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**EVALUATION REPORT:
FPMD TECHNICAL ASSISTANCE TO THE
PERU MINISTRY OF HEALTH**

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FAMILY PLANNING MANAGEMENT DEVELOPMENT

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ACRONYMS

AMIDEP	<i>Asociación Multidisciplinaria de Investigación y Docencia en Población</i> Multidisciplinary Association for Research and Teaching in Population
CER	<i>Centro Peruano de Estudios para el Desarrollo Regional</i> Peruvian Center for Studies in Regional Development
CQI	Continuous Quality Improvement
CSAP	Child Survival Action Project
DGI	Development Group, Inc.
FPMD	Family Planning Management Development
HIS	Health Information System
INPPARES	<i>Instituto Peruano de Paternidad Responsable</i> (Peruvian Institute for Responsible Parenthood)
MIS	Management Information System
MOH	Ministry of Health
MSH	Management Sciences for Health
PFPIP	Peru Family Planning Implementation Program
PRISMA	<i>Proyectos en Informática, Salud, Medicina y Agricultura</i> Projects in Information Sciences, Health, Medicine and Agriculture
PRITEC	<i>Profesionales en Informática y Nuevas Tecnologías</i> Professionals in Information Sciences and New Technologies
TA	Technical Assistance
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

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I. EXECUTIVE SUMMARY

The Family Planning Management Development (FPMD) project of Management Sciences for Health (MSH) has provided technical assistance (TA) to the Peru Ministry of Health (MOH) in two areas: the improvement of management skills and quality of services and the establishment of a smoothly-functioning management information system (MIS) for family planning programs. This TA has taken place in part through workshops and the development of a manual on administrative procedures. This evaluation of FPMD assistance was conducted through review of project documents and reports, interviews with persons in the MOH and Peruvian agencies assisting with the project, and informal focus group sessions with workshop participants from Puno and Juliaca.

Overall, the quality of MSH technical assistance was rated highly by interviewees. They especially cited the good coordination between MSH, the MOH, consultants, the local project coordinator and local private sector organizations. The workshop also received high praise; on a scale of one to five, the workshop consistently received an average rating of between four and five. Participants agreed that the most important result of the workshop was the development of a new understanding of "quality of services."

The manual of administrative procedures is an example of positive collaboration between MSH and the MOH. All users of the manual who were interviewed thought the manual well-organized, very concrete and very practical. All though it helped them in their jobs. There was also strong feeling that the manual should be adjusted to other health programs.

MSH also provided assistance in integrating two data collection systems (Health Information System, or HIS, and Quipus) into a unified and comprehensive Health and Management Information System (HIS/MIS). Despite problems in agreeing on items such as definitions, formats and procedures, and the challenges of reconciling views and attitudes of persons and government units who have invested time in a system, the project has done an excellent job toward integrating the systems.

FPMD's project in Peru has three important results:

- There has been an important change in government attitudes toward the conduct of family planning programs;
- There has been increased awareness of the importance of quality improvement; and
- The family planning service statistics and health information systems of the MOH have been integrated.

Several recommendations can be made for the future:

- There should be more in-depth study of effects of the project on quality of service and improvement of management skills. This can be done through focus

- groups with persons who attended the workshops and clients they serve. The Manual on Administrative Procedures should also be evaluated in-depth.
- Several groups of people, including those not directly part of the family planning service delivery system, should be exposed to the CQI approach. This should include people at all levels.
 - There should be more emphasis on the direct use of MIS for the quality improvement of programs.
 - If the project continues and becomes more complex, an administrative assistant should be brought into the office of the local coordinator so that the coordinator can devote all available time to technical assistance activities.

Population Policies in Peru

The new contents of the family planning program with its emphasis on quality improvement is an indication of the way things have changed in the family planning arena in Peru. For a long time family planning and population policy were controversial issues in the country. They found little political support from any part of the political spectrum. The burning question was not how to improve the family program but whether there would be a government supported family planning program at all. This seemed to change in 1976 when the government approved an "Outline of a Population Policy." The recommendations of this document were included in the Development Plan for 1975-1978. The document, a remarkably well-written text from the intellectual point of view, was the first official break with the dominant pro-natalist tradition. It recommended the elimination of all restrictions on public information and services concerning family planning. In practice, the situation regarding government family planning programs remained lethargic for many more years because of the lack of political will. Since the end of the eighties, the situation has changed drastically. The question is no longer whether to organize family planning programs, but how to improve their quality (UNFPA 1991). It is within this crucial change that MSH/FPMD is playing an important role.

II. BACKGROUND OF FPMD ASSISTANCE

Peru, under the USAID Priority Country Strategy, was selected for the implementation of a plan for population activities. The Peru Family Planning Implementation Program (PFPIP) aims to expand coverage, particularly in rural areas and among people in the greatest need who have traditionally received the least support for family planning. MSH/FPMD was requested by USAID to provide technical assistance to the Ministry of Health (MOH) for strengthening administrative systems and Management Information Systems (MIS) and improving the management of service delivery in the public sector. FPMD assistance to the MOH therefore consists of two components: one concerns the improvement of management skills and quality of services, and the other concerns the establishment of a smoothly functioning MIS for family planning programs.

Technical assistance to improve management skills has primarily taken place through workshops (see table below) and the development of a manual on administrative procedures. Technical assistance for MIS was provided primarily through MIS experts from MSH; contracts with private agencies such as PRITEC and DGI; an external MIS consultant; and the activities of the local coordinator—which included conducting small workshops in different parts of Peru—and one large workshop in Tacna.

Overview of Workshops Organized by MSH*				
Date	Workshop	Location	No. of Participants	Comments
November 1994	Workshop on HIS/Quipus	Huaraz	+/- 25	
Dec. 5-9, 1995	Field Testing the Administrative Procedures Manual	Lima	32	Testing the Manual of Administrative Procedures with regional FP Coordinators
March 21-24, 1995	Sub-regional Family Planning Development Workshop	Huaraz	21	
April 24-27, 1995	Service Management and CQI	Puno	29	
June 7-9, 1995	Service Management and CQI	Huaraz	26	
July 5-7, 1995	National Workshop of Service Management and Supervisory Skills	Lima	38	Training in use of Manual of Administrative Procedures
July 14-16, 1995	Workshop on: HIS/Quipus**	Tacna	32	Field testing newly integrated HIS/Quipus system

* Note that this does not include workshops organized locally by FPMD Regional Coordinator.

** See Section VI. A. for explanation.

III. THE QUALITY OF MSH/FPMD TECHNICAL ASSISTANCE

A. General Perceptions

The technical assistance from MSH was rated very highly by respondents at the MOH in Lima and those in the field. MSH consultants (internal MSH consultants from the MIS program and external MSH-sponsored consultants) and the personnel of FPMD's Latin America/Caribbean Unit, including the local coordinator in Lima, were repeatedly mentioned as important reasons for the success of the technical assistance provided by MSH. The project was especially praised for good coordination between MSH, the MOH, consultants, the local coordinator, and local Peruvian organizations from the private sector that had been selected to execute certain portions of the project. The following statement summarizes the generally shared perception of the MSH personnel and consultants at the MOH:

- MSH personnel and consultants are knowledgeable and flexible, always prepared to adjust when changes were needed. We in fact would like to have more time with them. One cannot profit sufficiently from them!

These positive evaluations of MSH work occurred in an environment where a multiplicity of agencies are operating under the umbrella of USAID. As one high level MOH manager puts it:

- We thought that with 25 million dollars in aid from USAID we had both the opportunity and the liberty to do a series of things. However with the assistance came the obligation to do certain things with the collaboration of a host of CAs, each for a specific area. The coordination of so many counterpart agencies becomes a real problem. We have to deal with the visits of representatives of at least 13 agencies. Because of that our personnel does not have sufficient time. Therefore now that I am convinced of the soundness of MSH contributions I want the same. Recently another agency approached me for total quality but I refused. We have MSH and that is the only agency which we want to deal with for this type of work.

B. MSH and Other Implementing Agencies

In implementing the project MSH has selected several agencies for their assistance. Two of them are local Peruvian agencies: PRISMA and PRITEC. The other one is Development Associates (DGI), with offices in Lima and headquarters in the Washington area. MSH defined their respective responsibilities, coordinated their efforts and supervised their work.

PRISMA (Proyectos en Informática, Salud, Medicina y Agricultura - Projects in Information Sciences, Health, Medicine and Agriculture) is a private non-profit agency. PRISMA's relationship with MSH is very recent and dates from the end of last year. It assisted MSH in logistics and provided the logistic support for the workshops (see table on Page 2). Staff members at PRISMA very much appreciate the opportunity to collaborate with MSH and would like to strengthen and institutionalize the links with MSH and develop joint projects

inside and outside Peru. Their logistic support allowed workshop facilitators to concentrate on the delivery of the training and on substantive interaction with the workshop participants. These last were unanimous in expressing their appreciation for the logistics and the daily organization of the workshops.

PRITEC (Profesionales en Informática y Nuevas Tecnologías - Professionals in Information Sciences and New Technologies), a local Peruvian firm and an offspring of The PRISM Consulting Group, was involved the establishment of health information systems and provided training and support at the UTES (regional) and UDES (subregional) levels. It was selected because of this past experience in the area of information systems and its excellent reputation with the MOH.

DGI (Development Group Incorporated), a USAID collaborating agency, has been heavily involved in the development of the Quipus statistical system for family planning program data and software. It was subcontracted by MSH as the lead coordinating agency for the integration of the family planning data from the health information system of the MOH into the Quipus system.

IV. WORKSHOP EVALUATIONS

The Workshop Evaluation Participant Feedback Sheets administered after every workshop (see table on Page 2 for a listing) show that the workshop participants thought very highly of them. On a scale of five, the workshops consistently received an average rating of between four and five. This evaluator discussed the workshops with respondents at the MOH and through informal focus groups with the participants from Puno and Juliaca in the workshop on Service Management and Continuous Quality Control Improvement organized in Puno.

Over-all impression of workshops, as perceived by participants. Participants from both Puno and Juliaca were extremely enthusiastic about the workshop and about the MSH consultant responsible for the conduct of the workshop. "One of the best workshops that I ever attended" was on the tongue of many of the participants. One participant saw the success of the workshop reflected in the attitude of the local hospital physicians towards the workshop:

- When a workshop is organized here in the hospital, physicians normally show up at the onset and then cease attending because they feel it is beyond their dignity to continue their attendance. This time the physicians were so entranced by both the contents and the presentation of the workshop that they stayed until the very end of the workshop.

Duration of workshop. At the MOH it was strongly felt that the duration of the workshops should be shortened from five to three days because "we just do not have the luxury to keep employees a full week away from their job." On the other side it was the unanimous feeling of

the participants of the Puno workshop that they could have profited from a slightly longer workshop (about 10 days was the modal answer).¹

Appropriateness of workshop contents. At the MOH the workshops were generally judged appropriate, but some doubts lingered about whether all aspects of the contents were so. For example in connection with the Huaraz workshop the following opinion was given at the MOH:

- I don't know whether all the contents of the course can be applied locally. In the case of Huaraz I guess it can be applied for about sixty percent. On balance it has helped much. The objectives have been reached. One hundred percent total quality is impossible to get. There is too much variety in the quality of the health units. Hopefully this will improve with World Bank and USAID assistance.

Logistic aspects of workshop. Participants generally thought that the logistics and the daily organization of the course were outstanding. The punctuality of the sessions was especially appreciated. Some participants in Puno mentioned that there was no need to organize these workshops in the lavish surroundings of the luxury hotel where the Puno workshop was held:

- The objective of the workshop was to put us into contact with the concrete reality of quality problems within the environment in which we work. This environment requires a continuous balancing of costs with what we can provide as adequate service. A luxury hotel is the wrong symbol for this perspective².

Striking characteristics. In the focus group discussions there was unanimous agreement that the most important result of the workshop was the discovery of "quality of services" as a concept with a content completely different from what they had imagined before:

- We had talked about quality improvement of our work but in the light of what we have learned from the workshops, we really did not know anything about it. We tended to confuse it with entrepreneurial skills. We learned that to be compassionate toward people is part of quality improvement.

The second most important characteristic cited was the communication and presentation methodologies used in the workshop:

¹ It is not the intention of the evaluator to promote ten-day duration workshops. However, the fact that participants in the Puno workshop, admittedly a limited sample, prefer a longer workshop seems to suggest that the workshops intend to do too much within the allocated time span.

² It is not always easy to walk the right road in the matter of accommodation. If no sufficiently comfortable accommodations are selected, participants might consider that the organization isn't treating them the way it should.

- There was a lot of variation in the methodology of the workshop. One's attention never wandered. There were discussion groups, there were workgroups, there were sociodramas. Group dynamics were used, examples were clear and concrete. The presentation was vivid. The workshop leader put her soul behind all these methodologies. It really makes you reflect on one's work and clients.
- The folders prepared for the workshops are excellent. They contain lots of useful material. (*elementos valiosísimos*) including extremely useful support material and bibliographies.

Effects on the clients. It was not feasible to get direct information on this issue from the clients at both hospitals (Puno and Juliaca) where the service providers had been interviewed. However, effects on the clients were very much discussed in the two focus groups. All participants were unanimous that their behavior had changed as a consequence of the workshops:

- The workshop has made us reflect on our own behavior towards our clients. Suddenly we became aware that we were too authoritarian toward the clients.
- We realized that quality improvement often lies in small details, but with big consequences. Before clients would knock on the door and wait reverentially before receiving the order to enter. Now we invite them to come in and we tell them: Please take a seat. Simple things but so important (*cosas simple! cosas importantes!*). The change in our behavior has made our clients change!
- The workshop has taught us how the irritations of daily life are reflected in the treatment of our clients. At home we get irritated because of problems with children. We should not let this irritation affect our clients.
- When a patient comes to the hospital, I now enter into a dialogue with her. How can I help you? What are your needs? Before, I really did not engage in a meaningful conversation with the clients about the selection of contraceptive methods. We did not impose a particular contraceptive but nevertheless the presentation of method selection was done in routine fashion without really involving the client in the decision process. Now I discuss the particular usefulness of the various methods in the light of the client's preferences and of the needs of the couple's daily life.
- I now listen much more to what my clients tell me. I give them confidence. Patients often are uneducated or have little formal education and spontaneously assume a submissive attitude. Externally they accept our views as oracles. In reality, however, communication barriers remain huge. Now with a different style of conversation they ask more questions which show that they have a real interest in learning more about reproductive health. In place of unilaterally prescribing a solution, my client and I become a small decision team.
- Our clients often have mythical beliefs about the causes of diseases or what certain contraceptives will do to their health. We tend to brush these off as just useless talk. Now

we listen to them, because it gives additional information on how they view family planning in the context of their own life.

- As a consequence of the workshop I have started to make the provider-client relationship more dynamic. The relationship has become much more vividly present in my mind. I try to be punctual and to be in the consultation room at the agreed time. I now leave all other work to first take care of the client. I use simple words which my clients can understand. Sometimes quality improvement can be obtained through changes in small things. Just some friendly humor can break the ice. I use much more "*por favor* (please)" in my conversations with the clients. All of us have started viewing the client as a real human person. Much more information is now transmitted to the client who absorbs it much more than in the past. And we also get much more useful information from them!

Some persons, while fully subscribing to the aspirations promoted by the workshops, indicated how difficult it sometimes is to change attitudes:

- I learned much from the workshop and how important it is to gain the confidence of our clients and to respect them. However, one has to recognize that it is not always easy to change one's behavior and that of others. It is easy to talk about quality. Better to start with small objectives and then gradually amplify them. We sometimes have to overcome the pessimism of certain personnel members, and even my own, in regard to quality improvement.
- There is still a lot of mistreatment of clients at all levels. From the janitor to the highest levels, the commandeering style predominates. Personnel sometimes fight among themselves. We have to rectify ourselves. We still use too much expressions such as "Come back another day (*venga otro dia!*)" or "*manita*" (diminutive of mother) in place of "*señora*." This mistreatment is the main cause why clients will not come back! They often come from far and such a reception kills all desire to come back. It will require persistent efforts to change these attitudes! We have to talk in a human voice with our clients!
- Sometimes there is useless physical separation from one service to the other. For certain things the client has to be on the first floor and next she has to go to the third floor. Also, as you can see, there is a lot of space in the hospital, but to get a minimum of additional space for more privacy for interviewing clients on contraceptive use and reproductive health is an upward battle.

A complete evaluation of this very important aspect would require interviews with the clients. Participants affirmed that the volume of clients had increased since they started giving more prominence to quality improvement in their work. The fact that the groups regularly meet to discuss problems of quality improvement is another indication of how important the theme of quality improvement is considered by the participants in the workshop.

Suggestions for additional activities. Participants generally would like to have more practice including sessions with real clients, and they also point to the necessity of organizing

workshops for all personnel levels. They also expressed a desire to have access to more didactic material, pamphlets, audiovisual materials, and texts on total quality (one participant complained she had been promised such material but had never received it).

- The greatest benefit that I got from this workshop is concern with the client. This concern should be a permanent one. I want to make two suggestions: organization of some workshops with direct participation of our clients and regular repeat workshops so that the concern with clients does not remain temporary.
- The movement toward higher quality, to be really effective, requires that workshops such as the one we were exposed to are organized for all levels of personnel. Many professionals frequently need to be reminded of the importance of quality enhancement in their own professional life.
- The interest in quality improvement I got through the workshop has made me aware of the absence of such a concern among many personnel members. There are especially four categories in need of more awareness of quality concerns. These are the people at the lowest level—such as janitors, cleaning personnel—who often boss the clients. Second, there are administrative personnel who have to fill out client forms and steer clients to appropriate services. To them the client is just a number. They have to tell her where to go. Often it sounds like a military command and the woman gets overwhelmed by the rude behavior and will be less inclined to come back to a place which even physically is already so different from her rural or urban dwelling. Those two categories are often the first type of personnel clients interact with. They create the initial environment for the client within which our efforts toward improved quality may be less efficient because of the rudeness at the gate. These people should be made aware of their own importance in the chain of quality improvement. The third category are the technicians who interact with the clients. To them the client is the recipient of the information concerning a test or a particular procedure the client has to follow. The technicians never think that their diagnosis might suffer from their indifference toward the client. Finally, physicians and high level managers remain very spotty in their attention to quality. On an abstract level they are all for it but when even very modest resources are needed to put it into practice, their absence is conspicuous. We need training sessions for all four categories of persons. Our efforts are important but they need to be supplemented by those of all personnel.

Low compensation was mentioned very strongly at the MOH and to a lesser degree during the focus group discussions as making attitude change among the service providers more difficult. One respondent at the MOH described the situation as follows:

- Our big problem with the subregional coordinators is their great mobility, especially if they are obstetricians. As MOH personnel they receive about \$200 monthly. This is too low! As a consequence the basic conditions for motivation are absent. Financial restructuring has not yet reached the MOH. In some ministries the staff has been cut substantially while increasing the salary of those staying who are supposed to be more qualified.

V. **MANUAL OF ADMINISTRATIVE PROCEDURES FOR THE MANAGEMENT OF THE FAMILY PLANNING PROGRAM** (*Manual de Procedimientos Administrativos para la Gestión del Programa de Planificación Familiar*)

This Manual, written specifically for family planning coordinators at the sub-regional level, is a conspicuous example of the result of the positive collaboration between the MOH and MSH. Its foundations were laid at a workshop with a group of persons responsible for the coordination of family planning activities at the sub-regional level in Peru and with the technical input of an MSH consultant. Participants at that workshop identified the basic elements, fundamental activities and administrative procedures that should receive priority attention in such a manual. A first draft of the manual was subsequently tested in Chavin and Jose Carlos Mariategui regions. On the basis of the field experience, the Manual was revised and finally published in 1995. Some terminology had to be changed to make it conform to Peruvian legislation, such as the law on abortion. Abortion cannot be considered a family planning method; the same is true for sterilization.

The Manual is organized in two parts. The first deals with management responsibilities of sub-regional coordinators (basically, the outline of a three week orientation program on the basic responsibilities of the function of the sub-regional coordinator). The second one deals with administrative activities and procedures (programming; budget management; logistics; training; information education and social communication; supervision; important aspects of information systems; and evaluation).

The success of the Manual is shown by several facts. First, all users who were interviewed thought the manual well organized, very concrete, and very practical. All agreed that it had helped them enormously in their job. Witness the following typical statement:

- Finally a manual to my taste! It doesn't get lost in verbiage. It gets straight to the point. For the first time in my professional experience I got the sense that management principles could improve my work.

Second, it is demonstrated by the feeling that the manual can and should be adjusted to other health programs. As one high level respondent in the MOH expressed:

- People from other sectors of the Ministry have told me how they would like to have such a Manual for their own sector. It indeed can easily be adjusted to other health sectors. Family planning programs, because they are relative newcomers to the health field, sometimes were indifferent about the quality of their operations. Now they are breaking new paths by showing how easily sub-regional coordinators can be convinced of the importance of attention to good administrative procedures.

VI. TECHNICAL ASSISTANCE FOR MIS

A. The Original Situation

The Peru situation in regard to MIS for health and family planning, together with MIS experience in other countries, shows the diversity of situations to which FPMD is normally exposed when attempting to provide technical assistance in this area.³ When MSH was asked to provide assistance in this area, it encountered a complex situation. Since 1988 under the Child Survival Action Project (CSAP), USAID had been providing support for the establishment of a unified and comprehensive Health and Management Information System (HIS/MIS). Because of debt-related problems, funding for CSAP had to be discontinued and the contract with The PRISM Consulting Group had to be prematurely terminated. However, the HIS portion of this system—consisting of a unified data collection system for MOH outpatient services in health centers, posts and hospitals—and a reporting system had been almost fully developed at that time and had been recently adopted by MOH as its official information system. The HIS/MIS has two unique characteristics: reliance on a single data collection form for all services and computerized entry of information at the level of patient visits. Coverage of the system, at about 80 to 90 percent, was high. The fact that it had reached these high figures in the span of a year speaks in favor of the system and those who helped in its implementation.

On the other hand, the office of Family Planning was using Quipus software, a vertical system, also supported by USAID, for most of its reporting needs. At the time of MSH's initial involvement, consolidated data from HIS/MIS forms were fed into the computer with the Quipus system. At that time data entry occurred at the Central level in the Family Planning Office using forms consolidated at the Department/Subregional level. It was then noted that Quipus provides the flexibility for reports at the UTES or regional level but that the additional work would overload the central level staff. In considering support for Quipus, MSH faced a dilemma. On one hand Quipus was a more direct approach to meeting the project goals. On the other hand, its continued autonomous use would result in fragmenting the integrated approach being promoted in the MOH.

In reviewing those systems MSH/FPMD recommended continued support of Quipus while integrating it into HIS/MIS. It described its own future role as that of an intermediary among different sectors and agencies active in information systems for health and management and as a coordinator of all information modules into an effective management information system for family planning.

Ideally, a complete family planning MIS consists of three components: service statistics, programming statistics, and statistics on logistics. At the time of the onset of FPMD's involvement with Peru there was no close integration of these three components.

³For more information on MIS assistance in Peru, see trip reports of Kip Eckroad and Edgar Necochea (Eckroad 1993, 1994 and 1995; Necochea and Eckroad 1993).

B. Problems with the Integration of HIS and Quipus

Problems in integrating two information systems always entail two interrelated problems. There are the intellectual challenges in agreeing on definitions, formats, procedures etc. On the other hand there are the interpersonal challenges in reconciling views and attitudes of persons and government units who have invested energy in either one of the two systems or in other parallel systems.

Intellectual Challenges

Some, but by no means all, challenges of this type are listed in the following paragraphs:

- ▶ The data structure and format used by the two information systems was different. In integrating them it was difficult to combine all the advantages of both systems. Ingenious efforts had to be made to retain as much as possible advantages of both systems while reducing the negative consequences of trying to integrate two systems with different histories and objectives.
- ▶ Programming languages on which both systems were based were different. Each of them had their own advantages and disadvantages (such as processing speed, efficiency of data storage, complexity, availability of persons familiar with language). The integration of both systems required changes to programming languages and other adjustments.
- ▶ The issue of data quality is probably the most challenging problem in the use of a particular information system. When two systems have to be integrated, the difficulties in detecting, analyzing and correcting errors are compounded. The demands of getting the HIS system started, prior to FPMD involvement, made it difficult to systematically pursue error detection and correction.
- ▶ Smooth data flow requires attention to issues such as error correction, handling of late data, concern for timeliness, consolidation, and upward movement of data flow. When two systems have to be integrated, problems of synchronization will become more pressing.
- ▶ Characteristics considered essential for one system may create their own problems. For example, the fact that the HIS system calls for the registration of a broad range of data in a single form necessitates multiple-coding for some fields which leads to potential confusion in filling out the form.
- ▶ When two data systems have to be integrated special care has to be exercised that essential data provided in one system are not eliminated for the sake of integration. For

example, at the onset of FPMD involvement HIS did not provide for data collection for in-patient hospital services such as surgical methods and post-partum IUD insertion. Similarly, the HIS system did not provide specialized entry for family planning campaign data.

- ▶ Actual and desired levels of aggregations may be different in both systems. Efficiency and speed in processing information has to be counterbalanced with the need to provide data at levels which are useful for microplanning and to guarantee the support of staff at lower levels of the command chain whose motivation to collect data will be strengthened if they get data and reports which are dealing with the area and segment of population for which they are directly responsible.
- ▶ The results, the reports, evidently are the most important output of the efforts to collect health and management data. Some systems may be more flexible than others. The HIS/MIS system produces more than 40 reports but originally only one of those dealt with family planning. This would not be so much of a problem if the HIS system had not hard coded its reports in the system which makes the system very inflexible. Program managers normally want control over content, format and aggregation levels.
- ▶ Ideally, a system should answer promptly to special queries. Frequently the query method in use is inefficient and difficult to use. The integration of two systems, if no adequate precautions are taken, can make such queries even more problematic.

Interpersonal challenges

There have been multiple struggles surrounding the HIS throughout its more than five-year history in the MOH. Although it was the policy of the MOH to accept the HIS system as the system to be generally used by all sectors of the MOH, several individual programs are reluctant to give up their independent vertical systems. As a consequence of the political turnover within the MOH (for example, during the two-year period of MSH's involvement there have been three different Directors of Reproductive Services) consensus-building around the HIS system as a unified, comprehensive service delivery statistics system has been difficult. Each change required new rounds of negotiations to maintain support for the decision to use HIS as the key information system for the MOH. At the end of May, according to consultant's reports, the commitment to the unified collection and processing of service statistics on the part of MOH remained uncertain.

C. Results of Efforts Toward Integration

In spite of the formidable problems that had to be confronted, the project has an admirable record in solving them. This was basically done through several technical assistance trips from MIS personnel at MSH, and through the contributions of a local MSH-sponsored consultant who made critical improvements to the original HIS program, and of the local technical

coordinator who provided technical assistance on a daily basis and conducted small special workshops to oil the transition toward integration. Through technical assistance from MSH and PRITEC—which developed a program for a flexible reporting module—and the presence of the local coordinator and in close collaboration with the Statistical Division of MOH, a full MIS for family planning services, integrated into HIS, was established. It was decided that the HIS data collection system for ambulatory care should be used as the primary method of data collection for family planning statistics in place of the use of an existing or new vertical data collection system exclusively for family planning because HIS contains all the service variables required by the Family Planning Program with the only exceptions, as previously indicated, being those related to hospitalized patients.

Technical assistance therefore concentrated on coverage (because not all MOH outpatients are currently reporting), accuracy (because of uncertainty about the extent of validity of data), and reporting (because, as also mentioned above, of the inflexibility in report format and contents). Therefore, among several actions, attention was given to quality and quantity of data through monthly monitoring by the MOH and the resident coordinator to check which health units are reporting and which are experiencing delays. PRITEC signed a purchase order with MSH to use this information to target its technical assistance to the subregions. Under the same purchase order, PRITEC took up the responsibility for establishing the necessary parameters for error detection.

PRITEC's tasks were essentially completed by the end of the project. However, there are doubts about the extent to which the newly-revised HIS is used in the field because of financial problems and continuing problems of general acceptance of HIS in the MOH. Implementation of the DGI subcontract, under which it is responsible for the integration of the Quipus system into HIS, has had several delays in regard to the workplan and misunderstandings concerning the terms of reference. Although newly set deadlines could not be met, lately there are positive signs of satisfactory progress. DGI has completed the compilation of Quipus Manuals for users and development of a satisfactory version of the Quipus software. Finally, a workshop was organized in collaboration with DGI in Tacna in July 1995 to field test the newly integrated HIS/Quipus system. However, an important problem concerning this software remains: the delivery of the software source code to the MOH. Contrary to the terms of the subcontract and to the past behavior of PRITEC, DGI is claiming proprietary interests in the Quipus software. To be fully useful, the MOH needs not only the ability to modify the reports (which is now supported by DGI) but the ability to modify all aspects of the software.

Limited efforts were also made by MSH to incorporate the other two key elements of a family planning MIS: programming activities and logistics. These efforts remain very incomplete and will in fact require substantial additional efforts in the future.

D. Use of MIS Data in Program Planning and Evaluation

Everyone agrees that the use of MIS data to improve management of family planning and other programs is the most important objective of any MIS. Likewise, as for many other MIS projects, this is undoubtedly the weakest aspect of the MIS portion of the Peru project. Nevertheless, circumstances in Peru are very favorable to the implementation of this key aspect of any MIS. There is a strong feeling in the Statistical Office and in the Family Planning Office at the MOH that this aspect should receive priority consideration. The current director of the Family Planning Office repeatedly emphasizes this in meetings and speeches at the FPMD-sponsored workshops and tries to imprint on the subregional coordinators the importance of the use of those data for quality improvement and better management. At the local level on the part of the regional coordinators, at least in the evaluator's contacts with them in Puno and Juliaca, there is a strong interest in having easy-to-use forms, in becoming better acquainted with the reports, and in their use for the improvement of their work:

- We do not yet have information into a format which is clear and interesting for the user. We have to spend more energy on getting the information in a format which is really appealing to the users. Substantial efforts will be needed in the future to obtain this basic and essential objective. This information is important to improve the quality of our services. In fact it would be useful if in the workshops on quality control and management improvement a session could be dedicated to this issue.

The evaluator was especially impressed by the quality of, and attention to, detail and the broad picture in the annual report of the subregional coordinator in Puno. Admittedly, this is the only such report reviewed by this evaluator. However, even if only fifty percent of similar reports in Peru have such characteristics, the soil for productive use of MIS reports at the subregional level will be very fertile.

VII. CONCLUSION AND RECOMMENDATIONS

The project has only recently started and needs more time to show full results. The project is a well-chosen one and, although not yet completed, can be credited for several important improvements in the family planning program of Peru. It is an example of successful collaboration between private technical assistance agencies (MSH, PRISMA, PRITEC and DGI) with the Ministry of Health and with its network of health/family planning services in a country where the public sector provides fifty percent of all family planning services. The evaluation has shown that the project is steadily progressing toward its goals and that no major revisions in the design and implementation of the project are required.

To date the result of the project can be summarized in the following points:

- ▶ Important change in government attitudes toward the conduct of family planning programs through emphasis on management issues and on the quality of family planning;
- ▶ Increasing awareness of the importance of quality improvement philosophy and techniques throughout all management levels, but especially at lower levels of the health sector; and
- ▶ Integration of family planning service statistics into the health information systems of the MOH.

In the future the project could profit from attention to the following aspects:

- ▶ In light of the widely-admired effects of the workshops on the improvement of the quality of services in the family planning program it would be extremely useful—not only for the Peruvian project but also for the quality improvement movement of family planning programs—to conduct during an eventual FPMD II project more systematic in-depth studies of the effect of the project on the quality of service and the improvement of management skills. This could be most aptly done with the use of a series of well-selected and well-designed focus groups with the persons who attended the workshops and the clients for whom they are responsible. Likewise, the Manual on Administrative Procedures deserves such in-depth evaluation
- ▶ The discussions I had with the participants in the workshop in Puno convinced me of the importance of exposing several groups of people, not directly part of the family planning program service delivery system, to the continuous quality improvement approach of family planning services. These groups range from administrative and service personnel at the lowest levels to intermediate-level managers in the National Health Service of Peru (especially hospital directors), even if not directly engaged in family planning services. If not convinced of the importance of family planning and the imperative to provide high-quality service the sub-regional level coordinator will fight against an immovable wall. This will require the formation of an effective team of trainers in Peru through satisfactory TOT programs.
- The MIS portion of projects needs to give more emphasis to the direct use of MIS for the improvement of the quality of programs. Also, more attention will have to go to the integration of statistics on logistics and on programming activities into the MIS for family planning. One avenue to be considered is to give more attention to MIS in workshops on quality control and management skills.

- Under the assumption that FPMD II will continue to be involved in Peru, the project is bound to become more complex. Because of this, the time of the local coordinator will become even more taxed. It is important that the local coordinator can focus on the substantial aspects of the project. There may therefore be merit in adding an administrative assistant to the local coordinator's office in Lima so that the coordinator can devote all available time to technical assistance activities⁴.

⁴ It has been suggested that MSH should have a completely autonomous office in Peru. There are both advantages and disadvantages to this proposal. The location of the office within the MOH provides for daily contact for a project concerning several segments of the MOH and likely reduces costs. On the other hand, an autonomous office would give more visibility to MSH and would also provide material facilities, such as communication hardware. Any decision on this issue should wait for the final approval of FPMD II.

ANNEX 1
METHODOLOGY

It should be emphasized that the FPMD subproject with the MOH of Peru has only recently started and that because of that, a full-scale end-evaluation of the project is not yet possible. However, the project is sufficiently advanced to get a provisional accurate picture of how the project is progressing to its objectives. The evaluation is based on three sources of data:

- ▶ project documents and reports (see Annex 2);
- ▶ interviews with persons intimately connected with the project in the MOH and in the Peruvian agencies executing part of the project under the guidance and in collaboration with MSH plus some outside observers.
- ▶ two informal focus group sessions with the persons in Puno and in Juliaca who attended the workshop on Service Management and Continuous Quality Improvement. The discussions centered around the quality and appropriateness of the workshop and how it had affected their work and their relations with their clients.

ANNEX 2
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ANNEX 3

LIST OF PERSONS INTERVIEWED

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WORKSHOP PARTICIPANTS

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