaries. Much of the communication and coordination work required to ship supplies and equipment purchased offshore by USAID to the regional level is carried out by the advisers and the person in the Department of Projects of the DSMIP at the central level.

Technical Advise for Logistics

The activities that the Technical Adviser has been carrying out at the MOH central level, mainly at the Directorate of Maternal and Child Health and Population, have principally been those of training and general help with problem-solving related to logistics and supply.

The Technical Adviser has made various suggestions and recommendations to improve certain aspects of supply, the handling of documents, certain procedures related to customs and supply, lists and estimated quantities needed of basic medicines, and activity reports and distribution plans for medicines and other inputs.

The Technical Adviser has actively participated in the distribution phase of products purchased with project funds, especially of oral rehydration salts, contraceptives, and medical equipment. In addition, he maintains statistical records of distribution and deliveries of these products. Much field travel is required on the part of the Technical Adviser and the personnel of USAID and DSMIP who have responsibility for the project logistics.

With regard to the terms of reference for the Logistics Technical Adviser, where a description is given of the activities to be carried out in the management of supplies and logistics, we have found that many of the activities have been completed satisfactorily. Others have not been completed yet, particularly those involving the ongoing training of management supply personnel and the establishment of adequate logistics information systems at the regional and local levels. To provide a thorough qualitative analysis of the achievements of the Technical Advisor would require a more in-depth and extensive analysis of the performance based on the results and final products.

Recommendations - Technical and Regional Advisers

Recommendation 4.3-17 regarding the role of the Regional Advisers. With regard to the participation of the regional advisers in the distribution of supplies such as contraceptives, such activities fall within their general supply functions. The regional advisors should increase and diversify their participation in the areas of distribution, control, and resupply, and help to ensure that the facilities in their region are adequately supplied. In addition, they should participate more actively in the preparation and regional approval of the Operational Plans to expedite the process, and should follow up their approval at the MOH central level and USAID. The regional advisors should gather direct information on supply and logistics activities in the health facilities in the region to help identify and resolve problems that have arisen using the established MOH channels.

Recommendation 4.3-18 regarding technical assistance in logistics and supplies. There is a continued need for technical assistance regarding logistics and supplies. The work in this area should be organized around a few high priority tasks, even if the scope of work also includes some service and support type activities. The MOH should participate in the selection of tasks.

Tasks for technical assistance regarding logistics that should be considered in setting priorities include the following:

- o analyze the feasibility of using customs brokers as discussed in Recommendation 4.3-16;
- o analyze the procurement procedures to simplify them (Recommendation 4.3-5) and assess the feasibility of introducing computers (Recommendation 4.3-9);
- o analyze the feasibility of using long term supply contracts (Recommendation 4.3-10);
- o analyze the division of procurement activities between USAID and the MOH (Recommendation 4.3-11);
- o analyze the supply needs by health facility in order to improve the plans for procurement and distribution (Recommendation 4.3-12);
- o analyze the transportation and vehicle maintenance and storage problems (Recommendation 4.3-15);
- o increase training sessions for personnel involved in logistics and supplies at the regional and local levels (Recommendations 4.3-2 and 4.3-6).

(The working group on logistics in March 1985 requested assistance from the Technical Adviser on various issues described earlier. It appeared that he would not have time to support all the tasks that deserved attention.)

4.4 Health Information System

4.4.1 Current Status of the Health Information System

An ideal and complete health information system is one which responds to both planning and management needs at all levels of the health care system. The qualitative and quantitative characteristics of the data required are different for planning than for operations, and the needs of the Minister and Vice-Minister of Health differ from the needs of the Director of a Health Center. Likewise, because of the diversity of health care, a variety of data--and therefore of collection systems--is necessary. For example, accurate birth and death data are ideally collected through an effective vital registration system, a system which is totally different from a supply information system necessary for supplying health care facilities. Yet both are necessary for the effective functioning of the entire system. Furthermore, some of these data can only be collected on a continuous basis, while others can be more efficiently and economically obtained through periodic surveys and studies.

The analyses of the MOH health information system recently carried out by the Westinghouse technical advisers revealed that Peru's health information system has only selected pieces of a health information infrastructure.* For example, there are statistical divisions within the MOH at both the central and hospital area levels, but these units primarily collate health services data received from the local level. The statistical units do not perform as a complete health information infrastructure with persons and resources operating in an organized way to perform all of the functions implied in a health information system: obtaining, processing, analyzing, and transforming all the necessary data into useful, adequate, and timely information for either planners or managers. Neither do managers at the regional level and below appear to use data for management purposes. The Westinghouse consultants further concluded that international donor agencies in general have tended to support specific activities related to information systems in an isolated manner. This has worsened the general separation and segregation among planners, program administrators, managers, and statisticians with the following results:

- lack of complete, timely, accurate, uniform information on mortality, morbidity, services, physical infrastructure, equipment, maintenance, finance, cost accounting, and human resources needed to effectively plan and manage health service delivery. Many data are available, but only in the separate divisions within the central ministry, or at the area or regional level and not in one central location;

- paucity of reliable birth and death estimates due to an inadequate vital registration system;

- little use of data for planning or management purposes;

*García Núñez, José, "Informe sobre sistemas de información," December 1983. Thomé, Marcio, "Informe sobre sistemas de información," July 1984.

- a great quantity of often duplicate and irrelevant data produced by the MOH and other institutions with little appropriate aggregation of data as it reaches the higher levels of the Ministry;

- a plethora of unstandardized, non-uniform data collection forms (226 different forms at the health center and health post levels alone) designed to satisfy a large number of potential consumers, resulting in poor quality data and an inefficient, extremely time-consuming, and expensive process;

- multiple, diverse and often contradictory plans for information systems due to numerous uncoordinated donor projects supporting information system improvements; much overlap in donor assistance;

- costly and sometimes redundant health care studies, the result of uncoordinated planning; lack of effective analysis of health data available from these numerous studies and the census;

- poor feedback of information to the delivery level;

- lack of the most basic supplies (paper, pencils, calculators, typewriters) at the local level; lack of any computer capacity at the MOH.

In response to this situation, the GOP primary health care strategy includes improvement of the health information system as one of its objectives. USAID is assisting the Ministry's effort by supporting a review of the conceptual framework of the national health information system and supporting two major improvements in the current system. USAID has programmed US$1.2 million for these improvements. Specifically, USAID is providing funding for:

- the design, testing, and implementation of a nationwide information system for collecting simple primary health care utilization data for project management and evaluation;

- the development and implementation of two major health studies to be used for health policy and planning purposes; these include a National Nutrition and Health Survey and a survey of selected primary health care providers.

4.4.2 A Primary Health Care Information System

An MOH Ministerial Resolution dated September 1984 officially approved the development and implementation of a completely revised national PHC medical record information system to organize data related to health services. This resolution was the culmination of many years and various efforts to improve the availability and quality of health services information in Peru and commits the Ministry to its implementation. The Director General of the MOH Office of Information and Statistics (OGIE) has been working to lay the groundwork for the design of the new system with a Westinghouse information system adviser supported by USAID project funds.

Major steps toward the design of the system have been taken. Meetings have been held with PAHO, the GTZ, and World Bank advisers to coordinate all international donor efforts in the area. The OGIE is using a group discussion and consensus approach to determine basic data needs. This approach involves meeting periodically with representatives of donor groups and all general directors of MOH directorates to design a plan that will be supported by the highest authorities of the MOH. The expected product of this approach is a preliminary list of variables of health services related data for health centers and posts by January 1985. The OGIE has developed and submitted to USAID for funding an operational plan for design and installation of the system.

After determination of the data elements, the OGIE plans to design new forms, pretest the forms in three regions at all levels of care, produce the new forms and related manuals, distribute these to regions, train OGIE personnel and regional statistics personnel, and finally install the system nationwide. The target date for national installation is August 1985.

4.4.3 The National Nutrition and Health Survey (NNHS) and the Provider Survey

The National Nutrition and Health Survey is designed to obtain important information on demographic, mortality, morbidity, and nutritional status patterns throughout Peru. It also is designed to collect data on socio-economic status and use of different health services. It is the first study of its kind in Peru in its breadth and depth, reaching an estimated 18,000 households and 100,000 individuals, of which 30,000 are women of reproductive age and 16,000 are children aged 0-6. Because the sampling is stratified by health region, the studies will provide important information for planning services on a regional level. The health and nutrition survey is being executed by the MOH and the National Institute of Statistics (INE) with the assistance of a survey coordinator supported by project funds. The Centers for Disease Control (CDC), the World Bank, the United Nations Statistical Office, and PAHO are providing technical advisers.

Complementing the NNHS is a health services provider study which is gathering information on health facilities, human resources, equipment, and supplies in three of the regions covered by the NNHS. The provider survey is being conducted by a researcher hired by USAID and the World Bank.

Data collection for the nutrition and health survey was completed on November 15, 1984, and results are expected in April 1985. The intervening period will be spent on data cleaning and editing, coding, and computer entry. The final report is anticipated no later than August 1985. Data collection for the provider survey is expected to be completed in January 1985.

An analysis group consisting of representatives of INE and of several divisions at the MOH has been formed and is meeting periodically to develop the analysis plan for the surveys. It will also review the results of the studies. It is intended that this group will assure that the data will be used by the Ministry for both planning and management purposes. It is anticipated that further analyses of the data will be performed at institutions such as the Nutrition Research Center (Centro de Investigaciones

en Nutrición), the major universities, and at foreign organizations such as the Centers for Disease Control, PAHO, the World Bank, and USAID.

4.4.4 Assessment and Recommendations

Remarkable progress has been made in the design of the health services/medical record system and in the design and completion of the field work of the NNHS and provider survey. The progress on the health services record system is due largely to the commitment of the Director General of the OGIE and to the considerable effort invested in informing, involving, and coordinating international donor agencies and important officials in various divisions of the central Ministry. The Westinghouse adviser's technical expertise in system design and his contagious enthusiasm certainly have been an important ingredient in the progress to date.

The surveys are well designed and the field work has been implemented carefully. In the health survey the refusal rate was very low (one percent), and the completeness and quality of data should be excellent, given the extensive supervision provided for the data collectors. There have been no delays in the execution of the survey since the field work phase and no delays are anticipated in the schedule for data cleaning, coding, computer entry, and analysis.

There has been significant progress in the information system and the surveys. However, several important issues remain to be addressed to make lasting improvements in the health information system. The technical advisers for the health information system have begun to take initial steps to address some of these, but further technical assistance will be required to assist the Ministry.

The most significant gap appears to be the lack of a critical mass of system users, health professionals at all levels of the Ministry who use data for management purposes in an organized way. Scattered individuals use available data, but no central or regional or local unit or designated individuals analyze these data and use them systematically for improving the performance of the MOH. Those units with some data responsibilities such as OGIE, regional statistics offices, or the Division of Epidemiology have little communication with operational units. More specifically, there are few people with the necessary research, data analysis, or computer programming skills in the OGIE, the MOH division responsible for providing information. Now is an opportune moment to help the OGIE develop analytic resources and skills, building on the enthusiasm generated by the OGIE's work on the health services/medical record system. Additional efforts are also necessary to improve the ability of regional and local professionals to use valuable data for management purposes.

Other sub-components of the information system also need to be developed systematically. The medical record/health services information system that has been designed addresses health services-related data and basic record-keeping data, but the systems for the financial, infrastructure, human resource, and logistics information are in very early stages of development and revision. These are equally important for linkage with the service data if the service information is going to be fully useful for management and

planning purposes. The technical advisers have taken some important steps in these subsystems, but much more support will be needed to put them into place.

Further strengthening of the medical record and service utilization information system is also needed. Logistical and time constraints have meant minimal involvement of regional and local levels of personnel in the design of the system. More effort will be required at these levels during the installation phase. The implementation schedule for system installation is ambitious given the known logistic and administrative constraints in Peru. The present material and equipment deficiencies in regional statistics units also may delay implementation. It is difficult to predict whether the targets will be reachable by August 1985 for printing and distributing forms and training personnel in the 17 regional systems, 64 area hospitals, and 2,000 health centers and posts.

The consensus building phase appears to have generated high level support for the system, which is an important achievement. However, experience elsewhere suggests that a consensus group of officials who have little experience as data analysts and users often produces a "wish list." The next step is to transform the "wish list" into a practical system that is actually useful for influencing management behavior.

Finally, nearly all of the emphasis to date has been placed on the design aspects of the system. More emphasis needs to be given to a plan and strategy for use of these data at the management level and to strengthening analytic capabilities. Fuller attention to the use of data is appropriate from the beginning of system design. A plan for developing the capability of key people at all levels of the Ministry to use the data for planning and management and for developing feedback mechanisms to the periphery is urgently needed in parallel with the design of forms and procedures. The analyst must develop appropriate channels for use of the new information, so that providing prompt and accurate information becomes generally accepted as a norm of behavior in MOH. The new system of forms and procedures probably will be only moderately useful until addressing the issue of encouraging appropriate use of data and developing the related subsystems. This is a long-term undertaking, but it is important to recognize and deal with it from the beginning.

In summary, important steps have been taken in the improvement of health information in Peru. These steps are the beginning of a process which needs to continue into the future to attain a positive impact on the health information system. Our recommendations are divided into short-term recommendations and long-term recommendations.

Long Term Recommendations - Health Information System

Recommendation 4.4-1 to strengthen the analytical capability of the MOH/OGIE. The MOH's statistical division (OGIE) must develop a broader orientation than simple data collation. The OGIE should have its own analytic capability and relationships with all areas of the MOH. More and better skilled personnel, computer facilities, and training would be essential elements, implying a need for donor funding and technical assistance. USAID and other international donors should support a comprehensive training program at all levels of the MOH in management and use of information. This should include

at minimum the strengthening of MOH analytic capabilities in use of data for management, planning, and feedback systems to the levels of health service delivery. Specifically, needs include:

- o basic understanding of the relationship between management and information systems for Directors and Deputy Directors of all divisions and units within the MOH;

- o biostatistics capability at the OGIE, the analysis group, and other divisions;

- o statistical programming capability at the OGIE and the analysis group through short term (3 months) training programs such as offered by the Escuela de Administración de Negocios para Graduados (ESAN). ESAN is currently training several OGIE staff members;

- o epidemiology capability in the Ministry through both short and longer term courses. This is needed at the level of Directors of Area Hospitals, mid-level employees of each division of the central MOH (who would have less turnover than other higher level officials), and Regional Directors.

Recommendation 4.4-2 concerning NNHS and the provider survey. Support the complete analysis of the health and nutrition and provider surveys as well as other recent major surveys; use the information thus generated for project management and health planning.

Recommendation 4.4-3 regarding other information subsystems. Support should be strengthened for step by step installation of information subsystems in finance, cost accounting, logistics, physical infrastructure, and human resources as soon as possible. Little management improvement can be expected without the linkage of service information to resource and management information.

Recommendation 4.4-4 on vital statistics. Develop a project to improve the system for registration of births and deaths in Peru.

Recommendation 4.4-5 on the computerization of the information system. The MOH should develop an integrated, phased plan for computerizing the different components of its information system with compatible microcomputers, requesting donor assistance as needed. Training for using microcomputers should also be part of this plan.

Short Term Recommendations - Health Information System

Recommendation 4.4-6 on coordination among donors. Develop a system for coordinating donor efforts related to information systems.

Recommendation 4.4-7 to assure continued support for the new information system. Continue the periodic meetings of the consensus group begun in the design phase of the information system into the installation phase to foster continued MOH support and to start building analytic capability. Special information sessions should be

held when the new government takes over to ensure continuation of the new information system.

Recommendation 4.4-8 regarding pretest of the new information system. An outside peer review for the information system will be the best guarantee of its feasibility and practicality. The principles and approaches used for NNHS provide a useful precedent. Support an outside official review panel of at least three respected professionals experienced in implementation of health information systems to review the results of the pretest and the detailed plans for implementation nationwide. This review should generate some useful suggestions for implementation, guarantee the acceptability of the information system to the MOH, and provide a quality check which allows refinements and modifications to be made prior to final printing of forms and procedures and nationwide installation.

Recommendation 4.4-9 for an implementation plan for the new information system. The OGIE should: a) prepare a detailed implementation schedule through August 1985 in order to be able to monitor progress closely and take corrective measures should they be necessary; and b) prepare a back-up alternative implementation schedule with a phased approach for the information system's introduction to the central MOH and the regions. This schedule should be implemented if it becomes apparent that the present plan is experiencing serious delays.

Recommendation 4.4-10 for continued technical assistance. USAID should support technical assistance beyond August 1985 to increase the probability of implementation of the information system. Continuity of TA is important given the 1985 change in government. The OGIE, with the aid of the Westinghouse consultant, should prepare and present to USAID a plan for TA needs to complete the information system implementation. This plan should emphasize how to improve data use and feedback in the MOH.

Recommendation 4.4-11 concerning specific applications of the NNHS results. Several items of information in the nutrition and health survey would be very useful for adjusting the strategies of specific components of project 219/230. Specific items include: radio/television ownership (the mass media component); ability to read (health education materials); person attending birth (the TBA training approach); nutritional status, breast feeding, and supplementary feeding (nutrition amendment focus); and expenditure patterns on medications (promoter remuneration).

Recommendation 4.4-12 regarding the applicability of the NNHS data to Bolivia. The results of the health and nutrition survey for the Puno area should be shared with the Bolivian MOH and USAID/Bolivia because of the Puno regions's similarity to Bolivia and the potential usefulness of the regional patterns for Bolivia.

4.5 Supervision System

In the past, the MOH supervisory system was very centralized, with individuals from the central Ministry attempting to inspect all levels of the health structure. Visits, on the whole, were made from the vertical divisions within the Ministry in an uncoordinated fashion. Regions often would receive visits one after another in a disruptive fashion because of this lack of coordination. Most supervision was directed to exercising control and authority rather than to analysis, feedback, teaching, problem resolution or follow-up.

The MOH identified supervision at all levels as an important means to improve primary health care. USAID and other donor agencies have supported the Ministry's efforts in improving supervision through provision of technical assistance, funds for training, and funds for lodging and transportation costs incurred during the supervisory visits. Considerable funding has been committed in projects 219/230 for supervision. (US$1,611,136). Other donors, particularly PAHO, IDB, and the World Bank, have also supported activities directed to improving supervision in primary health care.

There has been considerable improvement in the supervisory system during the life of the project. First, the Ministry has begun to address some of the coordination problems relating to supervision. At the central level of the MOH, the Directorate of Programming and Evaluation (DPE) is responsible for developing supervision guidelines for the other directorates within the MOH, including the Maternal Child Health and Population Directorate, which has operational responsibility for projects 219/230. Both directorates have operational responsibilities and have begun to coordinate some of their supervisory activities.

These two directorates have taken some important steps toward improving supervision. For example, they have produced carefully designed norms which cover the content, methodology, and the number of supervisory visits to be provided at each level of care. Supervision is supposed to be provided from the central level to the regions; from the regions, to the area hospital; from the area hospital to health centers; from health centers to health posts; and from health posts to promoters and TBAs in their communities. The annual target for supervisory visits to be received is two per region, four visits per area hospital, six visits per health center, and monthly visits to every health post and community worker.

The MOH now attempts to conduct supervisory visits in multidisciplinary teams and emphasizes continuing education as an important component of supervision. A supervision manual entitled "Módulo auto-instruccional sobre supervisión" has been prepared by the MOH with IDB/PAHO financing in conjunction with the development of the supervisory norms. This manual outlines good supervisory procedures and is being tested in three regions, but has not been distributed yet to all regions. Other accomplishments include the preparation of a supervisory procedures manual by the DSMIP and two regional seminars on supervision held in 1984.

The evaluation team found that all levels of the MOH recognized that an effective supervisory system was necessary. Many people at all levels of the MOH are aware that deficiencies remain and are making efforts to remedy some of these deficiencies. For example, while visits from the central to the regional level are still few and far between, there is a sincere effort to make the visits in a multidisciplinary fashion. The Ica region uses a team approach in all of its supervisory visits.

Two important problems remain: 1) There are too few supervisory visits per primary health care establishment and community worker, and 2) the quality of supervision still suffers many deficiencies. There is an average of less than one to three supervisory visits per year per health establishment or community worker. The estimated number of supervisory visits received annually by any given health establishment, health promoter, or TBA is shown in Table 15. This estimate of visits received by each facility was based on the reported number of supervisory visits during 1982-1983 and 1983-1984 in three regions involved in the projects divided by the number of relevant health care establishments for the same regions.* This is a very crude estimate since the MOH data available at the central level are known to be incomplete and because some facilities are not considered to be "under the USAID project". Thus, these figures may underestimate the frequency of supervision. Even if the estimate of visits per establishment were doubled, however, the amount of supervisory contact would still be very low. The very low rate of 0.6 to 0.9 supervisory visits per year for area hospitals is contrary to popular belief. However, this figure is consistent with the team's finding that there was little knowledge about either the project or primary care strategy at the area hospital level. While the situation for community workers appears to have improved, the situation for health posts appears to have worsened. The team's observations in nine regions confirmed that visits from the central area to the regions were also quite infrequent. On the brighter side, a visit to the Ica region showed that all health establishments are receiving an average of three to four supervisory visits a year and in many cases more. In the Ica region each level of facility visits all the levels below it. For example, the area hospital supervisory team visits its health centers, health posts, and community workers, not just its health centers. Even more notable was the fact that the regional director and his team visit each facility at least once annually.

The number of supervisory visits carried out compared to the number programmed is also quite low, varying from a low of 28 percent to a high of 52 percent for 1983 (see Table 16). Both the absolute number of visits and the proportion of visits made dropped between 1982 and 1983. The USAID Project Manager stated that supervisory visits had increased in 1984 as the result of increased funds availability. It would be appropriate to review data from more than three regions before making any definitive conclusions.

Supervision was a topic included in the questionnaire which the team administered during its visits. Contrary to expectations, health centers and posts received more visits in the last two months than regions and area hospitals. Table 17 suggests that

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*Only three regions reported these data for the two time periods.

Table 15

Estimated Number of Supervisory Visits Received per Establishment per Year for Five Levels of Care in Reporting Regions, 1982-1983, 1983-1984

Level of Establishment	Estimated No. of Communities/ Establishments	1982-1983 Total Visits	1982-1983 Visits/yr. per Facility or Community	1983-1984 Total Visits	1983-1984 Visits/yr. per Facility
Promoters/TBAs Trained under Proj. 219/230	472*	779	1.6	1,465	3.0
Health Posts	269	247	0.9	187	0.7
Health Centers	77	146	1.9	98	1.3
Area Hospitals	18	17	0.9	11	0.6
Health Regions	3	NA	-	-	-

*An estimate of 16 percent of the total 3,048 promoters and TBAs trained under the project was used, since the three health regions (Cajamarca, San Martín, and Ancash) contain approximately 16 percent of all of the other health facilities.

Source: Ministry of Health Operational Plans, 1982-1984.

Table 16

Summary of Number and Percent of Supervisory Visits Programmed and Made to Each Level of Care, Four Regions*
1982 - 1984

Level of Care	Number of Supervisory Visits					
	1982 - 1983			1983 - 1984		
	No. Programmed	No. Made	Percent	No. Programmed	No. Made	Percent
Promoters	2,975	1,669	56	3,010	1,571	52
Health Posts	996	367	37	579	226	39
Health Centers	422	179	42	431	122	28
Area Hospitals	45	20	44	45	19	42
Health Regions	no data					
TOTAL	4,438	2,235	50	4,065	1,938	48

*Data are for three regions reporting (Ancash, Cajamarca, and San Martín) and four USAID project areas of Lima.

Source: Operational Plans 1982-1984.

Table 17

Distribution of
Length of Time in Months Since Last Supervisory Visit
by Type of Health Facility, November 1984

Number of Months Since Last Supervisory Visit	Number of Facilities by Type			
	Region	Hospital Area	Health Center	Health Post
0-2	1	1	6	2
3-6	-	2	-	1
7-12	1	-	1	1
13-24	1	2	-	-
25 +	-	1	-	-

Source: Results from questionnaire administered by evaluation team.

the results are only indicative, given the small sample size. The question asked during the visits was: "When was the last time you received a supervisory visit?"

While the evidence is not conclusive, the team found considerable variation among the regions in both the number of supervisory visits conducted and in the qualitative aspects of the visits. Some regions found ways to carry out a fair number of supervisory visits despite logistic and administrative constraints.

Rita Fairbanks identified a number of factors which appear to be contributing to the low number of supervisory visits at all levels.* These include: lack of overnight facilities, failure of the financial system to promptly reimburse supervisory personnel for expenses incurred, lack of transportation or fuel, reluctance of doctors and/or other personnel to leave patient care activities at their respective establishments, poor understanding of management issues and of the potential usefulness of the role of supervision, and little use by supervisors of data generated by the information system for management purposes.** It is unrealistic to expect major improvements in the near future in the supervisory system as it is presently conceptualized and organized, given the current resource and logistical constraints of the MOH.

The current model for supervision is a pyramid. Each level of establishment is responsible for supervising the next lower level of establishment with the frequency of visits increasing progressively. This model of supervision implies a total of 2,358 supervisors if one assumes at least one supervisor per establishment from the regional to the health post level (see Table 18). The largest number of supervisory visits must be made by the health units with the fewest staff members with the least resources such as vehicles. The staff of these establishments also have the lowest educational level. To illustrate, if a health post has only one auxiliary who is responsible for supervising five promoters, each supervisory trip takes an average of one day in each direction, and each visit lasts one day, it means the health auxiliary will be absent from the health post 15 days per month just to make one round of supervisory visits. The reality of the situation is that health auxiliaries are often responsible for more than five promoters and trips often require more than one day. A similar but less acute situation occurs from the health center to the health post level.

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*Fairbanks, Rita, "Consultant's Report on Supervision Systems - Primary Health Care Projects - MOH Peru," 1983.

**Supervisors from each of the levels do not dedicate their time completely to supervision, but have full time service responsibilities in their own establishment and must coordinate their supervisory activities with their operational activities. Because the supervision takes place physically outside of their own establishment, the demands from their own establishment usually take precedence.

Table 18

Supervisory Visits Scheduled
Annually by Level of Establishment

	No. of Units	Number of Annual Visits Scheduled per unit	Total Annual Visits Scheduled
Regions	17	2	34
Hospitals	125	3	375
Health Centers	546	4	2,184
Health Posts	1,670	6	10,020
Health Promoters	3,048	12	36,576
TOTAL	5,406	-	49,189

Source: OGIE, 1983.

Supervisory visits to the health post and the health promoter level entail several hours to several days of travel in each direction, often under the most austere and harsh conditions. Numerous reports indicate that when staff plan supervisory visits, they are hampered because vehicles are unavailable or non-functional or there is no money for fuel. At all levels of the Ministry, the per diem payments for the trips made are perceived to be inadequate. Finally, and most importantly, there is a delay in receiving reimbursement for travel expenses of as much as a year or more. Given the rugged travel conditions and current inflation rates of over 100 percent per year, it is easy to understand the shortfalls. Money has been programmed under projects 219/230 for both per diems and fuel for supervisory visits, but this money is not reaching the local level in a timely way.

We conclude that it is unrealistic to expect supervisors to accomplish the number of supervisory visits programmed, given their responsibilities at their own facilities and given resource and logistical constraints at the health center and health post level.

The second problem in supervision relates to its quality. Many reports indicate that the quality of the interaction during a majority of supervisory visits still leaves much to be desired, and in fact, often may be counterproductive. The team's observations and other reports indicate that there is still no standard pattern of supervision executed by the regions. In some cases supervision is still carried out separately by different directorates and in others a team approach is used with representatives of the various directorates traveling together, e.g., supply, MCH, environmental sanitation, administration. The exception, as noted earlier, is the Ica region which consistently appears to use the team approach. Several people commented on an improvement in the quality of supervision in the three regions that were trained with the "Módulo autoinstruccional sobre supervisión" (Self-Instruction Module for Supervision).

One indicator of the quality of supervision is the extent of problem resolution occurring as a result of the supervisory interaction. The team evaluation asked if the supervisors had helped to resolve the problems identified during the visit. The responses were negative except in Ica, where at the regional level, supervision was oriented to problem resolution. Another indicator of poor quality supervision is the low level of staff knowledge about primary health care strategies and programs which the evaluation team observed at the delivery levels of care.

Several reports also point out the lack of knowledge and/or lack of application of the principles of supervision.* A ministry report reviewing primary care in late 1983 indicated that few people had a clear idea of what it means to supervise. It was reported that while there were some exceptions, most visits consisted only of some data collection about activities and "talking."

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*Townsend, John, "Sur Medio Evaluation," 1983; Fairbanks, Rita, "Consultant's Report on Supervision," 1983; MOH, "Evaluación de atención primaria," 1983; Management Sciences for Health, "Promoter Evaluation," 1984.

Other reports indicate an orientation to control and reprimand. Little task observation, data analysis, continuing education, staff motivation or problem resolution are reported to occur during the visits. Finally, there appears to be little understanding of the use of a management information system for supervisory purposes. It is not realistic to plan to teach a minimum of 2,358 persons the supervisory skills needed to improve the quality of supervision, given current MOH resources.

In summary, the key obstacles to effective supervision appear to be the following: 1) a seriously deficient administrative system which creates a strong disincentive to carry out supervisory visits, particularly due to the logistics problems and the extremely late and low levels of reimbursement for travel expenses; 2) the lack of knowledge of the basic principles of good supervision or the lack of their application at the time of the visit, making visits often unproductive; and 3) supervisory staff who do not know how to use even very simple data for management purposes leading to poor quality and low productivity in the supervisory process. Nothing presently planned by the MOH is likely to change these constraints or the Ministry's method of organizing supervisory visits. Thus, neither the quantitative nor the qualitative aspects of supervision are likely to improve significantly in the near future without modifications in the supervisory model.

Recommendations - Supervision System

Recommendation 4.5-1 to modify the current supervision model. Modify the current organization of the supervision system (and its quantitative targets) to a more feasible and realizable approach, particularly for supervisors of health centers, health posts, promoters, and TBAs.

Recommendation 4.5-2 of four alternatives to be considered for reorganizing supervision:

a. Identify the "good" supervision models currently in use in areas such as Ica and possibly Piura. Assess them and incorporate appropriate elements into the new organizational model.

b. Develop a system whereby every two to three months all health promoters convene at "their" health post and all health post personnel gather at "their" health center. This would work especially well at the area hospital level, since all personnel come once a month to receive their paychecks. A full plan must be developed for effectively using these group meetings for supervisory purposes. At these meetings the focus should be on a review of data for very simple indicators of performance for each unit. Using these data as a base, the meetings would concentrate on continuing education, problem identification and resolution, motivation, and follow-up. As problems are identified, follow-up visits should be made to those in need of a visit. The model developed should be based on a careful analysis of the relationships among different levels of health establishments.

c. Consideration should be given to setting up a small, permanent, full-time supervisory unit at the area hospital, but maintaining the multidisciplinary forms recently begun since health centers and posts have such low staffing levels. This supervisory unit would be responsible for supervising health centers, health posts, and community workers. In order to avoid the problem that has befallen the training units, it would be extremely important that these units have line responsibility for supervision. This more limited number of full-time supervisors would make adequate training regarding supervisory skills more feasible. For example, to provide each of the 125 area hospitals with a two-person supervisory team would mean teaching 250 persons supervisory skills. This is a much more realistic objective than teaching 2,358 persons, most of whom normally would dedicate 95 percent of their time to non-supervisory activities. This full-time supervisory team might be reinforced on a rotating basis by other relevant staff. If this is the model chosen, the team cannot emphasize strongly enough the necessity of a line relationship for such teams, i.e., that they should have the authority to resolve problems for the people they are supervising.

d. A combination of alternatives a, b, and c.

(Discussions at DSMIP in March 1985 suggested that operations research would be appropriate, but that none of the models suggested by the evaluation team provides a general solution.)

Recommendations 4.5-3 regarding supervision self-instruction materials. Evaluate the impact of the "Modulo autoinstruccional sobre supervisión" on the quality of supervision and, if it is worthwhile, use it together with the new "model" for supervision.

4.6 Training

USAID projects 219/230 were both designed to respond to the excessive concentration of health resources in Lima and the disproportionate number of physicians and nurses relative to other health personnel to extend and improve the delivery of primary health care services. Since 1962, the number of physicians increased 76 percent and the number of nurses 157 percent. Up to 75 percent of these professionals are concentrated in Lima, which has one third of the population. Data from 14 health regions in 1982 show that less than 5 percent of both physicians and nurses work in the primary care level of the health system. Auxiliaries are better distributed with approximately 2,000 staff spread over 2,000 health centers and posts. Since 1979, when the MOH began its primary care program, there has been a slight improvement in the staffing trends of primary care establishments.

The most important factors contributing to resource maldistribution in Peru are summarized in Laura Altobelli's report.* These factors include inappropriate candidate selection, urban pull and political power, lack of incentives to work in underserved areas or in primary care, inappropriate teaching methods and content, the lack of clear or appropriate role definition for community workers, professional competition, lack of trained decision makers in public health and administration, and perhaps most important, serious management and administration problems.

The MOH embarked on a plan for training and equipping health post auxiliaries, community leaders, health promoters and traditional midwives in response to these problems as part of its primary health care strategy. The principal component of this low cost delivery strategy is the development of a new nationwide cadre of community-based health workers--promoters and traditional midwives or birth attendants--who will be supported by health auxiliaries at the health post level. The community-based health workers will extend primary care services to both rural and marginal urban communities. This strategy was chosen because of Peru's long experience of using community level health workers in a variety of small local projects. USAID and several other donor agencies have supported this PHC strategy, providing significant support for training of community workers as well as support for training of other central and regional level personnel in various aspects of primary care.

4.6.1 Overall Training Program

The major thrust of training thus far has been initial training of promoters and TBAs and more recently to their refresher training. Refresher training for health auxiliaries also has been emphasized due to the wide variability in the initial training given to auxiliaries in Peru. USAID funds principally have supported initial and refresher training for health promoters and TBAs, refresher training for health auxiliaries, and training for a variety of health professionals and administrative personnel. USAID funds were also to have been used to supply these community workers with transportation, initial basic medicines, and supplies upon completion

*Altobelli, Laura, "Report on Human Resources Development," 1984.

of training. Health posts were to be supplied with basic medications, contraceptives, oral rehydration salts, and some equipment. A total of US$2.0 million has been programmed for support of training.

The volume of training carried out to date has been an impressive achievement. Table 19 summarizes the already completed training activities have already been supported under the projects. A total of 234 courses or seminars relating in some way to improving the delivery of primary care have been given in Peru to 6,328 participants.* Over 3,000 participants have been new promoters and TBAs. As shown in Table 20, another 529 courses with 9,239 participants are programmed to be completed by the end of the projects for a total of 15,567 participants.** The School of Public Health has been the key actor in these training efforts and in attempts to improve training methods.

Despite this impressive performance, the evaluation team agrees with previous reports that certain problems need resolution to make the training more effective. Detailed exploration and analyses of these issues are available in other documents.***

First, the ambitious targets for training that the MOH is undertaking at all levels make good management essential to avoid unnecessary duplication, overlap, and waste of resources and opportunities. USAID, the World Bank, IDB, UNFPA, UNICEF, PAHO are all heavily supporting training activities in primary health care. Table 21 illustrates the types and levels of training anticipated in the IDB/PAHO- and the World Bank-funded projects. If all training targets are reached by the primary care projects supported by these three donor agencies, a total of some 130,862 participants will have received PHC training in the next two to three years. This is a staggering amount of training to be undertaken even in the most sophisticated institution. Even though these activities are programmed over a four-year period, the demands on management will be formidable.

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*These data are estimates from six reporting regions. Reliable up-to-date data for the total number of persons trained under projects 219/230 are not available at the central MOH.

**These numbers may involve double counting of some individuals who participate in several courses. No data are available on individuals participating in more than one course.

***Altobelli, Laura, "Report on Human Resource Development," 1984.
Management Sciences for Health, "Evaluation Health Promoter Program," 1984.
Davidson, Judith, "Evaluación de la efectividad de los cursos de capacitación para los parteros,"1983.
Townsend John, "Sur Medio Evaluation," 1983.
Ministerio de Salud Pública, "Capacitación de recursos humanos en el primer nivel," 1984.
Management Sciences for Health Consultants' Report, "Extensión de salud primaria integral," 1980.

Table 19

Training Activities Implemented Under Projects 219/230
by Type of Course, Number of Courses, and Number of Participants
1979-1984

Type of Course	No. of Courses	No. of Participants
IN COUNTRY		
Initial Training		
Auxiliary		221
Promoter	73	1,703
Traditional Birth Attendant	81	1,710
Refresher Training		
Auxiliary	6	275
Promoter	26	514
Traditional Birth Attendant	23	448
Administrative, Accounting and Supply	8	692
Orientation in Integrated Health/Family Planning	13	693
Epidemiology	1	14
Primary Health Care		
Nurses and Midwives	2	34
Training Trainers	1	24
SUBTOTAL	234	6,328
LONG/SHORT TERM U.S./THIRD COUNTRY		
Long Term	2	9
Training Trainers	1	2
Community-Based Distribution	1	2
Pharmacy	1	2
Medex	1	1
SUBTOTAL	6	16
TOTAL	240	6,344

Source: MOH Operational Plans, 1982 - 1984.

Table 20

Additional Training Programmed
Projects 219/230

TYPE OF COURSE/SEMINAR	NO. OF COURSES	NO. OF PARTICIPANTS
Auxiliary Training	5	75
Auxiliary Refresher Training	23	416
Maternal Child Health and FP	47	784
Epidemiology	30	731
Orientation to Primary Care	27	503
Supervision	19	570
Environmental Sanitation	19	216
Mass Media	3	65
Statistics Workshop	8	250
Communication Methods/Community Education	8	194
Training of Trainers/Teaching Methods	7	95
Promoter/Initial	75	1,283
TBA/Initial	55	896
Promoter/Refresher	67	757
Traditional Birth Attendant/Refresher	63	151
Long Term Training	1	6
Reproductive Risk	18	440
Nutrition and Breast Feeding	2	100
Diarrheal Disease/Oral Rehydration	6	215
Planning, Programming, Evaluation	35	848
Logistics/Accounting	8	164
Immunizations	3	45
Miscellaneous*	10	435
TOTALS	529	9,239

*Referral, Pharmacy Auxiliaries, Community Leaders, Laboratory Technicians, Perinatology.

Source: Regional Operational Plans 1984-1985.

Table 21

Training Programs and Targets
Supported by the World Bank and IDB/PAHO

Theme or Target Group and Donor	No. of Participants*
IDB/PAHO	
Orientation, Directors of Regions/Area Hospitals	98
Instructors	66
Primary Care Workshops for Nurses	1,000
Continuing Education	6,500
Promoters	80,000
Hygiene Education for Mothers	2,000,000
Subtotal (excluding mothers)	87,664
WORLD BANK	
Training Trainers	42
Directors, Health Centers	180
Nurses, Health Centers	180
Physicians, Nurses, Others	2,089
Nurses, Health Posts	640
"Auxiliares de Campo"	4,500
Promoters	20,000
Subtotal	27,631
GRAND TOTAL (excluding mothers)	115,295

*Precise numbers may differ slightly depending on source document, but the order of magnitude is the same.

Source: World Bank and IDB project documents.

The difficulties of attempting to fulfill these targets are reflected in the fact that the annual targets for most of the training activities programmed are not met, curricula are hastily and inadequately prepared, teachers use inadequate teaching materials, materials are insufficient in quantity, participants are hastily and poorly selected, and there is no regular evaluation of the effectiveness of the various training programs.

Duplication and overlapping of training efforts has occurred with a large number of activities funded by the different donors. Overlap is also occurring in other aspects of support for primary health care such as information systems, supervision systems, health education materials, and supplies.* In training alone, there is duplication in the type of persons trained, level of the MOH participating in the training, curricula, training materials, geographic coverage, etc. There is little follow-up or assessment of the impact of most of the training. Lack of coordination among the donors underscores the gaps and contradictions.

The donors are supporting a vast training effort in primary health care. Unfortunately, each donor "project" uses a different strategy, materials, and occupational profile for the first level of care. They are scattered administratively throughout different divisions of the Ministry, jeopardizing the development of a clearly articulated PHC "doctrine" and a sound, practical plan for training in primary health care.

Another major concern affecting training is the predominance of non-participatory lecture techniques for all levels of training. This is especially true at the lowest levels of service delivery and in community education. A recent IDB-supported study revealed that 96 percent of personnel used these traditional methods.** The study recommended that the MOH address these issues in order to improve primary health care delivery.

Insufficient educational materials affect the quality of training of health personnel and community education efforts. Materials are deficient both in quantity and quality. The lack of cohesive administration, preparation, and continuous distribution of educational materials to the local level means that a majority of the health posts and community workers have limited educational supplies.

There is little reinforcement of the concepts and procedures taught during the course of the training programs because supervision in the field is weak (see section 4.5 of this report). Furthermore, the training units which have been established in each region to follow up training activities are not doing so because of time and logistical constraints. The team found that these units performed primarily administrative and logistics functions and did not teach. This suggests that the courses for "training trainers" may be inappropriate for these personnel since they do not actually do the training but merely organize it.

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*Altobelli, Laura, "Report on Human Resources Development," 1984.

**Ministerio de Salud, "Capacitación de recursos humanos en el primer nivel," 1984.

The lack of follow-up training undoubtedly contributes to the low level of performance observed in many health workers and the high drop-out rates of health promoters. Many observers believe that the poorly supplied health facilities also frustrate even the most ardent health workers in delivering primary care services. Thus, problems of supply of basic materials may dilute the effect of training programs. Health promoters and TBAs often do not receive their initial basic equipment and supplies due partially to the failure to coordinate the delivery of supplies with the completion of training. The other causative factors such as problems in programming, administration, financing, and logistics are discussed in other sections of this report.

The last, most critical problem and the principal cause of most of the other problems is the lack of a clear, cohesive training strategy for primary health care which clearly sets out objectives, priorities, and a plan of action. The MOH has recognized the problem and is in the process of developing a plan of action.

Recommendations - Overall Training Program

Recommendation 4.6-1 that the MOH develop a comprehensive training plan. Training is needed in many important areas for MOH's primary care programs. The entire training component being supported by both USAID and the other donors should be reassessed and consolidated as soon as possible to make training in primary care both feasible for the MOH to implement and effective in meeting real needs. A coherent, action-oriented training plan for primary care should be developed. Alternatives for organizing the training or reprogramming some of the monies into deficient areas related to training, such as provision of adequate training and educational materials, should be explored.

Recommendation 4.6-2 to assess training needs. The training plan should address both short and long term training needs after an assessment of these needs has been made. The results of the recent School of Public Health (SPH) survey of training needs could serve as a starting point for this national training assessment for primary care.* The assessment also should include an analysis of available materials and supplies. The plan of action should be developed based on an analysis of the different training alternatives available in Peru, the United States, and third countries. For example, the SPH may be the more appropriate trainer for some types of training, whereas the Instituto Nacional de Investigación y Desarrollo de la Educación (INIDE), ESAN, or in-country workshops given by consultant groups may be more effective for other types of in-country training. The Ministry should dedicate a full-time person to coordinating all training in primary care..

Recommendation 4.6-3 to incorporate specific training needs identified in this report into the overall training strategy. This evaluation team has identified needs for training

*For example, the 1984 SPH survey of all regions asked how many people had obtained degrees in Masters of Public Health.

in other sections of this report which should be part of the MOH training strategy.

Recommendation 4.6-4 concerning USAID technical assistance for training. USAID should consider supporting technical assistance in training at the macro level to assist the Ministry in assessing training needs and consolidating and organizing its approach. A second activity worthy of technical assistance at the operational level would be to assist the Ministry in the implementation of the training strategy and action plan. USAID should strengthen its support to the School of Public Health.

Recommendation 4.6-5 to use existing and available educational materials. Adequate production and distribution of training and health education materials to primary health care workers is critical and should be addressed in conjunction with the above recommendations. Other materials should be distributed to the regions taking into account the promoter and TBA evaluation. Many good materials already exist. It might be more effective to reproduce or purchase a sufficient number of a few good materials than to spend many months and resources developing new ones. For example, distributing 10,000 copies of Donde no hay doctor to health posts and health promoters might be more beneficial than spending the budget currently allocated to local production of health education materials. This plus a number of PAHO, UNICEF, and World Bank materials distributed regularly and in sufficient quantity would contribute significantly to the effectiveness of training.

4.6.2 Promoter and Traditional Birth Attendant Training

The use of community level health workers--traditional birth attendants and health promoters--for the delivery of services in areas of low access is a major component of the primary care strategy promoted by the MOH and supported by the donors. Both types of workers were to be provided with initial basic medicines and supplies. A revolving fund was to be developed for continuing the resupply cycle. The strategy included approximately one month of initial training for health promoters and 15 days of initial training for TBAs. TBA training is oriented to specific tasks and knowledge, while promoter training is multipurpose and covers a wider range of themes including nutrition, MCH, environmental sanitation, immunizations, family planning, and infectious disease control.

The total number of promoters trained by all sources is thought to be quite large, around 5,000 since the mid-1970s. USAID alone has supported the initial training of over 3,000 promoters and TBAs. It is not known exactly how many promoters or TBAs have received initial training, or the number currently working since current and reliable data for the total number of promoters and TBAs trained under projects 219/230 are not available at the central MOH. Consistent records are not kept on drop-outs, although attrition is estimated at ten to fifty percent.

What do we know about the impact this training has had and what these community workers are doing? The results of several studies and the team's observations point to some important successes as well as some significant

problems. Judith Davidson's study of five health regions summarizes these accomplishments and issues for traditional birth attendants:*

- o there is a marked difference between the quality of care (for example, hand-washing and umbilical care) and the health messages imparted to mothers by trained birth attendants and those by untrained birth attendants;
- o the difference is particularly dramatic in more traditional rural areas;
- o trained birth attendants remember what they have been taught regardless of literacy levels;
- o their patients are satisfied with and prefer their care to that of an untrained TBA;
- o patients attended by trained TBAs have more favorable health attitudes and are actually using the hygiene and nutrition information they received from the TBAs;
- o quality of services and referral of complicated cases suffered when there was little supervision and lack of transport.

Davidson found that the major issues in the training and performance of TBAs related mostly to the demand for and use of their services, and secondarily to their selection and supervision. For example, few members of the communities studied were aware of the presence of trained TBAs. Only four to five percent of adult women in the area of study knew that trained birth attendants were present in their communities. Similarly, the use rate of trained TBAs was very low. The study showed that culturally traditional areas seemed to exhibit the highest use rates. Training in the appropriate language of the region also affected performance. The team identified another possible reason for low use rates - it is suggested that most births are attended by women's husbands. For example, a 1977 study in Bolivia showed that 56 percent of births were attended by a family member and only 14 percent by traditional midwives.** Data from the Nutrition and Health survey will help to clarify this issue in Peru. The team identified one region with high use rates of TBAs. In Ica TBAs are reported to attend approximately 18 percent of births. TBAs also refer a large number of women to the hospitals in the Ica region.

The major findings of the 1984 promoter evaluation, confirmed by this team's observations and other reports, indicate a somewhat different picture for health promoters.*** On the positive side, promoters have been chosen primarily by the communities in which they live and most communities are aware of the presence of the promoter. Most promoters are reported as

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*Davidson, Judith, "Evaluación de la efectividad de los cursos de capacitación para los parteros," 1983.

**Frerichs, Ralph R., "Health and Illness in Rural Bolivia, A Household Survey - Montero Region, Bolivia," 1977.

***Enge, Kjell I, et al., Reporte Consultor en "La extensión de salud primaria integral", 1984.

being enthusiastic during their training and the majority of them report organizing their communities for health promotional activities. In several isolated instances promoters are actively distributing contraceptives, referring pregnant women to care, and referring children for vaccination.

While these are important achievements, the promoter program is plagued by problems, chief of which are:

- o a high drop-out rate: (20-50 percent)*;
- o a low service delivery rate in general and great variability among promoters; the range of activity is reported to be from 10 to 468 encounters per promoter per year;
- o promoters are only reaching a small portion (19 percent) of their target population;
- o their knowledge levels of preventive care are low;
- o most activities are in adult curative medicine;
- o their training and refresher courses are carried out in a haphazard manner;
- o while most communities are aware of their presence, communities don't know what promoters do;
- o there is no standarization in data nor system to collect service data from promoters; evaluation of their performance is therefore nearly impossible.

The team believes that these problems arise from three key factors: 1) promoters have no clear, task-oriented role; 2) logistical and supervisory support of promoters is either poor or nonexistent; and 3) promoters receive no remuneration for their activities (the model of a rotating fund has never been developed or implemented for these community workers) and few other incentives.

Most of the promoters' difficulties appear to result from one factor, the lack of a simple, clear, task-oriented role definition. All other issues (training, continuing education, supervision, information, and even logistics and payment mode) could be improved if this one issue were resolved. By contrast, the traditional birth attendant has very clear and precise tasks. The importance of this simple, task-oriented approach is evident in the results of the TBA evaluation which demonstrated that the TBAs are doing the few simple tasks taught. TBAs are also remunerated for the tasks performed. It should be noted that in its field visits the team found scattered instances of experiments and attempts to provide a variety of incentives to promoters and to define their tasks clearly. The Ica and Callao regions and selected other local sites are experimenting with these ideas and seem to be using promoters more effectively than the country as a whole. Cuzco is using health committees instead of health promoters, an interesting approach that deserves development and evaluation.

*The Ica region's drop-out rate has been reduced from 90 percent to 14 percent.

Recommendations - Promoters and Traditional Birth Attendants

Recommendation 4.6-6 to define the role of the promoter. The policy issue of the role definition of the promoter needs to be addressed by the MOH. The team questions the advisability of continuing training new promoters without first addressing this issue. Related to this, the team questions whether "promotion," which is the only "task" now agreed upon, is having any positive impact on the system and whether it is worth the investment being made.*

The following are strongly recommended for all projects using a promoter strategy if the performance of promoters is to be improved and they are to have any real impact:

a) The MOH norms for promoters should provide a clear, simple, task-oriented role that would include such activities as the distribution of ORS and specific contraceptives, prenatal care, etc. These tasks should be based on the needs of the rural and urban poor and not on professionals' competitive needs. Training for tasks could then be done on a modular basis based on the varied needs of the regions and could develop a permanent retraining focus.

b) After a policy is reached on promoters: 1) Develop an action plan to retrain promoters in a modular fashion; 2) develop a simple task-oriented modular training package which would be focused on providing continuing training so different modules can be used for different areas of the country; 3) develop standardized training materials in sufficient quantity; 4) train trainers in new approaches; 5) develop a simple information and tracking system based on tasks; and 6) reorient the supervisory system based on the new tasks using the information system.

Recommendation 4.6-7 on promoter incentives. Resolution of the remuneration and incentive issue is important. Given the current economic situation, it is unrealistic to assume that promoters will want or be able to work on a volunteer basis. If this issue is not resolved, the promoter program will continue to experience high drop-out rates and low performance.

Several different approaches to financial and non-financial incentives should be systematically developed, tested, and evaluated for impact. Several regions already are experimenting with some incentives for promoters. Such innovations should be identified and assessed for their potential usefulness. The approaches tested should include at a minimum a real attempt at establishing a revolving fund and teaching promoters how to reasonably establish charges for services. Charging for services will be much more effective after the role definition issue is resolved. The

*The estimated cost of initial promoter training is in the range of US$232 to US$632 per promoter. Thus, the total cost of "producing" the promoters already trained under the 219/230 projects ranges between US$347,000 and US$945,000. The total investment is considerably higher when all the other donor promoter training programs are also included.

possibility of making a policy of selecting outstanding promoters for training to become health auxiliaries should also be explored as an incentive. Additional TA to assist the Ministry in organizing its training activities is very important. Analysis of promoter incentives is needed, e.g., simple operations research studies to test different models currently being used. A model which might be tested as a way of enhancing the status of the promoter in the community is the use of promoters to assist in weighing or measuring children, or use of their homes as food distribution centers in USAID-supported nutrition and disaster relief operations.

(The evaluators were told in March 1985 that MOH has decided that promoters will not be paid. Consequently, it is essential to focus on non-monetary incentives to attract, motivate, and retain promoters.)

Recommendation 4.6-8 on the need for continual supervision and support. The final necessary ingredient for a successful promoter and TBA program is an effective supervisory system (see section 4.5). It is unreasonable to expect someone with only two weeks to one month of training in health tasks to continue to perform effectively without a system of continuing training, follow-up and minimal supplies.

Recommendation 4.6-9 to identify model sites or approaches. Identify sites that seem to be using TBAs or promoters more effectively or that are using innovations in task assignment, payment mechanisms, and supervision. Conduct small, simple operations research studies to assess real differences and identify the ingredients that seem to make the difference. Use successful sites for training or assess ways in which the successful ingredients can be incorporated into programs at other sites.

Recommendation 4.6-10 on promoters in urban areas. Health workers in urban areas suggested that urban dwellers, no matter how poor, seem to use existing health facilities rather than minimally trained community workers. Consider abandonment of the promoter program in urban areas if data from the nutrition and health survey confirm this, unless specific tasks related to immunization, prenatal care, ORS or contraceptive distribution can be developed for promoters. In urban areas, radio and other media probably are more effective for "difusión" than health information provided through promoters. Continue the promoter program in areas that already are using a specific task-oriented approach for promoters.

Recommendation 4.6-11 to concentrate TBA training in more traditional areas. Consider offering TBA courses only in more traditional areas or those areas in which the nutrition and health survey shows high use of TBAs to consolidate and improve performance of the TBA program.

Recommendation 4.6-12 for birth attendance training of other family members. Consider the feasibility of offering courses similar to the TBA course to fathers or other family members if survey results indicate high attendance of family members at births.

Recommendation 4.6-13 on translation of training materials. MOS should support development of training materials and instructions for TBAs in languages other than Spanish and Quechua for the relevant areas. Birthing kits to pregnant women with instructions could be an alternative to teaching family members.

Recommendation 4.6-14 on the use of radio messages. Explore the possibility of using radio on a pilot basis to inform communities of the presence of TBAs.

5.0 NON-MINISTRY OF HEALTH ACTIVITIES IN POPULATION/FAMILY PLANNING

5.1 The Private Sector

5.1.1 Private Voluntary Organizations (PVOs) Active in Family Planning

There are 143 Private Voluntary Organizations (PVOs) working in family planning and health in Peru.* Most are relatively small in scope and coverage and carry out fragmented activities. These activities range from combined primary health care and family planning services provided by organizations, such as PROFAMILIA, to natural family planning methods provided by the Asociación de Trabajo Laico Familiar (ATLF). These organizations do not frequently contact each other to share resources or experiences. INPPARES, the International Planned Parenthood Federation's affiliate, does provide some limited support to other PVOs, but currently is not acknowledged as a leader in this respect. There is also very little exchange between public and private sector entities. For example, many of the staff of the MOH facilities visited by the evaluation team were not aware of the private organizations that were providing health and family planning services in their immediate areas. The MOH does little beyond approving the PVO activities included under project 230. This approval process takes from two to eight months.

PVOs in Peru are major private sector participants in family planning efforts. Some twenty private and voluntary agencies carry out population/family planning activities. Some have received or are receiving funding under project 230, and others receive financing from other international donors, USAID/Washington, and PVO cooperating agencies like FPIA and Pathfinder. PVOs are involved in research, training, education, family planning service delivery, and population policy (see Table 22). It is estimated that approximately 75,000-100,000 persons obtain family planning services from PVOs. Coverage is mostly concentrated in urban and poor semi-urban areas, such as the "pueblos jovenes."

USAID and other cooperating agencies have provided one million dollars to PVOs and cooperatives in 1983 for family planning service delivery, training, policy development, and education. The team estimates that as a result of this support, 100,000 people received services at a cost of about US$8-10 per couple-year of protection. The independent contribution of cooperating agencies would raise the total cost by at least 25 percent. By comparison, the project 230 funds which directly supported the Ministry's activities in MCH/FP in 1983, plus the UNFPA's contribution for 1984 are estimated at US$2 million. The addition of the GOP's contribution would increase this amount. The estimated beneficiaries of MOH services were 175,000 people who received family planning services. This is a very rough estimate based on statistics for the first half of 1984 showing 100,000 new acceptors in Lima and 10,000 elsewhere. The estimate allows for continuing acceptors from past years and continued promotion in the second half of 1984. This would mean a cost of US$10 to 12, which is not drastically different from the cost of services through PVOs.

*USAID, "Dirección de organizaciones privadas voluntarias en el área de salud con trabajo en el perú," September 1983.

Table 22

Peruvian Organizations Receiving USAID and Cooperating Agency Support for Population/Family Planning

ORGANIZATION BY TYPE	Source of Support	
	USAID	Cooperating Agencies
Service Delivery		
Ministry of Health (13 regions)	x	x
Sur Medio Project (MOH)	x	x
IPSS	x	x
Carmen de la Legua		x
PROFAMILIA	x	x
INPPARES		x
SAN ALONSO		x
FENDECAAP	x	
Training (including service delivery)		
ATLF	x	x
Cayetano Heredia University*	NA	NA
Instituto Marcelino		x
Policy/Information/Research		
Consejo Nacional de Población	x	x
AMIDEP	x	x

*Receives support from the MOH.

NA = Information not available.

The family planning specialist of the evaluation team visited six PVOs involved in family planning/population activities. The organizations visited were not all funded under the project, but did represent a broad range of family planning activities. A structured interview form was used which included questions about contraceptive supply and source, reporting, type of service provided, number and kind of staff, funding source, population served, and actual number of clients served during the previous month.

The results of the survey are as follows:

a. Five of the six organizations visited provide family planning services; the sixth, AMIDEP, works in the population policy area. The five service organizations visited each stated that adequate contraceptive supplies were sometimes not available. Reasons given included problems clearing customs, cost, problems with local procurement, and bureaucratic complications in obtaining supplies from the MOH.

b. All service PVOs were providing more than one method of contraception in their programs. Three of them were operating community-based distribution systems (CBD) as well as clinical services. One PVO was conducting clinical training for other institutions.

c. Financial and service statistics varied considerably, reflecting different management styles and variations in the type of service delivered. Standard service definitions were not used, so it is not possible to compare the data from the different PVOs.

d. The six PVOs visited had a total of thirty-seven professionals and forty-four support staff plus CBD promoters. Nearly all professional staff were delivering services. The public sector institutions visited had many more support staff relative to the number of professional staff.

e. Ten to fifty percent of the organizations' budgets comes from foreign donor support.

f. There are an estimated 31,193 family planning acceptors receiving family planning services from these six PVOs, or 13.4 percent of the target population of 233,000 women of the fertile age group in the areas served by PVOs.

g. PVOs in Peru also are playing a less tangible but valuable role of pioneering with innovative initiatives which the government cannot or will not attempt. For example, almost all of the community-based distribution of contraceptives is done by PVOs.

5.1.2 Family Planning PVOs Funded by the Project

Three private sector organizations involved in family planning efforts which are being supported under project 230 are described below.

5.1.2.1 FENDECAAP - Federación Nacional de Cooperativas Agrarias Azucareras del Perú

FENDECAAP is an association of twelve sugar cooperatives in four provinces. The association has four of its own hospitals and eight clinics. In addition, there are 63 FENDECAAP health posts. The hospitals and health posts have a total of 112 doctors, 11 pharmacists, 18 midwives, and 36 nurses. Contraceptives are provided by the MOH.

FENDECAAP was not originally included in the Project 230 Agreement because of problems within the organization at the time the agreement was approved. However, FENDECAAP later requested assistance from the MOH and USAID to include basic health care and family planning as part of the medical services provided to its members and their dependents.

FENDECAAP is now operating well. As of June 1984, after only nine months of operation, staff had been trained in family planning, community education was ongoing and 1,363 new acceptors had received services during the prior three months. FENDECAAP had also provided information and educational materials on family planning to its clients. Project 230 funds support two full-time staff members. The others are paid directly by the cooperative association. USAID officers are pleased with FENDECAAP performance and consider it a good example of effective cooperation between the private and public sector. The MOH provision of contraceptives will require monitoring to assure that contraceptives are made available to FENDECAAP.

> Recommendation 5.1-1 regarding FENDECAAP. Continue and expand support for FENDECAAP due to its positive performance, low overhead, and high potential to reach potential acceptors outside Lima.

5.1.2.2 Asociación Multidisciplinaria de Investigación y Docencia en Población (AMIDEP)

AMIDEP is a non-profit organization which studies and disseminates demographic information. It publishes a bi-monthly bulletin which is widely read in Andean countries. It has published six books and numerous articles, conducted six seminars on population for high level personnel in government and community leaders, and supported twenty-six demographic studies. AMIDEP is well established, having been organized seven years ago with support from USAID and the Ford Foundation. Although Ford no longer provides support, the organization has received a total of US$209,350 under project 230 during the 1982-84 period. During 1984 AMIDEP activities will be expanded to include support to university libraries for establishing population sections. AMIDEP also provides materials on population issues to the MOH for its distribution.

The evaluation team reviewed the materials produced by AMIDEP and found their content appropriate and the design and printing to be of high quality. It is the team's opinion that continued USAID support of AMIDEP is justified on the basis of what the organization has accomplished. AMIDEP may be particularly helpful when the new government administration assumes power to make it aware of population issues such as the problems created by the

pressure of population growth in Peru and to encourage a positive approach to population/family planning activities.

Recommendation 5.1-2 regarding AMIDEP. Continue support for AMIDEP.

5.1.2.3 Peruvian Association of Medical Schools (ASPEFAM)

Under the original project agreement, US$260,000 was to be granted to the Peruvian Association of Medical Schools (ASPEFAM) to expand family planning services in four hospitals in its delivery system and to provide professional training to medical students and staff in one-third of the major area hospitals outside of Lima.

ASPEFAM received money in the first year of the project, but ASPEFAM never developed or submitted a suitable proposal to participate further in the project.

Recommendation 5.2-3 regarding ASPEFAM. No further assistance is recommended at this time.

5.1.3 Problems and Opportunities for Improved Service by PVOs

The PVOs interviewed reported difficulties in the implementation and expansion of their family planning activities. Many of these problems are similar. PVOs have problems getting contraceptives (either imported or from from the MOH), difficulty in preparing financial reports and service statistics, problems caused by the negative effects of inflation on their costs, difficulty in obtaining funding for continuing or expanding their activities, and difficulties obtaining approval from the MOH to operate. Obtaining approval to provide surgical contraception outside MOH facilities has been a major problem. The MOH has yet to approve a request by PVOs to provide this needed service. The resulting lower access to this service affects most severely high risk, low income women. Many of these problems are administrative and are potentially solvable with some technical and financial assistance.

Most of the PVOs depend on outside financial support. There is little opportunity for Peruvian PVOs to support themselves from local contributions. Also, it appears that cooperating agencies may soon decrease their financial support to Peruvian PVOs. Thus it seems likely that these PVOs will require outside financial assistance for a considerable period if they are to provide effective family planning/population-related services.

Recommendation 5.1-4 regarding management support for PVOs. Study the feasibility of establishing a management support organization for Peruvian PVOs comparable to the Asociación Demográfica de Costa Rica. A study should verify demand for such services, the best means to provide management assistance, the estimated costs, and the potential benefit in expanded coverage and reduced unit costs. The Asociación Demográfica de Costa Rica is responsible for central accounting and the distribution of funds and supplies for a number of PVOs providing family planning services in Costa Rica. The cost of establishing such an agency is estimated to be four to seven percent

of the total donated funds in family planning and could save 20 percent in operations as well as improve services. This cost could be paid initially by the cooperating agencies and donors as a part of their grants to the recipients. The kinds of services this type of organization could provide in Peru include management training, help in rapid clearing of contraceptives from customs, assistance in procuring local supplies at lower prices through bulk purchases, help in developing proposals for funding, obtaining international or local funding, designing ways for better utilization of personnel, establishing uniform service statistics, and developing financial records and logistics systems.

Recommendation 5.1-5 regarding dollar funding of PVOs. Allow PVOs and other private sector organizations to receive grants in dollars from international cooperation agencies and convert them as needed in order to avoid the disruptions caused by the rapid inflation in Peru today.

Recommendation 5.1-6 regarding surgical contraception. Allow competent private clinics to provide surgical contraception to high risk women defined by the norms currently in force in the MOH. As noted, these norms do not provide clear guidance for the private sector. It is believed that demand will exceed the public sector's ability to provide this service. Therefore the team recommends that procedures for surgical contraception be reviewed, clarified, and simplified so these services can be provided through private sector channels.

5.1.4 Other Private Sector Channels for Family Planning Services

USAID and cooperating agencies have concentrated their assistance on PVOs with less attention to developing channels of distribution through profit-making businesses, pharmacies, insurance companies, cooperatives, pharmaceutical producers and distributors, hospitals, the social security system, doctors, and other health professionals outside the MOH. The resources for this evaluation did not permit time to systematically identify promising opportunities for private sector service delivery, but the evaluation of the project makes it appear appropriate to open multiple channels of distribution for contraceptive services rather than depending exclusively on the MOH. The "Social marketing" program for contraceptive services begun a year ago is appropriate to the need.

There are innovative and potentially productive approaches for providing needed family planning services in Peru through the private sector. Some approaches, such as commercial retail sales of contraceptives, have a well defined approach, but there are others that need systematic development. The team notes a few ideas from our very preliminary review of current efforts in the private sector in Peru:

- Prepaid family planning services could be established through pharmacies and private physicians. Contraceptive methods would be provided on a prepaid annual basis, 13 cycles of orals and appropriate quantities of other methods as desired. The client would have a card which would be punched at every visit. This

approach would have advantages for the provider and for the client. For example, a pharmacy could anticipate regular repeated business from the clients who would come to the establishment at regular intervals and could purchase other products or services at the time of the visit. Also, better continuation rates could be expected because the client would tend to obtain what was already paid for if an annual fee were paid.

- o Contraceptives could be sold on a commission basis through the "informal sector" such as street vendors and "stop light sales persons," taxi drivers, etc.

Recommendation 5.1-7 regarding a project for private sector family planning activities. USAID should consider developing a separate project to assist private sector family planning activities. The major reason for a separate project is the long delay presently experienced by private organizations providing family planning services under project 230 to obtain approval of operational plans from the MOH. In some cases this delay has even forced them to stop operations for lack of funds. Another reason for a separate project is that it appears that cooperating agencies may be decreasing their funding support for projects in Peru, which could cause a decrease in the level of effort by the grantees. An assessment of funding needs is necessary so that momentum in the private sector is not lost. Promising innovative approaches should also be considered for assistance.

Recommendation 5.1-8 concerning public and private sector cooperation. Cooperation between MOH and the private sector should be encouraged. There are currently several examples of such cooperation, such as the use of MOH contraceptives and facilities by the National University of Trujillo and the MOH provision of contraceptives to FENDECAAP.

5.2 Peruvian Non-MOH Public Sector Health and Family Planning Agencies

5.2.1 Instituto Peruano de Seguridad Social (IPSS) Family Planning Program

The IPSS serves a population of approximately 1,400,000 in some forty polyclinics and operates hospitals in five health regions, as well as the main 1,500 bed hospital and satellite clinics in the Lima Metropolitan Area. According to the current estimates, the IPSS has responsibility for providing health services to 20 percent of the Peruvian population. Those covered under these services are workers, their spouses, and children up to six years of age.

The IPSS system is currently undergoing serious financial problems. Nevertheless, its employees are better paid than those in the MOH system, and its facilities are newer and better constructed. An Executive Board makes policy decisions which are carried out by the program staff.

USAID began support for family planning assistance by the IPSS in 1984, integrating it into project 230. This assistance of $60,000 plus

contraceptives, medical equipment and transportation pays for contraceptives, other commodities, and technical assistance. With this support, family planning services were provided to 11,107 clients during the first six months of 1984.

The family planning activities in IPSS are currently being managed by one physician, two nurses, and a midwife in the Lima Metropolitan Area and there are plans to expand nationwide. More support staff certainly will be needed along with more technical staff when and if the program expands. An excellent overview of the IPSS family planning activities is available in a report by Melody Trott, ST/POP/IT, dated October 20, 1984.

Dr. Nazario Carrasco, the physician in charge of the IPSS's family planning activities, told the evaluation team that considerable progress is being made despite the lack of support staff, poor logistics, and complicated clinic procedures. He expressed a keen interest in surgical contraception and indicated that attempts are being made to amend the Peruvian Civil Code to allow wider use of this method. Within IPSS much of family planning activity is being done in OB/GYN departments. The project now has one laparoscope and four mini-lap sets which are being used to the maximum.

Recommendations - IPSS Family Planning Program

Recommendation 5.2-1 regarding the Trott report. The team concurs with the four low cost, short-term recommendations which appeared in the Trott report: 1) provision of management training, 2) simplification of clinic practices and reporting, 3) improvement of purchasing and supplies management, and 4) providing support for outreach efforts.

Recommendation 5.2-2 regarding post-partum surgical contraception. USAID should also consider encouragement of post-partum surgical contraception in the IPSS service system. Training could be provided through JHPIEGO or IAVS. OB/GYN physicians in IPSS could be provided training in surgical contraception as well as equipment. The project director should also be sent for training in family planning program management. Efforts should be made to secure a stronger commitment to support family planning from the IPSS Executive Board. Perhaps the Consejo Nacional de Población could be helpful in this regard.

Recommendation 5.2-3 regarding cooperation between the MOH and the IPSS. Under project 230, USAID should encourage the MOH and the IPSS to sign an agreement whereby the Ministry of Health provides USAID-financed contraceptives to IPSS in those regions where IPSS has medical facilities. It is feasible for the MOH to do this since there is no lack of contraceptives at the regional level and there is a precedent in Trujillo, where the MOH is providing contraceptives and use of its facilities to a non-MOH facility.

Recommendation 5.2-4 concerning technical assistance for the IPSS. It is recommended that the Westinghouse logistics adviser spend one or two months at IPSS to help develop a better logistics system.

5.2.2 Consejo Nacional de Población

The Consejo Nacional de Población (CNP) was created in November 1980. Its Director is appointed by the President. The CNP's mandate is to coordinate all population matters in the country. Specifically, it has five functions: 1) analysis, formation, and evaluation of Peru's population policy as it relates to social and economic development; 2) promotion and coordination of public and private efforts in population; 3) promotion and implementation of studies in population; 4) provision of support for the distribution of research documents and statistics on population; and 5) representation of Peru in international population matters.

The CNP has a Director and an Advisory Council of fifteen representatives of the various Ministries, Universities, IPSS, INE, and the Medical Union. The CNP has an executive committee and an Executive Director who manages an evaluation section, a public relations and information section, and an administrative section. The CNP has a total of approximately fifty employees. USAID has committed funds for institutional support almost from CNP's inception. Under project 230, USAID has provided US$475,500 for 1982 through 1985.

The CNP has provided a number of information and educational materials on demographic statistics and family planning. It published six articles on topics such as urban immigration and "Family Planning Policy and Programs in Peru," conducted studies on population dynamics in Ica and Arequipa, held a conference on population for journalists, and conducted a joint project with the Ministry of Education in the area of adult literacy. The CNP has also recently completed a study on the status of family planning statutes and information in Peru.*

The CNP has provided access to various governmental institutions and ministries so that problems relating to population can be identified and solutions sought. For that reason, USAID's support is valuable. However, the CNP is now established and directly connected to the President's Office; it may be subject to political capriciousness and its role expanded or decreased according to the wishes of the government in power.

The CNP does not seem to be stimulating private sector involvement in family planning activities.

> Recommendation 5.2-5 regarding the Consejo Nacional de Población. USAID should continue to support CNP, but limit its support to those specific activities which directly improve programs in Peru. The CNP should be encouraged to obtain institutional support from other sources. An example of a specific activity worthy of support might be the analysis of data obtained from the national nutrition and health study which could be used to improve family planning programs.

*Sobrevilla, Luis, and Pizarro, Luis, "Información y Estadísticas sobre Planificación Familiar," October 1984.

5.2.3 Instituto Nacional de Estadística (INE)

The National Statistics Institute (INE) is the major source of demographic and other socio-economic statistics for the country. It has received funding from UNFPA, primarily to support the 1981 census.

In 1982, at the request of the INE and the MOH, USAID agreed to provide US$60,000 for a study of a demonstration project in four departments. The project was a "follow-on" of an earlier effort started in 1978 by the INE with technical assistance from the U.S. National Center for Health Statistics. Under the project a new vital registration system was developed which the INE wished to test in demonstration areas. The objectives of the project were to expand registration of vital statistics, to improve the quality of the data, and to reduce processing time.

As noted earlier, the INE is also responsible for the National Nutrition and Health Survey (see section 4.4.3). The survey includes approximately 18,000 households, gathering information on household structure, mortality, and morbidity, and examining the nutritional status of children within the household. The field work was completed in December 1984 and data processing is under way.

The INE also assists in the collection and analysis of data on population growth. An example is their participation in the 1981 Contraceptive Study with Westinghouse Health Systems. The INE also publishes current demographic profiles. In this respect it makes a valuable contribution to population information and supports the government's population policy. The Director of the INE serves on the advisory committee of the CNP.

6.0 TECHNICAL ASSISTANCE

In the Project Agreement for project 219, USAID originally budgeted US$210,000 for a total of 28 months of technical assistance. The specialties programmed included fiscal management (3 months); logistics (2 months); health, family planning, training, and supervision (5 months); evaluation and studies (6 months); and nutrition planning (12 months). It became apparent that difficulties were being experienced in completing the conditions precedent and in beginning project implementation, so the amount of technical assistance was increased and the categories of TA modified to correspond more closely to the needs identified during the initial project phase. Management Sciences for Health and several short consultants provided technical assistance at the beginning of the project. During a six- to twelve-month period without technical assistance, there was almost no progress on project implementation. USAID decided there was a strong need for TA and proposed a plan to MOH. The Ministry cut the amount of proposed TA by half, and in April 1983, Westinghouse Health Systems was contracted to provide this technical assistance. More recently the TA component was increased further to support six regional advisers, because problems in project implementation were identified at the regional levels. The technical assistance package presently approved for both projects is budgeted at US$2.73 million.

The technical assistance provided as part of projects 219/230 is classified under three rubrics: long term assistance, short term assistance, and special studies. Most of the assistance has been provided through project funds, but a few related studies have been supported from non-project funds.

The long-term assistance consists of 221 months broken down into 37 months for the chief of party, 30 months for a logistics adviser, 10 months for an information adviser, and 24 months each for 6 regional advisers plus secretarial and administrative support.

Short term assistance has been provided for the supervision, training, information system, and finance components of projects 219/230 for a total of 23 person months. Funds have been exhausted for this category of TA.

Short term studies and evaluations for projects 219/230 are summarized in Table 23. At least fourteen studies related to elements of projects 219/230 have been completed with an investment of 90 person months. These studies provide an intensive view of program accomplishments and constraints and offer more than 154 recommendations for program improvement. In its review of project documentation, the team noted that a number of the same recommendations have been made by different studies over the course of the past five years. Many recommendations have been implemented. It was not clear to the evaluators why many other recommendations have not been followed. It would appear that duplication of efforts might be avoided by keeping better records of the review process by USAID and MOH by evaluating the appropriateness of the recommendations and establishing priorities for action. In this mid-term evaluation, the evaluation team returned to Lima with the draft report to build consensus among USAID and MOH about the appropriate actions, taking into consideration the findings, conclusions, and recommendations of the evaluation. The results of this review process in March 1985 are documented in this final report.

Table 23

Technical Assistance and Studies Related to Projects 219/230
Funded from Project and Non-Project Funds

SUBJECT OF STUDY/TA	SOURCE OF FUNDS	PERSON MONTHS OF EFFORT	NO. OF RECOMMEN-DATIONS
Extension of Integrated Primary Health Care (June 1980)	219	7.5	NA
Evaluation of Midwife Training Program (April 1983)	230	15	NA
Case Study of MCH Activities in Sur Medio (PROSMIP) (May 1983)	224	3	6
An Assessment of Private Family Planning Programs in Peru (June 1983)	PD&S	4	18
Investigation of Health Services Delivered in Three Elements of the Peruvian Private Sector (November 1983)	PD&S	3	NA
Family Planning Communication Technical Assistance Mission to Peru (November 1983)	AID/W-PCS	0.5	NA
Report on Information Systems (December 1983)	*	3	NA
Report on Supervision Systems (2 reports) (December 1983, September 1984)	*	5	2
Report on Human Resources Development (May 1984)	*	8	13
Evaluation Health Promoter Program (June 1984)	219	16	26
Report on Post-Graduate Public Health Training and Research in Selected Peruvian Institutions (July 1984)	PD&S	1	0
Report on Information Systems (July 1984)	*	10	8
PRITECH Disease Control Strategy Assessment (October 1984)	AID/W	6	11
Report on Financial Systems in Primary Health Care (2 reports, Oct. 1984)	*	6	4
Others		-	58
TOTAL		88	146

NA = Not applicable
* = Westinghouse reports

A review of the project's revised technical assistance package suggests that in general it corresponds to project needs. Each of the major project components has received some type of technical assistance. The technical assistance appears to have been critical to improving project implementation. The Westinghouse long term advisers have exercised an important facilitation, coordination, and communication role among USAID officers, central and regional MOH officials, other donors, and short term consultants. The short-term consultants have provided crucial help in the areas of training, supervision, finance, and information systems. The regional advisers are expected to play a key role in strengthening the project at the regional level. Many regional MOH officials expressed appreciation for the positive contribution of the advisers. USAID is to be commended for its responsiveness in increasing technical assistance for the areas of need identified.

Focus on two important areas would increase the positive impact of technical assistance on the project. First, more short-term technical assistance is needed, and second, an adjustment in the current activity and process-oriented approach utilized by the long term technical advisers would increase the effectiveness of the TA.

The need for increased short-term technical assistance has been noted in each of the appropriate sections of this report, and in summary includes the following areas:

Specifically, problems in the Ministry's logistics and financial systems seriously affect the delivery of primary health care services. Both require further assistance for improvement in their operations. A short term consultant has analyzed the financial system, uncovered bottlenecks, and made recommendations for practical improvements. The next step should be the approval and execution of specific measures to speed the flow of funds to the regions. This probably will not happen without further assistance. Additional technical assistance is also necessary to help the MOH develop an efficient system for procurement and distribution of commodities. The program management area also would benefit greatly from additional technical assistance, perhaps in the form of training sessions for top and middle level administrators. These issues are explained in detail in the sections of this report dealing with these subjects. USAID has financed computer training for several MOH officials at ESAN.

Additional TA to assist the Ministry in rationalizing its development of promoters is very important, as noted in the discussion of training. Analysis of promoter incentives is needed, e.g., simple operations research studies to test different models currently being used. A model which might be tested as a way of enhancing the status of the promoter in the community is the use of promoters to assist in weighing or measuring children, or use of their homes as food distribution centers in USAID-supported nutrition and disaster relief operations. The development and implementation of a revolving fund for the promoter program will also require assistance. Action in regard to promoter incentives deserves high priority. Please note related material in Section 4.6.

In summary, there will be a continued need for short term TA throughout the remainder of the project. The team recommends that the MOH and USAID make a list of tasks to be accomplished and set priorities after review of this evaluation and other reports. Due to the difficulty in locating qualified consultants and processing the related paperwork, needs for technical assistance must be anticipated well in advance.

An output-oriented role for the advisers is recommended. The facilitative role of the long term advisers has been very important. The pace of project implementation has improved significantly because of their contribution to the project. It was premature to evaluate the outputs from the work of the regional advisers since most of them did not begin work in their positions until June 1984 and the evaluators were observing results in November 1984. The job descriptions for the long term advisers are very broad and general and oriented to activities rather than achievements. However, providing clear scopes of work with clear outputs and a precise purpose will help the project achieve useful results by focusing attention and effort on the agreed targets. It will help the Westinghouse team clarify what they must have from the MOH and USAID to achieve the projects' planned outputs and avoid criticism later. This will facilitate a meaningful evaluation of the projects' impact on the system at the end of the project by providing a realistic standard of performance instead of vague and romanticized ideals. In logical framework terminology, the advisers need an expected "end of project status" (EOPS) and clearly defined output targets.

The Westinghouse quarterly reports reflect this activity orientation. Instead of achievement-oriented reports, the current reporting is primarily anecdotal and descriptive and the reports are long and wordy. The reports would be more useful if they were brief and concise. The contractors' consolidated report might also be more helpful if it were given a brief 5-10 page format. It also would be helpful to end the report with a short summary of problems, the necessary steps planned to correct them, and identification of the action agents. More important, the reports should be tied to reoriented targets in the new scopes of work (i.e., intended outputs).

The advisers should focus on a limited set of high priority tasks and measure a few basic performance indicators at each program site. The advisers would work with MOH personnel to collect and interpret data as is presently being done in the Ica region. Such focused assistance should improve management. At the regional and area hospital levels, advisers should help MOH personnel to compile, analyze, and use the data to permit relevant comparisons between reporting units. Emphasis should be placed on using the data to evaluate performance in the key primary health care service areas (e.g., ORT, prenatal care, vaccinations, family planning, and growth monitoring) and on specific project output indicators. In this manner they can detect areas where guidance, training or other resources might best be allocated.

Finally, the team suggests that short term consultants should work at both the national and regional levels as much as possible. Their scopes of work should normally allow for two periods of work. The second period should be a follow-up visit to assess progress on solving the problems identified and solutions developed during the first visit.

In March 1985, the evaluators were asked to provide some suggestions for developing output-oriented scopes of work. Suggestions follow:

1. Program at least two-thirds of the advisers' time for achievement of clear outputs directly related to high priority objectives of MOH in the area served. This leaves a maximum of one-third of the advisers' time for unavoidable tasks, miscellaneous services, and for long term investments that may not show up in any short run indicators but deserve support. This will probably mean choosing two to four primary tasks. Additional tasks can be added to the list to be done "to the extent that time and resources permit."

2. Set priorities based on consultations with the MOH counterparts who are being assisted. Be sure that the adviser is working on tasks that the counterpart considers important, and that the counterpart will do everything necessary from his side to ensure that the advisers' work will have a positive impact on the PHC services provided. If agreement cannot be reached on what the adviser should do, use the adviser somewhere else.

3. Set realistic targets rather than romanticized dreams that no one expects really to achieve. For example, a target could be that 90% of the PHC facilities in the region have at least 60 days supply of ORS packets and contraceptives to distribute.

4. Start out deciding what problems or opportunities are very important (e.g., ORT, family planning, and immunizations) and how much progress is feasible. Some problems will be too difficult with the resources available. Identify all the major tasks that are necessary and sufficient to make a major improvement in each situation. Look for problems that are manageable and that need the initiative, energy and technical assistance of an adviser, who is a resource available to MOH for a limited period of time and at a relatively high cost.

5. Identify what must be achieved with the adviser's assistance using an objectively verifiable indicator of its achievement, e.g., (i) information available on stocks and consumption of ORS, contraceptives, etc. at all facilities in the region within fifteen days after the end of the month; (ii) storage problems in five health centers, seven posts and one regional center are corrected to permit at least ninety days stocks under recommended conditions; (iii) repair two broken trucks and then maintain a fleet of at least three operational trucks at all times; (iv) clarify reordering procedures and ensure that all facilities use the system properly.

6. If the task is too big to achieve in a single step, break it into several time-phased steps and set specific target dates to achieveeach interim step. For example, work first with one-third of the health facilities to get the system working smoothly, then another third, and then the remainder. Another alternative is to handle the trucks and storage first, then the procedures, and then the training.

7. Select some tasks that will show prompt results to build confidence and momentum. Work together with counterparts to get more tasks done and for "institution building." The service delivery statistics should improve, and the improvement (or lack thereof) should be used to modify plans and motivate the staff.

Recommendations - Technical Assistance

Recommendation 6-1 regarding specific areas for technical assistance. Increase technical assistance in the priority areas identified in this report.

Recommendation 6-2 regarding "performance boards." Westinghouse would benefit from a "performance board" as recommended in 4.1-2. A national level "performance board" with the same data as used in DSMIP and USAID would be appropriate for the national level adviser. A regional "performance board" should be considered for each region or group of health regions served by a Westinghouse adviser. Estimates of coverage are desirable and should be feasible with the technical talent available to Westinghouse.

Recommendation 6-3 regarding scopes of work and reporting. The scopes of work of all long term advisers should be reviewed with the MOH and USAID, and their work should focus on achieving specific high priority outputs. The quarterly reporting system should be simplified and modified to focus attention on progress toward achievement of the planned outputs.

Recommendation 6-4 regarding periodic review of data with regional and local MOH personnel. The Westinghouse regional advisers should help MOH regional staff begin systematically collecting a minimum set of data on five or six primary care service indicators. They should use this as an opportunity for teaching regional and local personnel how to use data for management purposes, for continuing education, and for assisting the regional staff to solve problems and to establish priorities for action while always respecting the established channels of MOH.

Recommendation 6-5 regarding the use of evaluation reports. The MOH and USAID should continue the systematic review process already started with regard to this proposal, i.e., identify promising recommendations, dialogue and "consensus building" about specific actions to be taken. Short- and long-term action plans should be developed for implementation of specific recommendations selected by the MOH and USAID. (In March 1985, the evaluators noted that action had been initiated already on various recommendations made in the working papers of November 1984, and the written draft of January 1985. The action-orientation is commendable.)

7.0 SUMMARY OF RECOMMENDATIONS

This Chapter brings together all the recommendations of the report in one place for the convenience of the reader, although a few of them are abbreviated here. The recommendations are numbered according to the section of the report where they appear in full together with the supporting analysis. For example, Recommendation 4.1-2 is the second recommendation in section 4.1. At the end of Chapter 7 the institutions involved in each recommendation are identified in Table 24.

7.1 Summary of All Recommendations from the Evaluation

MOH Family Planning Services Recommendations

Recommendation 3.1-1 regarding improved provision of family planning services. Make orals, condoms, creams, and tablets available at all health posts. Allow all the health staff, including auxiliaries and nurses, of all facilities to distribute orals to continuing users. Unless non-physicians are allowed to resupply continuing users with orals, use of this important contraceptive method will probably remain low in areas without doctors.

Recommendation 3.1-2 regarding MOH Norms for service providers. Paragraphs 1.1.17 and 1.1.18 should be combined and changed to clarify that those seeking family planning services for their first time be counseled by a person trained in counseling in the various contraceptive methods and be provided a temporary method such as condoms or foaming tablets. If the client wants a more permanent method such as orals or an IUD, an appointment should be made with a person qualified to provide this service. It should also include a statement that a person requesting service for the first time be provided a temporary method regardless of where they live...

Recommendation 3.1-3 on increasing support and assistance to hospitals for family planning services...There seemed to be much interest on the part of the MOH hospital staff and selected MOH facilities to provide family planning services, and efforts should be made to find ways to support these interested groups. Service statistics indicate that hospitals are already major providers of family planning. More family planning equipment, supplies, and training should be given to hospitals where the program is more productive without neglecting health posts and health centers.

Recommendation 3.1-4 on quantities of contraceptives distributed. Inform MOH staff at all facilities that plenty of contraceptives are available, and that they should distribute contraceptives in larger quantities per visit to each acceptor to foster higher continuation rates. This is especially important when acceptors have to travel long distances to obtain family planning services. Specifically, it is recommended that users at each visit be given the following: three cycles of orals, two dozen condoms, two tubes of cream spermicide, and two tubes of vaginal tablets.

Recommendation 3.1-5 on training in family planning methods. Strengthen training of all MOH personnel in family planning methods, particularly health post personnel.

Recommendation 3.1-6 to evaluate current community-based distribution efforts. Assess the community-based distribution experiments in Callao and Ica for their effectiveness. If warranted, use these sites as training sites for other areas which have the potential to implement the same model.

Oral Rehydration Therapy Recommendations

Recommendation 3.2-1 to develop an action plan for ORT. The MOH should continue to give high priority to ORT, and USAID should continue to support MOH efforts because of the high potential for reducing mortality with ORT. An action plan for more effectively extending ORT to the community level should be prepared without making it into a vertical program. ORT should continue to be an integral part of the PHC strategy.

Recommendation 3.2-2 regarding local production of ORS. Pursue any opportunities to increase Peruvian production, lower costs, and encourage the passing through of the cost savings. For example, WHO has recently approved the preparation of ORS with a citrate base; since citrate is available locally, it might reduce the cost of production significantly. Several Peruvian scientists have conducted studies on ORS. These scientists should be brought together with private sector representatives interested in production of the new formula to assess the feasibility of production in Peru.

Recommendation 3.2-3 to educate pharmacists and physicians. A program to educate pharmacists about ORT and the WHO standards for ORS should be considered. The public is accustomed to buying medications from private pharmacies with a physician's recommendation, so they are also likely to go to pharmacies for ORS. There may be ways to integrate pharmacists into the advertising and education of communities about ORT. A promotion effort through the Colegio Medico to reach MDs deserves exploration.

Recommendation 3.2-4 on promoting homemade solutions. Standardized and medically appropriate information about home-made solutions should be prepared and distributed to health centers, health posts, and promoters. Similar information should be prepared for broader public dissemination using mass media (especially radio), particularly for use in areas where the distribution of ORS packets will continue to be deficient, such as where the population is highly dispersed.

Environmental Sanitation Recommendations

Recommendation 3.3-1 to consolidate environmental sanitation activities. Consolidate environmental sanitation activities by completing activities already initiated and reprogramming the

remainder of project 219 environmental sanitation funds into regions not covered by the larger sanitation project or into other project activities.

Recommendation 3.3-2 regarding study on the type of latrines. Conduct a study of preferences regarding type of latrine to increase the use of latrines.

Recommendation 3.3-3 regarding USAID support. Increase USAID support of new environmental sanitation and rural water supply projects.

Recommendations - Community Education

Recommendation 3.4-1 regarding health education materials. The MOH should make a commitment to purchase, produce and distribute a sufficient quantity of health education materials to all levels of the PHC system. On a routine basis instead of on a one-shot or sporadic basis, the Spanish Education materials being made available to the area hospitals should be made available to health centers, health posts, and promoters.

Recommendation 3.4-2 to increase use of radio for health education. USAID should consider supporting development of regional radio campaigns in ORT, immunizations, prenatal care, and family planning and supporting the planning for ongoing, regular, periodic radio spots and other types of radio programs in the different indigenous languages. The messages and tapes developed in the mass-media campaign should be sent to the regions, and funds should be made available to allow regions to program spots on local radio stations and in local languages. Radios are available where health personnel will not reach in the near future. It appears to be an underused and potentially very effective medium for health messages as it is in messages for commerce, politics, and agriculture. The team suggests assessment of the cost-effectiveness of television media campaigns versus frequent regular spots on radio in urban and rural areas for future programming.

(In March 1985 it was decided that the program for mass media will continue. An increase in the use of radio will be considered when there are evaluation results in July 1985. Tapes can be sent to the regions for local programming.)

Recommendation 3.4-3 to coordinate community education with delivery of services. Link and coordinate health education and media efforts to stimulate demand in a timely fashion with the providers of related services and with the delivery of supplies (such as ORS and contraceptives).

Project Management and Admininstrative Structure

Recommendation 4.1-1 regarding a PHC management team for Peru's primary health care program. Reorganize present personnel with responsibility for overseeing PHC activities into a PHC management coordination and improvement team for PHC, including but not limited

to projects 219/230 and 224. The team should include officials from the central Department of Projects (DSMIP) and the Regional Coordinators of all participating regions. The PHC team should improve PHC activities, including financial and logistics problems, work towards setting realistic performance targets, collect information to be analyzed to improve management, and work to improve reporting to the MOH and international agencies. The PHC team should avoid becoming a new obstacle to the efficient progress of plans and requests. The main thrust of the recommendations in other sections is to delegate greater responsibility to the regions. The PHC team should become a source of assistance to the regions, not a new layer of review and approval above the Regional Director.

People from the successful project teams for Ica, Piura, Trujillo, Callao, etc., should be included in the PHC team. This will ensure that some members of the team have had a successful experience as part of a PHC team.

Special training for the PHC team would be useful to strengthen their knowledge and skills and for "team building". The training might include a workshop on setting objectives, clarifying the PHC team role relative to toher PHC organizations, setting realistic PHC performance targets, and mobilizing resources as necessary.

The Westinghouse advisers should participate in the training as trainers and/or as participants by accepting a collegial role on the team. They should be available as a resource to help accomplish a few high priority tasks requiring Westinghouse assistance. This kind of collegial dialogue should generate useful tasks for the Westinghouse team.

The training workshop might also develop better work distribution for the PHC team related to the coordination and management improvement work that the team should implement. This includes planning, control, and evaluation of PHC activities for problem identification, resolution and any required reprogramming.

(In March 1985 the evaluators were informed that seminars are being pushed now with Ica people coming to Callao, Callao to Ica, Piura, etc.)

Recommendation 4.1-2 regarding "performance boards" A clear and relatively simple technique for reinforcing an "output orientation" is a "performance board" for DSMIP and for the Vice Minister as well as for the offices of USAID, Westinghouse, and other offices involved in PHC. A "performance board" is used to monitor the status of the project focusing attention on indicators of PHC services to the population in need of health care. Table 1 of this evaluation illustrates the kind of indicators- ORS packets distributed, prenatal and post natal consultations, new family planning acceptors (and active contraceptive users), children protected against polio, etc. Most of the data are available at the hospital level even though they are not widely used.

Similar "performance boards" for the regional, hospital, health center, and health post levels are both useful and feasible. One evaluator saw performance boards in Panama years ago displayed in the waiting room of health centers together with the budget for the health center; it made transparent to the patients the inputs and outputs of "their" health center.

The next level of sophistication in a "performance board" is to plot targets for each indicator, e.g., show last year's actual monthly average and monthly targets for the current year if data are collected monthly, so that performance can be easily compared to the targets.

The third level of sophistication, also well within the capabilities of Peru's MOH, is to estimate the size of the target population for each kind of service and monitor the "coverage" indicators. Some technical guidance may be needed to estimate the target population and procedures for estimating coverage correctly. It may be best to start out using coverage indicators only for management purposes at the higher levels in MOH and at USAID since very low coverage may be discouraging for field staff. Once there is positive momentum in several areas and coverage is improving, introduce the coverage indicators to give a sense of perspective about the magnitude of the task of providing adequate coverage to the massive population in need of PHC services.

Recommendation 4.1-3 related to adding one USAID officer for primary health care work. USAID should consider adding one officer to the Health and Nutrition Division to assist in PHC activities in the Health and Nutrition Division. An assistant to help with processing project documents (and with simplifications of procedures on the Peruvian side) should free the Project Manager to participate more in other aspects of the project and to promote and coordinate other PHC activities.

Recommendation 4.1-4 regarding setting priorities and output targets for USAID contractors. Establish clear output targets for the Westinghouse contract resulting from a dialogue including USAID, Westinghouse, and the MOH. There is sufficient experience to identify potential targets, judge what is realistic, and set priorities. This process should orient the Westinghouse team toward some specific realistic output targets now while they have discretionary resources. Some suggestions regarding output targets for the Westinghouse advisers appear in Section 6.

USAID would benefit from "performance boards" in the office of the Project Manager and the Division Chief. See Recommendation 4.1-2 regarding "performance boards."

Recommendation 4.1-5 regarding financial controls in future health programs. In preparing the project paper for follow-up projects supporting PHC, USAID should analyze the need for and feasibility of modified financial procedures conducive to decentralized operations by MOH. For example, consideration might be given to using an

auditing firm in Peru, working for USAID or working for GOP to go to the regions as necessary for financial management and control.

Recommendation 4.1-6 regarding the participation of regional personnel in the planning process. Involve regional personnel more in planning. The GOP should review its procedures for requesting the points of view of the professional personnel in regional offices of the Ministry to determine: a) to what extent these procedures contribute to plans that are later considered to be unrealistic by operating personnel, as well as to the loss of motivation on the part of the regional personnel, and b) how the opinions and perspectives of the regional offices can be obtained systematically and integrated into the plans of the General Planning Office...

The scopes of work of the six regional Westinghouse consultants should give high priority to assisting the health officials in the development of data on costs, unit costs, and performance as well as to clearly communicating to the General Planning Office the true situation and relating actual practices to health priorities of the region.

Recommendation 4.1-7 regarding the Monitoring Committee. The Ministry of Health should continue to develop a Monitoring Committee and to use the Office of International Exchange for the coordination of international projects. Draw up terms of reference that fit the strategy of PHC, give a clear and realistic specification of the expected results, and a specific plan of activities. The General Office of Organization and Methods...and USAID should provide ...technical assistance as needed...

Recommendation 4.1-8 regarding the use of Integrated Regional Health Plans instead of Project Operational Plans. Integrating any future USAID and other foreign assistance projects into Regional Health Plans should be considered, since no additional operational plans will be drafted for projects 219/230. International organizations would benefit from this measure in various ways. A consolidated regional budget would facilitate determining project complementarity and calculating each project's overall contribution. A considerable reduction in the processing work for the preparation and execution of the regional plan could be expected since only one plan rather than several would be drafted, as is currently the case.

Recommendation 4.1-9 regarding delegation. The Ministry of Health should analyze the feasibility and desirability of delegating responsibility for day-to-day operations from the central to the regional and subregional levels. The Office for Organization and Methods could analyze specific situations with outside technical assistance as needed. The analysis should include interviews with regional as well as central MOH directors. In analyzing which functions can be done better from the regional level and how much delegating should be done, the study should consider the recommendations in other sections of this report, especially 4.2 regarding financial systems, and 4.3 regarding logistics. There are already regions, such as Ica, that have good experience managing more autonomously.

Recommendation 4.1-10 related to control and evaluation. Examine the control methods currently used in projects 219/230 to ensure that they contain the essential elements of a good feedback and administrative control system. These are: realistic performance targets with simple indicators that are easy to monitor, a process for collecting and interpreting information to improve the situation, and a process for taking corrective measures. The Head of the Project Department should develop a plan of action for creating this monitoring system, with technical assistance as necessary. USAID should promote the development of this feedback/replanning system.

Periodic reports are useful if they are concise and focus on critical information on problems and opportunities to improve the efficiency of specific PHC components. Report content normally should not remain unchanged from one period to the next. A mix of achievement reporting and exception reporting is normally appropriate. For projects 219/230, the report content should be classified by project component, each with a target showing expected achievement in terms of quantity and time. Reports comparing actual and planned performance should be prepared, and operating personnel should be offered the chance to report on problems and be given the opportunity to call for help from the central level.

Recommendation 4.1-11 regarding the preparation of norms. Change the MOH approach of using norms to communicate policy; place more emphasis on providing practical guidance to the operating units. This would entail more participation from operating units in norm preparation and review. Innovations could be tested selectively to provide realistic and flexible guidelines. Norms should be output oriented, instructing the operating units on objectives and should allow more discretion to respond to unusual situations with these objectives in mind.

National norms could provide principles, but give the regions flexibility to set specifics in cases like per diems. Recommendation 4.2-7 deals more specifically with travel expenses.

Recommendation 4.1-12 regarding improved systems and procedures. The MOH should analyze systems and procedures and make recommendations to eliminate delays that hamper operating personnel. The General Office of Organization and Methods (OGR) will need help fulfilling its role as internal consultant for MOH systems and procedures. Starting points should be the changes in the Financial and Logistics Systems recommended in sections 4.2 and 4.3. Detailed analysis of needs and implementation of changes should be supported by outside advisors from Westinghouse or elsewhere, but the OGR should participate actively both to contribute and to improve the OGR's capacity for independent analysis.

Recommendation 4.1-13 regarding in-service training for management and administration skills. MOH personnel need more in-service training to perform their management and administrative responsibilities efficiently. Section 4.6 regarding training

indicates that a great deal of foreign money is available for training PHC personnel at the periphery, and that PHC training funds should be more carefully rationed. Some of these funds should be redirected to training in basic management and administration skills, such as the development of output targets, unit costs, and using feedback to solve problems. The MOH would benefit much from additional training, but it should not come from projects 219/230 in view of the PHC priorities of these projects. Other agencies with different priorities may be interested in filling this gap.

Recommendation 4.1-14 regarding increased continuity of regional health leadership and use of "teams". The MOH needs to analyze the problem of high regional turnover with outside technical assistance from Westinghouse or elsewhere. The analysis should evaluate the impact of leadership continuity on the PHC program and what factors influence the most effective leaders in their decisions to stay or leave a regional post. These factors might include financial and non-financial incentives, opportunities for advancement, and other elements of job satisfaction.

One suggestion is to hire a Deputy Director for each region for a three year term to provide regional continuity even if the Director is moved more frequently. The Deputy Director position would be reserved for a person with the management and administrative skills to run the region in case the Director is a physician lacking good management skills. The MOH could thus make physicians Directors without forfeiting good administration. Some physicians do have appropriate management skills or can develop them with management training. In these cases the Deputy Director position can be a stepping stone to becoming Regional Director.

It is important to consider experimenting with different monetary and non-monetary incentives and to adopt a policy of encouraging productive field personnel to continue in their jobs. Non-monetary incentives may be experimented with, ranging from public recognition to transfering management and professional personnel from a less attractive region to a more attractive one as a reward for good performance.

Building a good team is another approach to providing continuity at the regional level. A good team can help motivate team members to work hard, achieve useful results, and derive more satisfaction from their jobs. Please note related comments on team management preceding Recommendation 4.1-1.

Recommendation 4.1-15 on providing specific training to management, administrative, and professional personnel. Provide specific training for management, administrative, and professional personnel based on the training needs identification in their areas of responsibility. Training should be periodic, progressive, and directed to resolving problems impeding the achievement of expected results in PHC services.

Recommendations on Financial Systems

Recommendation 4.2-1 regarding a plan to improve financial management. With the support of Westinghouse consultants and/or outside consultants, OGA should develop a plan for the effective implementation of the MOH policies described in Section 4.2. This evaluation report and the specific recommendations made in the pages that follow should constitute the basis for such a plan.

Recommendation 4.2-2 regarding budget preparation to include performance targets and estimated unit costs. In the budget preparation and presentation, data on performance targets should be integrated with resources needed to accomplish them through the establishment of unit costs. The budget should then be focused on achieving goals at reasonable costs.

(The Director of OGA commented that the use of performance targets and other "program budgeting" methods make a lot of sense, but are not possible now, because the Ministry of Finance has discarded program budgeting in favor of a set of "ceilings" and negative controls to reduce government expenditures.)

Recommendation 4.2-3 regarding a Budgeting and Planning Committee. Developing useful estimates of unit costs will require a closer integration and coordination between the organizational units that presently deal separately with the projection and evaluation of programmatic goals and the resources needed to achieve these goals. The integration and coordination may be accomplished by means of a Budget and Planning Committee in which the following units are represented. A similar structure should be established at the regional level:

- Executive Office of Accounting (OECPF):
  - Budget Accounting Section
    - (Area de Contabilidad Presupuestaria)
  - Scheduling Section
    - (Area de Calendarización)
  - Accounting Information Section
    - (Area de Información Contable)
- General Directorate of Health Services (DGSS)
- Directorate of Programming and Evaluation (DPE)
- Directorate of Maternal and Child Health and Population (DSMIP)
- General Planning Office (OGP)

(The Director of OGA commented that the recommendation was a good idea, but that the Planning Office should be responsible and should involve the other offices.)

Recommendation 4.2-4 regarding delegation of authority. Delegate greater authority to the Regional Directors concerning the budget management and execution. Initially, the regional level should be delegated control of the budget execution for specific line items of

expenditure. The central level of the MOH should limit its control to the major or generic items of expenditure, even though it continues to receive expenditure reports by specific line items for information purposes to MEF. Simultaneously, efforts should be made to establish a system of budgetary controls based on results, goals, and resources, as is contemplated in the MOH policies.

(The Director of OGA commented that the delegation can be done; training would be required. The recommendation to report by specific line items is only to allow MOH to comply with MEF requirements. The USAID Controller's office expressed concern if MOH central level only reviews generic items: "Central MOH has established internal control units which should not be bypassed if USAID is to accept financial reports as a basis for reviewing project expenditures.")

Recommendation 4.2-5 regarding reporting of expenditures. Reporting of expenditures by major items of expenditures is recommended. Accordingly, the expenditure report should be controlled at the central level only by generic items. The invoices and receipts supporting the expenditures incurred should be sent to the central level for controlling the budgetary ceiling on expenditures only. In due time the regions will have to account for the allowability of the expenditures. This is the function of post-audit accounting which is the current usual practice in public and private enterprises. The post completion audit should be done by an organization independent of the MOH.

(The USAID Controller's office commented that original invoices and receipts need not be sent to USAID, but in view of the effective internal control system in place at the central level of MOH, regions should continue sending original invoices and receipts to central MOH. The original recommendation was to keep the invoices and receipts at the regional level using post-audit accounting. As PHC expands the level of operations in the field (after projects 219/230 have ended) this further delegation should be considered again with changes in USAID procedures, if necessary, such as sending Peruvian auditors to the regions as has been done in the Disaster Relief Project.)

Recommendation 4.2-6 regarding lengthening the budget and reporting period to a quarterly cycle. Extend the calendar of obligations cycle to three months. A period of three months allows reasonable time for an objective analysis of the budget execution and for taking appropriate and timely measures to adjust the expenditures to the projected costs in the calendar of obligations.

(After the November 1984 evaluation work, the calendar process was modified to allow spending up to the middle of the following month, which ameliorates the problem of a monthly cycle. There is precedent for a quarterly cycle as used for the Peruvian armed forces; however, changing the cycle is beyond the authority of MOH (See Recommendation 4.2-16). The Ministry of Finance must be involved.

Recommendation 4.2-7 regarding per diem. The control of per diem and travel expenses (viáticos) merits special attention because of its direct and immediate impact on health services and personnel. It is recommended that the payment or reimbursement of per diem and travel expenses be made on the basis of a certification made by the two most immediate levels of supervision above the employee claiming the payment. The certification would be as to the date, time, place, and purpose of the field visit made by the employee. Payment would be made on the basis of pre-determined fixed rates. The rate structure would consider such variables as day and time of departure and arrival, type of transportation used, and distance traveled.

(The Director of OGA commented in March 1985 that a better process for per diem and travel expenses (viáticos) had just been approved.)

Recommendation 4.2-8 regarding reprogramming of disbursement schedules. As a general rule, the regional level should initiate any reprogramming of the "Calendarios de Compromiso" and disbursement plans. If the central level of the MOH detects a need to reprogram before the region does, the central level should inform the latter and advise regarding the need for reprogramming. These cases should be exceptional. If they were not exceptional, the solution should not be substituting the central for the regional level doing the reprogramming.

(The Director of OGA commented that only the Minister can reprogram disbursements and only under strictly controlled circumstances.)

Recommendation 4.2-9 regarding program and project coordination. The MOH should experiment with different coordination mechanisms and strategies such as:

- Regularly scheduled meetings between units with a significant functional interdependence and shared objectives. These meetings should follow a predetermined agenda, structured so as to foster an integrated approach in the definition of goals, evaluation of the accomplishment of goals, analysis of factors that contribute to or hinder their accomplishment, and the actions required to correct deviations from the targets.

- Interchange of work plans and reports about tasks completed.

- Occasional seminars and workshops.

- "Living" workshops for the employees to share perceptions and concerns which often constitute communication barriers and interfere with communications.

A great part of the communication barriers will be eliminated with the implementation of the above recommendations.

(The Director of OGA commented that "if MOH can do it, so can the regions.")

Recommendation 4.2-10 regarding motivation. Making major improvements in motivation requires more analysis and goes far beyond what can be done in this evaluation. The implementation of the above recommendations should contribute to the creation of a more motivating environment. All the above recommendations will, directly or indirectly, satisfy human needs. According to behavioral science theories, people seek self-fulfillment; they want to assume responsibilities commensurate with their competence; they want to be considered part of the organization and to contribute to the accomplishment of its goals; and they want to feel needed by the organization.

Recommendation 4.2-11 regarding Operational Plans ("Planes Operativos"). (No more Operational Plans will be submitted for projects 219/230, but the recommendations of the evaluator are presented for their relevance to streamlining the financial procedures for future projects in Peru.) The review of the Operational Plans (see Table 5, step 2) should have the benefit of the advice of the Executive Accounting Office (OECPF) to make sure that they are compatible with the overall MOH budget. Similar participation may be given to the General Office of Planning to make sure that the "Planes Operativos" are compatible with the "Plan Nacional de Desarrollo-Plan Operativo Sectorial del Ministerio de Salud." In addition, the "Planes Operativos" could be simplified considerably. This would facilitate their preparation, analysis, review, approval, and implementation. Three copies of the implementation letter ("carta de implementación") or PIL that USAID sends to the DGSS (step 3) could be sent directly and simultaneously to the OGA (one copy) and to the OECPF (two copies) (steps 4 and 8). The OECPF could send directly and simultaneously one copy of the PIL to the "Unidad de Contabilidad - Administración Central" and the second copy to the "Area de Convenios" (step 8).

Recommendation 4.2-12 concerning the request for funds. The requests for USAID funds that originate at both the regional and central MOH levels (Forms 1 and 2) could be appropriately consolidated by the DGSS (Forms 3 and 4) (Table 7, steps 1, 2, 3, 4, and 5). The DGSS should reconcile the requests for USAID funds in coordination with the "Area de Contabilidad Presupuestaria" and the "Unidad de Calendarios y Control de la Ejecución del Presupuesto" of the OCEPF to assure their compatibility with the requests for funds from other sources. The DGSS could send all this documentation directly to "Area de Convenios" of the OECPF. All documentation concerning the requests for USAID funds could be sent directly to USAID by theDirector General of OGA with an information copy to the Director General of the "Oficina General de Intercambios Internacionales" (OGII) (steps 8 and 9).

Recommendation 4.2-13 regarding receipt of funds. USAID funds should be sent directly to the regions. USAID would send simultaneously a copy of the corresponding Remittance Form (SF 1034) and a photocopy of the check to the DGSS. The DGSS would make three copies of those documents and would distribute them directly and simultaneously to the Director General of the OGA, the Director of the OECPF, and the Office of the Treasury (steps 14 and 15).

(USAID payment directly to the regions was approved in principle by OGA in September 1984.)

Recommendation 4.2-14 regarding reporting of expenditures. The documents concerning the liquidation of funds should be sent by the OGA directly to USAID. An information copy would be sent to the OGII. The Report of Expenditures should be limited to the major or generic items of expenditures. Finally, the review of the invoices and receipts that support the disbursement of funds and the certification of their allowability should be delegated to the Regional Directors. Both USAID and the MOH central level could verify the allowability of the expenditures and the supporting documentation by means of financial audits at the end of each fiscal year.

(The Director of OGA commented favorably on sending OGII an information copy as recommended (see related recommendations 4.2-4 and 4.2-5.)

Recommendation 4.2-15 regarding technical assistance in financial systems. The General Office of Organization and Methods should contract a full-time systems analyst to provide technical assistance to the MOH. The analyst should have adequate preparation and competence in "Systems Analysis" so as to approach the financial systems from a broad and integrated prespective. This includes understanding the components of a financial system (financial accounting, cost accounting, budgeting, cash flow, capital investment) and the relationship of the financial system to the administrative structure and other systems, including the information system. The Systems Analyst should develop and implement a work plan to gradually make the necessary modifications to the financial systems and procedures that would expedite the work of the health delivery system and make its functioning conform to existing policies. This will require a process of consciousness-raising and training of everyone served by the financial system. The basic modifications required have been recommended in this section of the evaluation. (The Director of OGA commented that technical assistance in financial systems was a good idea and he welcomed it. Westinghouse concurred. USAID plans to provide more TA in financial systems.)

Recommendation 4.2-16 regarding USAID's offering assistance in Public Expenditures Management. USAID should discuss with the Ministry of Finance the negative effects on "performance" of the operating ministries that result from the system now being used to restrain public expenditures. The negative effects of poor performance in PHC services and other public services on the legitimacy of government and popular political support should be noted. USAID should offer assistance to the newly elected government of Peru in public expenditures management as one option available to the new government, if this kind of assistance fits the priorities of the new government.

Recommendations - Logistics and Supplies

Recommendations - USAID Procurement Procedures

Recommendation 4.3-1 regarding USAID procurement. Require the Directorate of Maternal and Child Health (DSMIP) to draw up equipment specifications and descriptions of materials as completely as possible to facilitate and simplify procurement at USAID. In the case of equipment purchases, it would be appropriate to receive the technical guidance of the personnel originating the request for preparing the specifications. If possible, the source of the information about the kind of item desired should also be provided, e.g., the catalogue and page number, catalogue or factory illustrations, or photocopies of the illustrations with the purchase order are highly recommended.

Recommendation 4.3-2 regarding training/orientation for personnel involved in procurement. Arrange training or orientation seminars for USAID and the MOH to discuss concerns and resolve doubts regarding procurement systems common to both, resolve problems, and improve the professional training of the personnel assigned to these tasks.

Recommendation 4.3-3 regarding analysis of the USAID purchasing office. Consider an analysis in greater depth than was possible in this evaluation of the procedures for USAID purchasing, particularly to determine to what extent the program's operating personnel can provide better guidelines to the USAID purchasing office for preparing specifications for equipment and pharmaceutical purchases.

Recommendation 4.3-4 regarding purchasing handled in Washington. Investigate the feasibility of shortening even more the purchasing cycle for purchasing in the USA, by taking advantage of every opportunity that presents itself.

Recommendation 4.3-5 regarding procurement at the MOH central level. The procurement system of the MOH merits an exhaustive evaluative study followed by technical assistance to modernize it and make it more efficient. To achieve this goal it probably will be necessary to change the laws and decrees that currently govern the procurement system. A better inventory control system with maximum and minimum inventory levels should be considered in the study.

(The Logistics Group commented that conflicts between international agreements and Peruvian law cause major problems, but not in this project. The international agreement should prevail, but there are differences of interpretation. Some projects have less trouble. The "Ley de Presupuesto" (page 12) Articles 25-28 creates the conflicts. The group concluded the problem was important enough to justify OGA and an adviser studying the problem to identify long term solutions.)

Recommendation 4.3-6 regarding training in procurement for MOH staff. Arrange for refresher courses and other training opportunities for the technical procurement staff regarding modern

procurement practices in Peru and abroad. Training abroad is appropriate for two officials of DASA such as the current Executive Director, Lic. Julio V. Herrera-Fernández, and one other well known employee who is deeply involved in procurement work. They will benefit from meeting other procurement specialists and the work of their units will benefit. Continuity among the key employees of DASA, especially at the Executive Director level and the headquarters of the technical procurement office, is important for sustained improvement by generating ideas, testing new approaches, and carrying the successful innovations into the daily work of the unit.

(MOH commented that training abroad may not be appropriate because Peru's laws for procurement are very strict, rigid, and conservative,making it hard to learn anywhere outside Peru. The training is needed but the people who are trained abroad are likely to go to another job. The Department of Personnel could do something about it but turnover is a general problem.)

Recommendation 4.3-7 regarding avoiding mail rooms. Study the possibility of eliminating some of the intermediate steps and transactions by using fewer mail stations (at each Division for internal mail and for the transmittal of documents) so that, for example, the documentation or purchase orders go directly to the Executive Supply Office from the person requesting them at an Executive Office. This change could save time and would facilitate the delivery and distribution of merchandise. The alternative of handling mail and documents through one central mail station should be considered.

Recommendations - Procurement at the Central Level

Recommendation 4.3-8 regarding notifying DASA of purchase transactions initiated. A copy of all purchase orders forwarded to USAID by MOH offices like DSMIP should be sent to DASA for information purposes.

(The Logistics Group agreed with the recommendation.)

Recommendation 4.3-9 regarding introduction of computers in procurement at MOH. The analysis of the MOH procurement system contemplated in 4.3-5 should consider the use of computers in the key functions. Computers could improve the effectiveness and efficiency of purchasing and storage control. The computers could also facilitate operations while supplying valuable statistical data necessary for the modernization of the procurement system and possibly installing CRTs (terminals with a cathode ray tube screen) in the health region offices. In addition to analyzing the potential impact on procurement and supplies, the analysis should also consider the impact on employment and the ability of MOH to maintain and support the system and pay for the on-going expenses.

(MOH commented that computers are much desired and USAID assistance is requested. In the current inflationary environment, good management dictates buying early to get as many goods as possible

with a given budget in soles and maintain higher inventories. However, it is essential to have a good inventory control system to know when to reorder to avoid overflowing the facilities, to control theft and spoilage, etc. Computer based systems are desired as is "operations research." DSMIP and OGA want computers. It would facilitate dispatching goods directly from Callao to the regions without the delay at Central MOH. Westinghouse will study DSMIP needs. No decision was made on analyzing OGA needs.)

Recommendation 4.3-10 regarding long term supply contracts. One system that has proven efficient in other countries involves purchasing through long term supply contracts (i.e., six to twelve months) for supplies at prices agreed upon through public bidding for those articles, equipment, and products used daily or more often.

Even though the impact of inflation makes it difficult to implement this recommendation, it may be applied selectively at this time to identify responsible and capable suppliers who are willing to take into account the effects of inflation when submitting their bids.

In some other countries with serious inflation, purchase prices have a built-in indexing tied to the dollar, the cost of living, or an index of construction costs, etc. (Jack Wolff considers long term contracts infeasible until inflation is under control.)

Recommendation 4.3-11 regarding continued use of USAID procurement. It will continue to be appropriate for USAID to make direct purchases and assign the responsibility to the MOH for articles or products that are hard to procure and for products where there is likely to be an important advantage regarding price, quality, delivery capabilities, and the origin of the manufacturer. Nevertheless, the MOH should participate, at the central level as well as at the health region level, in a study to determine which articles or products which are difficult to procure and consequently should continue to be procured directly by USAID, which purchases should be assigned to the MOH for purchasing, and which merchandise should be procured directly by the health regions. Naturally, the final determinations for equipment purchases should take into account guarantees and the availability of replacements as well as maintenance and repair considerations. The progress of DASA should be taken into consideration in the allocation of responsibilities to be taken over immediately.

Recommendations - Procurement at the Regional Level

Recommendation 4.3-12 regarding improvement of procurement at the regional level through better planning and supervision. Better planning and supervision are probably more important than money in the short run, since some important items are purchased with donated and loan funds and are available in Peru for the PHC system, e.g., oral rehydration salts, contraceptives, and essential drugs. Improving the financial situation and the financial systems will be important for the longer term for the MOH purchasing and distribution process.

Better planning and supervision can improve the distribution of supplies to locations that presently do not get adequate supplies.

Recommendations - Technical and Regional Advisers

Recommendation 4.3-13 regarding an inventory of latrine construction and installations. Carry out a complete inventory of the latrine construction and installation project to determine the status of the program and provide a basis for making realistic estimates of which regions are working effectively and where the program is paralyzed.

Recommendation 4.3-14 regarding management and motivation. The general recommendations of sections 4.1 and 4.2 are applicable to the procurement and supplies function, i.e., attention is needed to motivate the people involved, to set performance targets at all levels, and to measure performance compared to the targets to analyze where there are important opportunities for improved effectiveness and efficiency.

Recommendation 4.3-15 regarding transportation and vehicle maintenance and storage. Analyze in greater depth the extent of the transportation problem, making a study of all the vehicles available, their operating condition, the availability of maintenance and actual use. The study should consider the feasibility and desirability of contracting out transportation work where the costs are higher and the service is less satisfactory from the MOH than from an outside contractor. The second study of storage should be kept separate.

(The Logistics Group agreed that studying transportation and doing a separate study of storage were sensible. Jack Wolff recommended a study for one region earlier regarding cannibalizing, but it was not done. DASA should do the studies with TA from Westinghouse.)

Recommendation 4.3-16 regarding customs brokers. Analyze the feasibility of using the services of customs brokers for the handling of customs dealings, putting these professionals in charge of all processes related to customs as soon as the donated or ordered merchandise are received, or as soon as the bills of lading arrive at the MOH. Customs brokers are used successfully in other countries, and the functions and responsibilities of these agents are duly regulated by the respective governments. Specialists in their fields, these brokers may be able to speed up bureaucratic processes and facilitate the customs process at a reasonable or reduced cost for projects 219/230 in particular and for the broader PHC program of the MOH as a whole. Customs brokers do not charge for storage in their warehouses.

(The Logistics Group agreed that a study was worthwhile, especially considering that brokers do not charge for storage in their warehouses. PAHO uses customs agents and is pleased with them. The Westinghouse agent got personal effects in three days with an agent, while USAID people may wait three months. However, there was disagreement about the potential for important improvements through

agents due to problems internal to customs that will not be affected. New complications are also developing. New import regulations require the importer to pay the import duties (i.e., AID) but the Ministry is being charged currently, so conflicting legal interpretations are likely. Also, LUSA has challenged the imports of ORS (oral rehydration salts) so the packets were delayed in customs in March 1985.)

Recommendation 4.3-17 regarding the role of the Regional Advisers. With regard to the participation of the regional advisers in the distribution of supplies such as contraceptives, such activities fall within their general supply functions. The regional advisors should increase and diversify their participation in the areas of distribution, control, and resupply, and help to ensure that the facilities in their region are adequately supplied. In addition, they should participate more actively in the preparation and regional approval of the Operational Plans to expedite the process, and should follow up their approval at the MOH central level and USAID. The regional advisors should gather direct information on supply and logistics activities in the health facilities in the region to help identify and resolve problems that have arisen using the established MOH channels.

Recommendation 4.3-18 regarding technical assistance in logistics and supplies. There is a continued need for technical assistance regarding logistics and supplies. The work in this area should be organized around a few high priority tasks, even if the scope of work also includes some service and support type activities. The MOH should participate in the selection of tasks.

Tasks for technical assistance regarding logistics that should be considered in setting priorities include the following:

- o analyze the feasibility of using customs brokers as discussed in Recommendation 4.3-16;
- o analyze the procurement procedures to simplify them (Recommendation 4.3-5) and assess the feasibility of introducing computers (Recommendation 4.3-9);
- o analyze the feasibility of using long term supply contracts (Recommendation 4.3-10);
- o analyze the division of procurement activities between USAID and the MOH (Recommendation 4.3-11);
- o analyze the supply needs by health facility in order to improve the plans for procurement and distribution (Recommendation 4.3-12);
- o analyze the transportation and vehicle maintenance and storage problems (Recommendation 4.3-15);

- o increase training sessions for personnel involved in logistics and supplies at the regional and local levels (Recommendations 4.3-2 and 4.3-6).

(The working group on logistics in March 1985 requested assistance from the Technical Adviser on various issues described earlier. It appeared that he would not have time to support all the tasks that deserved attention.)

Recommendations - Health Information System

Long Term Recommendations - Health Information System

Recommendation 4.4-1 to strengthen the analytical capability of the MOH/OGIE. The MOH's statistical division (OGIE) must develop a broader orientation than simple data collation. The OGIE should have its own analytic capability and relationships with all areas of the MOH. More and better skilled personnel, computer facilities, and training would be essential elements, implying a need for donor funding and technical assistance. USAID and other international donors should support a comprehensive training program at all levels of the MOH in management and use of information. This should include at minimum the strengthening of MOH analytic capabilities in use of data for management, planning, and feedback systems to the levels of health service delivery. Specifically, needs include:

- o basic understanding of the relationship between management and information systems for Directors and Deputy Directors of all divisions and units within the MOH;

- o biostatistics capability at the OGIE, the analysis group, and other divisions;

- o statistical programming capability at the OGIE and the analysis group through short term (3 months) training programs such as offered by the Escuela de Administración de Negocios para Graduados (ESAN). ESAN is currently training several OGIE staff members;

- o epidemiology capability in the Ministry through both short and longer term courses. This is needed at the level of Directors of Area Hospitals, mid-level employees of each division of the central MOH (who would have less turnover than other higher level officials), and Regional Directors.

Recommendation 4.4-2 concerning NNHS and the provider survey. Support the complete analysis of the health and nutrition and provider surveys as well as other recent major surveys; use the information thus generated for project management and health planning.

Recommendation 4.4-3 regarding other information subsystems. Support should be strengthened for step by step installation of information subsystems in finance, cost accounting, logistics, physical

infrastructure, and human resources as soon as possible. Little management improvement can be expected without the linkage of service information to resource and management information.

Recommendation 4.4-4 on vital statistics. Develop a project to improve the system for registration of births and deaths in Peru.

Recommendation 4.4-5 on the computerizing the information system. The MOH should develop an integrated, phased plan for computerizing the different components of its information system with compatible microcomputers, requesting donor assistance as needed. Training for using microcomputers should also be part of this plan.

Short Term Recommendations - Health Information System

Recommendation 4.4-6 on coordination among donors. Develop a system for coordinating donor efforts related to information systems.

Recommendation 4.4-7 to assure continued support for the new information system. Continue the periodic meetings of the consensus group begun in the design phase of the information system into the installation phase to foster continued MOH support and to start building analytic capability. Special information sessions should be held when the new government takes over to ensure continuation of the new information system.

Recommendation 4.4-8 regarding pretest of the new information system. An outside peer review for the information system will be the best guarantee of its feasibility and practicality. The principles and approaches used for NNHS provide a useful precedent. Support an outside official review panel of at least three respected professionals experienced in implementation of health information systems to review the results of the pretest and the detailed plans for implementation nationwide. This review should generate some useful suggestions for implementation, guarantee the acceptability of the information system to the MOH, and provide a quality check which allows refinements and modifications to be made prior to final printing of forms and procedures and nationwide installation.

Recommendation 4.4-9 for an implementation plan for the new information system. The OGIE should: a) prepare a detailed implementation schedule through August 1985 in order to be able to monitor progress closely and take corrective measures should they be necessary; and b) prepare a back-up alternative implementation schedule with a phased approach for the information system's introduction to the central MOH and the regions. This schedule should be implemented if it becomes apparent that the present plan is experiencing serious delays.

Recommendation 4.4-10 for continued technical assistance. USAID should support technical assistance beyond August 1985 to increase the probability of implementation of the information system. Continuity of TA is important given the 1985 change in government. The OGIE, with the aid of the Westinghouse consultant, should prepare

and present to USAID a plan for TA needs to complete the information system implementation. This plan should emphasize how to improve data use and feedback in the MOH.

Recommendation 4.4-11 concerning specific applications of the NNHS results. Several items of information in the nutrition and health survey would be very useful for adjusting the strategies of specific components of project 219/230. Specific items include: radio/television ownership (the mass media component); ability to read (health education materials); person attending birth (the TBA training approach); nutritional status, breast feeding, and supplementary feeding (nutrition amendment focus); and expenditure patterns on medications (promoter remuneration).

Recommendations - Supervision System

Recommendation 4.5-1 to modify the current supervision model. Modify the current organization of the supervision system (and its quantitative targets) to a more feasible and realizable approach, particularly for supervisors of health centers, health posts, promoters, and TBAs.

Recommendation 4.5-2 of four alternatives to be considered for reorganizing supervision:

a. Identify the "good" supervision models currently in use in areas such as Ica and possibly Piura. Assess them and incorporate appropriate elements into the new organizational model.

b. Develop a system whereby every two to three months all health promoters convene at "their" health post and all health post personnel gather at "their" health center. This would work especially well at the area hospital level, since all personnel come once a month to receive their paychecks. A full plan must be developed for effectively using these group meetings for supervisory purposes. At these meetings the focus should be on a review of data for very simple indicators of performance for each unit. Using these data as a base, the meetings would concentrate on continuing education, problem identification and resolution, motivation, and follow-up. As problems are identified, follow-up visits should be made to those in need of a visit. The model developed should be based on a careful analysis of the relationships among different levels of health establishments.

c. Consideration should be given to setting up a small, permanent, full-time supervisory unit at the area hospital, but maintaining the multidisciplinary forms recently begun since health centers and posts have such low staffing levels. This supervisory unit would be responsible for supervising health centers, health posts, and community workers. In order to avoid the problem that has befallen the training units, it would be extremely important that these units have line responsibility for supervision. This more limited number of full-time supervisors would make adequate training regarding supervisory skills more feasible. For example, to provide each of

the 125 area hospitals with a two-person supervisory team would mean teaching 250 persons supervisory skills. This is a much more realistic objective than teaching 2,358 persons, most of whom normally would dedicate 95 percent of their time to non-supervisory activities. This full-time supervisory team might be reinforced on a rotating basis by other relevant staff. If this is the model chosen, the team cannot emphasize strongly enough the necessity of a line relationship for such teams, i.e., that they should have the authority to resolve problems for the people they are supervising.

d. A combination of alternatives a, b, and c.

(Discussions at DSMIP in March 1985 suggested that operations research would be appropriate, but that none of the models suggested by the evaluation team provides a general solution.)

Recommendations 4.5-3 regarding supervision self-instruction materials. Evaluate the impact of the "Modulo autoinstruccional sobre supervisión" on the quality of supervision and, if it is worthwhile, use it together with the new "model" for supervision.

Recommendations - Training

Recommendations - Overall Training Program

Recommendation 4.6-1 that the MOH develop a comprehensive training plan. Training is needed in many important areas for MOH's primary care programs. The entire training component being supported by both USAID and the other donors should be reassessed and consolidated as soon as possible to make training in primary care both feasible for the MOH to implement and effective in meeting real needs. A coherent, action-oriented training plan for primary care should be developed. Alternatives for organizing the training or reprogramming some of the monies into deficient areas related to training, such as provision of adequate training and educational materials, should be explored.

Recommendation 4.6-2 to assess training needs. The training plan should address both short and long term training needs after an assessment of these needs has been made. The results of the recent School of Public Health (SPH) survey of training needs could serve as a starting point for this national training assessment for primary care. The assessment also should include an analysis of available materials and supplies. The plan of action should be developed based on an analysis of the different training alternatives available in Peru, the United States, and third countries. For example, the SPH may be the more appropriate trainer for some types of training, whereas the Instituto Nacional de Investigación y Desarrollo de la Educación (INIDE), ESAN, or in-country workshops given by consultant groups may be more effective for other types of in-country training. The Ministry should dedicate a full-time person to coordinating all training in primary care.

Recommendation 4.6-3 to incorporate specific training needs identified in this report into the overall training strategy. This evaluation team has identified needs for training in other sections of this report which should be part of the MOH training strategy.

Recommendation 4.6-4 concerning USAID technical assistance for training. USAID should consider supporting technical assistance in training at the macro level to assist the Ministry in assessing training needs and consolidating and organizing its approach. A second activity worthy of technical assistance at the operational level would be to assist the Ministry in the implementation of the training strategy and action plan. USAID should strengthen its support to the School of Public Health.

Recommendation 4.6-5 to use existing and available educational materials. Adequate production and distribution of training and health education materials to primary health care workers is critical and should be addressed in conjunction with the above recommendations. Other materials should be distributed to the regions taking into account the promoter and TBA evaluation. Many good materials already exist. It might be more effective to reproduce or purchase a sufficient number of a few good materials than to spend many months and resources developing new ones. For example, distributing 10,000 copies of Donde no hay doctor to health posts and health promoters might be more beneficial than spending the budget currently allocated to local production of health education materials. This plus a number of PAHO, UNICEF, and World Bank materials distributed regularly and in sufficient quantity would contribute significantly to the effectiveness of training.

Recommendations - Promoters and Traditional Birth Attendants

Recommendation 4.6-6 to define the role of the promoter. The policy issue of the role definition of the promoter needs to be addressed by the MOH. The team questions the advisability of continuing training new promoters without first addressing this issue. Related to this, the team questions whether "promotion," which is the only "task" now agreed upon, is having any positive impact on the system and whether it is worth the investment being made.

The following are strongly recommended for all projects using a promoter strategy if the performance of promoters is to be improved and they are to have any real impact:

a) The MOH norms for promoters should provide a clear, simple, task-oriented role that would include such activities as the distribution of ORS and specific contraceptives, prenatal care, etc. These tasks should be based on the needs of the rural and urban poor and not on professionals' competitive needs. Training for tasks could then be done on a modular basis based on the varied needs of the regions and could develop a permanent retraining focus.

b) After a policy is reached on promoters: 1) Develop an action plan to retrain promoters in a modular fashion; 2) develop a simple task-oriented modular training package which would be focused on providing continuing training so different modules can be used for different areas of the country; 3) develop standardized training materials in sufficient quantity; 4) train trainers in new approaches; 5) develop a simple information and tracking system based on tasks; and 6) reorient the supervisory system based on the new tasks using the information system.

Recommendation 4.6-7 on promoter incentives. Resolution of the remuneration and incentive issue is important. Given the current economic situation, it is unrealistic to assume that promoters will want or be able to work on a volunteer basis. If this issue is not resolved, the promoter program will continue to experience high drop-out rates and low performance.

Several different approaches to financial and non-financial incentives should be systematically developed, tested, and evaluated for impact. Several regions already are experimenting with some incentives for promoters. Such innovations should be identified and assessed for their potential usefulness. The approaches tested should include at a minimum a real attempt at establishing a revolving fund and teaching promoters how to reasonably establish charges for services. Charging for services will be much more effective after the role definition issue is resolved. The possibility of making a policy of selecting outstanding promoters for training to become health auxiliaries should also be explored as an incentive. Additional TA to assist the Ministry in organizing its training activities is very important. Analysis of promoter incentives is needed, e.g., simple operations research studies to test different models currently being used. A model which might be tested as a way of enhancing the status of the promoter in the community is the use of promoters to assist in weighing or measuring children, or use of their homes as food distribution centers in USAID-supported nutrition and disaster relief operations.

(The evaluators were told in March 1985 that MOH has decided that promoters will not be paid. Consequently, it is essential to focus on non-monetary incentives to attract, motivate, and retain promoters.)

Recommendation 4.6-8 on the need for continual supervision and support. The final necessary ingredient for a successful promoter and TBA program is an effective supervisory system (see section 4.5). It is unreasonable to expect someone with only two weeks to one month of training in health tasks to continue to perform effectively without a system of continuing training, follow-up and minimal supplies.

Recommendation 4.6-9 to identify model sites or approaches. Identify sites that seem to be using TBAs or promoters more effectively or that are using innovations in task assignment, payment mechanisms,

and supervision. Conduct small, simple operations research studies to assess real differences and identify the ingredients that seem to make the difference. Use successful sites for training or assess ways in which the successful ingredients can be incorporated into programs at other sites.

Recommendation 4.6-10 on promoters in urban areas. Health workers in urban areas suggested that urban dwellers, no matter how poor, seem to use existing health facilities rather than minimally trained community workers. Consider abandonment of the promoter program in urban areas if data from the nutrition and health survey confirm this, unless specific tasks related to immunization, prenatal care, ORS or contraceptive distribution can be developed for promoters. In urban areas, radio and other media probably are more effective for "difusión" than health information provided through promoters. Continue the promoter program in areas that already are using a specific task-oriented approach for promoters.

Recommendation 4.6-11 to concentrate TBA training in more traditional areas. Consider offering TBA courses only in more traditional areas or those areas in which the nutrition and health survey shows high use of TBAs to consolidate and improve performance of the TBA program.

Recommendation 4.6-12 for birth attendance training of other family members. Consider the feasibility of offering courses similar to the TBA course to fathers or other family members if survey results indicate high attendance of family members at births.

Recommendation 4.6-13 on translation of training materials. MOS should support development of training materials and instructions for TBAs in languages other than Spanish and Quechua for the relevant areas. Birthing kits to pregnant women with instructions could be an alternative to teaching family members.

Recommendation 4.6-14 on the use of radio messages. Explore the possibility of using radio on a pilot basis to inform communities of the presence of TBAs.

Recommendations - Non-MOH Activities in Population/Family Planning

Recommendation 5.1-1 regarding FENDECAAP. Continue and expand support for FENDECAAP due to its positive performance, low overhead, and high potential to reach potential acceptors outside Lima.

Recommendation 5.1-2 regarding AMIDEP. Continue support for AMIDEP.

Recommendation 5.2-3 regarding ASPEFAM. No further assistance is recommended at this time.

Recommendation 5.1-4 regarding management support for PVOs. Study the feasibility of establishing a management support organization for Peruvian PVOs comparable to the Asociación Demográfica de Costa Rica. A study should verify demand for such services, the best means to provide management assistance, the estimated costs, and the

potential benefit in expanded coverage and reduced unit costs. The Asociación Demográfica de Costa Rica is responsible for central accounting and the distribution of funds and supplies for a number of PVOs providing family planning services in Costa Rica. The cost of establishing such an agency is estimated to be four to seven percent of the total donated funds in family planning and could save 20 percent in operations as well as improve services. This cost could be paid initially by the cooperating agencies and donors as a part of their grants to the recipients. The kinds of services this type of organization could provide in Peru include management training, help in rapid clearing of contraceptives from customs, assistance in procuring local supplies at lower prices through bulk purchases, help in developing proposals for funding, obtaining international or local funding, designing ways for better utilization of personnel, establishing uniform service statistics, and developing financial records and logistics systems.

Recommendation 5.1-5 regarding dollar funding of PVOs. Allow PVOs and other private sector organizations to receive grants in dollars from international cooperation agencies and convert them as needed in order to avoid the disruptions caused by the rapid inflation in Peru today.

Recommendation 5.1-6 regarding surgical contraception. Allow competent private clinics to provide surgical contraception to high risk women defined by the norms currently in force in the MOH. As noted, these norms do not provide clear guidance for the private sector. It is believed that demand will exceed the public sector's ability to provide this service. Therefore the team recommends that procedures for surgical contraception be reviewed, clarified, and simplified so these services can be provided through private sector channels.

Recommendation 5.1-7 regarding a project for private sector family planning activities. USAID should consider developing a separate project to assist private sector family planning activities. The major reason for a separate project is the long delay presently experienced by private organizations providing family planning services under project 230 to obtain approval of operational plans from the MOH. In some cases this delay has even forced them to stop operations for lack of funds. Another reason for a separate project is that it appears that cooperating agencies may be decreasing their funding support for projects in Peru, which could cause a decrease in the level of effort by the grantees. An assessment of funding needs is necessary so that momentum in the private sector is not lost. Promising innovative approaches should also be considered for assistance.

Recommendation 5.1-8 concerning public and private sector cooperation. Cooperation between MOH and the private sector should be encouraged. There are currently several examples of such cooperation, such as the use of MOH contraceptives and facilities by the National University of Trujillo and the MOH provision of contraceptives to FENDECAAP.

Recommendations - IPSS Family Planning Program

Recommendation 5.2-1 regarding the Trott report. The team concurs with the four low cost, short-term recommendations which appeared in the Trott report: 1) provision of management training, 2) simplification of clinic practices and reporting, 3) improvement of purchasing and supplies management, and 4) providing support for outreach efforts.

Recommendation 5.2-2 regarding post-partum surgical contraception. USAID should also consider encouragement of post-partum surgical contraception in the IPSS service system. Training could be provided through JHPIEGO or IAVS. OB/GYN physicians in IPSS could be provided training in surgical contraception as well as equipment. The project director should also be sent for training in family planning program management. Efforts should be made to secure a stronger commitment to support family planning from the IPSS Executive Board. Perhaps the Consejo Nacional de Población could be helpful in this regard.

Recommendation 5.2-3 regarding cooperation between the MOH and the IPSS. Under project 230, USAID should encourage the MOH and the IPSS to sign an agreement whereby the Ministry of Health provides USAID-financed contraceptives to IPSS in those regions where IPSS has medical facilities. It is feasible for the MOH to do this since there is no lack of contraceptives at the regional level and there is a precedent in Trujillo, where the MOH is providing contraceptives and use of its facilities to a non-MOH facility.

Recommendation 5.2-4 concerning technical assistance for the IPSS. It is recommended that the Westinghouse logistics adviser spend one or two months at IPSS to help develop a better logistics system.

Recommendation 5.2-5 regarding the Consejo Nacional de Población. USAID should continue to support CNP, but limit its support to those specific activities which directly improve programs in Peru. The CNP should be encouraged to obtain institutional support from other sources. An example of a specific activity worthy of support might be the analysis of data obtained from the national nutrition and health study which could be used to improve family planning programs.

Recommendations - Technical Assistance

Recommendation 6-1 regarding specific areas for technical assistance. Increase technical assistance in the priority areas identified in this report.

Recommendation 6-2 regarding "performance boards." Westinghouse would benefit from a "performance board" as recommended in 4.1-2. A national level "performance board" with the same data as used in DSMIP and USAID would be appropriate for the national level adviser. A regional "performance board" should be considered for each region or group of health regions served by a Westinghouse adviser. Estimates of coverage are desirable and should be feasible with the technical talent available to Westinghouse.

Recommendation 6-3 regarding scopes of work and reporting. The scopes of work of all long term advisers should be reviewed with the MOH and USAID, and their work should focus on achieving specific high priority outputs. The quarterly reporting system should be simplified and modified to focus attention on progress toward achievement of the planned outputs.

Recommendation 6-4 regarding periodic review of data with regional and local MOH personnel. The Westinghouse regional advisers should help MOH regional staff begin systematically collecting a minimum set of data on five or six primary care service indicators. They should use this as an opportunity for teaching regional and local personnel how to use data for management purposes, for continuing education, and for assisting the regional staff to solve problems and to establish priorities for action while always respecting the established channels of MOH.

Recommendation 6-5 regarding the use of evaluation reports. The MOH and USAID should continue the systematic review process already started with regard to this proposal, i.e., identify promising recommendations, dialogue and "consensus building" about specific actions to be taken. Short- and long-term action plans should be developed for implementation of specific recommendations selected by the MOH and USAID. (In March 1985 the evaluators noted that action had been initiated already on various recommendations made in the working papers of November 1984, and the written draft of January 1985. The action-orientation is commendable.)

7.2 Institutions Involved in the Recommended Actions

Table 24 summarizes the institutions that will be involved ih the recommended actions. The evaluators assumed additional technical assistance could be contracted through the existing Westinghouse contract. However, we understand that USAID has decided to contract the work through a competitive procurement.

Table 24

Evaluation Recommendations Summarized by the Institutions Involved

Rec.#	Recommendation	Institutions Involved*: USAID	MOH	WHS	Other
Family Planning-MOH					
3.1-1	Improved provision of family planning services		x		
3.1-2	Change norms for family planning service providers		x		
3.1-3	Support for family planning in hospitals	x	x		
3.1-4	More contraceptives each visit		x		
3.1-5	Train all MOH regarding family planning		x		
3.1-6	Evaluate community-based distribution		x		
Oral Rehydration Therapy					
3.2-1	Action plan for ORT	?	x		
3.2-2	Local production of ORS	?	x		
3.2-3	Educate pharmacists and physicians		x		
3.2-4	Promote home-made solutions		x		
Environmental Sanitation					
3.3-1	Consolidate environmental sanitation activities	x	x		
3.3-2	Study preferences for type of latrine	?	?		
3.3-3	New water and sanitation projects	x			
Community Education					
3.4-1	More health education materials		x		
3.4-2	More use of radio	?	x		
3.4-3	Coordinate education with service providers		x		
Project Management and Administrative Structure					
4.1-1	PHC management team		x		
4.1-2	Performance boards	x			
4.1-3	Additional USAID health office	x			
4.1-4	Set priorities/output targets for contractors	x	x	x	
4.1-5	Financial controls for follow-up projects	x			
4.1-6	Regional personnel participate in planning		x		
4.1-7	Strengthen monitoring committee	x	x	?	x
4.1-8	Integrated regional health plans	x	x		x
4.1-9	Increased delegation to regional/subregionals		x		
4.1-10	Improve feedback and administrative control	?	x		
4.1-11	Use norms for practical guidance		x		
4.1-12	Improve MOH systems/OGR		x	x	
4.1-13	In-service training in management/admin.		x		x
4.1-14	Increase continuity regional leaders/teams		x		
4.1-15	Specific training to mgmt.& admin. professionals		x		

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MOF: Ministry of Finance

Rec.#	Recommendation	Institutions Involved*: USAID	MOH	WHS	Other
Financial Systems					
4.2-1	Plan to improve financial management		x	x	
4.2-2	budget preparation with unit costs		x		
4.2-3	Budget and planning committee		x		
4.2-4	Control of specific budget items by regions		x		
4.2-5	Report expenditures by major items to central		x		
4.2-6	Quarterly cycle schedule of obligations		x		MOF
4.2-7	Per Diems		x		
4.2-8	Regional level initiates reprogramming		x		
4.2-9	Program and poliy coordination		x		
4.2-10	Improving motivation		x		
4.2-11	Operational Plans modifications		x		
4.2-12	The request for funds		x		
4.2-13	USAID funds direct to regions	x	x		
4.2-14	Reporting of expenditures		x		
4.2-15	Technical assistance in financial systems	x	x	?	
4.2-16	Assistance to MOF in public expenditures mgmt.	x			MOF
Logistics and Supplies					
4.3-1	DSMIP prepares better specs for USAID		x		
4.3-2	Training/orientation re procurement	x	x		
4.3-3	Analysis of USAID Purchasing Office	x			
4.3-4	Study to shortening cycle for US purchases	x			
4.3-5	Study of procurement MOH central level	x	x		
4.3-6	Training in procurement	x	x		
4.3-7	Using fewer mailrooms		x		
4.3-8	Notifying DASA of purchases		x		
4.3-9	Computers for purchasing & storage control	x	x		
4.3-10	Long term contracts for purchasing		x		
4.3-11	Hard-to-procure items	x	x		
4.3-12	Regional level procurement, planning/supervsn		x		
4.3-13	Inventory of latrine project		x		
4.3-14	Motivation and performance targets		x		
4.3-15	Transportation, vehicle maintenance, storage	?	x	x	
4.3-16	Analysis using customs brokers	?	x	?	
4.3-17	Regional advisors help on procurement			x	
4.3-18	Technical assistance in logistics	x		x	
Health Information System					
4.4-1	Strengthen analytical capability OGIE/all MOH	x	x	?	x
4.4-2	Analysis/use of NNHS and provider surveys	x	x		
4.4-3	Installation of information sub-systems	x	x		
4.4-4	Improve vital statistics	?			?
4.4-5	Computerize information system	?	x		?
4.4-6	Coordinate donors on information systems	x	x		x
4.4-7	Continue consensus group on info systems		x		
4.4-8	Outside review re implementation of info system	x	x		
4.4-9	Implementation plan for new info system		x	?	

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Rec.#	Recommendation	Institutions Involved*: USAID	MOH	WHS	Other
Health Information System (cont.)					
4.4-10	Technical assistance continued/data use	x		?	
4.4-11	Specific applications of NNHS results	x	x		
4.4-12	Share NNHS results from Puno with Bolivia	?	x		Bolivia
Supervision Systems					
4.5-1	Modify supervisory model	?	x	?	
4.5-2	Four alternative approaches		x		
4.5-3	Evaluate self-instruction for supervision	?	x		
Training					
4.6-1	Comprehensive training plan	x	x		other donors
4.6-2	Assess training needs		x	?	x
4.6-3	Training needs from evaluation into plans		x		
4.6-4	USAID technical assistance re training	x			
4.6-5	More training/health education materials	?	x		other donors?
4.6-6	Define role of promoter	?	x		
4.6-7	Promoter incentives	?	x		
4.6-8	Supervision for promoters,TBAs		x		
4.6-9	Operations research re promoters/TBAs	?	x		
4.6-10	Promoters in urban areas	?	x		
4.6-11	Concentrate TBA training in traditional areas		x		
4.6-12	Birth attendance training for fathers		x		
4.6-13	Training materials in indigenous languages		x		
4.6-14	Radio to inform about TBAs		x		
Population/Family Planning Outside MOH					
5.1-1	Support FENDECAAP	x			
5.1-2	Support AMIDEP	x			
5.1-3	Nothing to ASPEFAM now	x			
5.1-4	Management support organization for PVOs	x			
5.1-5	PVO grants in dollars	x	?		MOF?
5.1-6	private clinics surgical contraception	x	x		
5.1-7	separate project for private sector fam plan.	x			
5.1-8	public and private cooperation		x		private
5.2-1	Trott Report	x			IPSS
5.2-2	IPSS-post partum surgical contraception	x			IPSS
5.2-3	Cooperation MOH-IPSS	x	x		IPSS
5.2-4	Technical assistance for IPSS-logistics	x		x	IPSS
5.2-5	Selective support at Population Council	x			CNP
Technical Assistance					
6-1	Increase technical assistance	x		?	?
6-2	Performance boards			x	
6-3	output-oriented scopes of work	x	x	x	
6-4	Regional advisers help with data collection/use		x	x	
6-5	Continue using this evaluation	x	x	x	x

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Annex 2

Foreign Donors in Health and Family Planning

There are approximately 60 international organizations contributing in some way to health care activities in Peru. The MOH has received donations and loans of US$64.9 million and DM (Deutsch Marks) 13.5 million. This includes World Bank US$33.5 million (loan), I.D.B. US$675,000 (grant), USAID US$17.9 million (US$9.8 million loan and US$8.1 million grant), UNFPA US$1.1 million (grant), and Federal Republic of Germany 13.5 million Marks (with DM 10 million loan, and DM 3.5 million grant). USAID is also funding an US$11 million project (US$10 million loan, US$1 million grant) for environmental sanitation activities.

The internationally funded projects include an MCH/FP project funded by UNFPA, and AID funded Integrated Health and Family Planning and Rural Potable Water Systems and Sanitation. Training of Primary Health Personnel is funded by IDB. A Primary Health Project is funded by World Bank. Development of Primary Health Care in Cuzco, Apurimac, and Madre de Dios is funded by Germany. These projects include wide range of activities which include training, construction, administration, health education, provisional commodities, and equipment. Some local expenses, such as per diem, etc., are also covered. The activity receiving the most resources is training of personnel.

Careful project monitoring by donors and MOH is needed to minimize the present duplication of efforts and overloading the MOH's ability to respond to the various demands. It is imperative that good communication channels and coordination be maintained among the donors and at the MOH. At present each donor agency imposes reporting requirements on the MOH which are different in format, content, and frequency. Each donor has a different administrative unit and project director in the MOH. There are definite plans under way to develop donor coordination mechanisms in the Ministry of Health. These are reviewed in section 4.1 of the report.

Inter-American Development Bank (IDB)

The IDB is funding a project which provides training for primary health personnel and community health education in 16 regions and 33 areas. It includes supoport for 14 months of technical assistance, three studies, production of training materials, training courses for 1,973 health staff and 76,000 promotors, plus course evaluation.

The World Bank (IBRD)

The GOP borrowed US$33.5 million from the World Bank for support of a project to increase access to primary health services, including family planning, for approximately 3.5 million people living in La Libertad, Lima, Centro Medio, and Huanuco. These areas were selected because of the relatively poor health status, low access to health care, low income, and low education of the inhabitants.

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The model the project is using is the development of primary health care modules which are intended to provide better family care, ambulatory medical care, and community health care. The focus is on improving the organization of health resources, i.e., home care auxiliary nurses, health post nurses, and a health team at the health center under the charge of a physician.

The project is designed along the lines of the primary health care project in Cali, Colombia. It includes seven components: 1) organization and delivery of PHC through 131 PHC modules, construction and equipping health centers and posts, providing vehicles and equipment; 2) training of health manpower including health volunters; 3) community health education and participation using various types of media; 4) monitoring, supervision and evaluation through development of an information system, a supervisory system, a health pharmacy, and cost recovery system; 5) maintenance of facilities and equipment by contructing two maintenance centers; 6) staff development through fellowships and courses to improve managerial capability of key MOH personnel for 8,500 health personnel and 20,000 promotors; and 7) project administration support by strenthening administrative capability through technical assistance and support materials.

The project, because of its complexity in design, has been slow in getting started by the MOH. According to bank officials the project is two years behind schedule.

Federal Republic of Germany Project

This project is directed toward improving the health structure in Cuzco, Apurimac and Madre de Dios. Its objectives are rehabilitation of 27 health posts, five health centers, and four hospitals. In addition the project plans to re-equip 90 health posts and eight health centers, and provide 145 health posts and 19 health centers with refrigerators. It also includes funds for rural water systems and latrine construction.

United Nations Fund for Population Activities (UNFPA)

UNFPA has been actively supporting population/family planning programs in Peru since 1979. It supported the 1981 census, provided funds for fellowships and seminars on population, studies on migration, feasibility studies on combining family planning with food distribution program, limited commodity support for family planning and MCH family planning education. The majority of UNFPA support to Peru was for the 1981 census and other population relatec activities. The total amount spent through 1982 was US$5,944,027 with a 1983-84 budget of US$1,382,873 making a cumulative total of US$7,326,900. UNFPA funded programs are managed by the Pan American Health Organization (PAHO) for technical assistance and research. The International Labor Organization and the World Food Program also act as executive agencies for UNFPA in Peru.

Peruvian institutions receiving UNFPA support included the MOH, Instituto Nacional de Estadistica (INE), and the National Office for Nutrition Support. UNFPA funding has decreased considerably during the past several years.

PAHO has also provided $228,000 from its own funds for research on orals and for training carried out by two Universities in 1982-83.