

**A Mid-Term Review of the
USAID/Peru Strategy in Health, Population & Nutrition**

Strategic Plan 2002 – 2007

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Abbreviations & Acronyms

AD	Alternative Development
AMI	Amazon Malaria Initiative
CA	Cooperating Agency
CDC	Centers for Diseases Control and Prevention (U.S.)
CSH	Child Survival and Health
DHS	Demographic and Health Survey
DISA	Dirección Regional de Salud (Regional Health Administration)
DIGESA	General Health Administration (MOH)
DIGEMED	Dirección General de Medicamentos, Insumos, y Drogas (MOH)
EPS	Empresa Prestadora de Servicios de Salud (Health Service Provider)
EREID	Emerging and Re-Emerging Infectious Diseases
FP	Family Planning
GOP	Government of Peru
IEC	Information, Education and Communication
ID	Infectious Diseases
INS	Instituto Nacional de la Salud (INS)
LAC	Latin America and the Caribbean region
MDR TB	Multi-Drug Resistant Tuberculosis
MMR	Movimiento Manuela Ramos
MOH	Ministry of Health
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
NTP	National TB Program
OGE	Oficina General de Estadísticas (Office of General Statistics, MOH)
PAHO	Pan-American Health Organization
PLWHAs	People Living With HIV/AIDS
RH	Reproductive Health
SI	Sanitary Intelligence program
SIGA	Sistema Integral de Gestión y Administración
SIS	Integral Health Insurance (provided by the MOH)
SIU	Sistema de Identificación de Usuarios (User Identification System)
SOAT	Mandatory Traffic Accident Insurance
VSC	Voluntary Surgical Contraception
USG	United States Government

Introduction & Methodology

In 2001, USAID/Peru developed a Mission strategy for development activities for the years 2002-2006, which has since been extended through 2007. USAID programs in Peru have evolved within this strategic framework, and have also taken new shapes and directions to adapt to a changing environment. The Mission portfolio and budget have appropriately shown their flexibility to respond to shifts in U.S. foreign policy interests, integrate lessons learned, and adapt to rapidly changing conditions and trends in the Peruvian government and civil society.

As USAID/Peru's Office of Health, Population and Nutrition now moves into the second half of the health sector framework set forth in this strategic plan, it called for a comprehensive mid-strategy review of the Mission's health portfolio. The purpose of this mid-term assessment is to review experiences to date within the current strategy, to provide perspectives from outside the Mission on the accomplishments and challenges in its health portfolio, and to suggest directions for the remainder of the strategy period and beyond. The intent of this review is not to evaluate activities rigorously, but rather to examine qualitatively the partners and approaches that have been implemented thus far, with an eye toward future directions.

This assessment was conducted in February 2005 by a team of health sector staff from USAID/Washington who traveled to Peru to work with the Mission to carry out key informant interviews and review relevant mission and partner documents. The review team, led by Lindsay Stewart, consisted of the following individuals:

- Susan Bacheller, Infectious Diseases Advisor, Bureau for Global Health (Feb. 22-27)
- Karen Cavanaugh, Health Systems Management Analyst, Bureau for Global Health (Feb. 13-25)
- Lindsay Stewart, Senior Advisor on HIV/AIDS & Family Planning, Bureau for Latin America and the Caribbean (Feb. 13-25)
- Ben Zinner, Program Assistant, Bureau for Global Health (Feb. 13 – Mar. 2)

Priority topics for the review were set in consultation with Mission HPN staff and the guidance of HPN Director Dick Martin and Deputy Director Susan Thollaug, who submitted two initial lists of questions to the USAID/W team before their arrival in Peru (see Appendix 1). The team used these questions as a guide for this review.

The agreed-upon structure for the review identified a number of priority technical areas and cross-cutting themes of relevance to the Peru health team. The USAID/W team worked collaboratively to address cross-cutting themes, and each team member focused on one or more priority technical area.

Activities related to health sector reform and private sector business models for reaching the poor were reviewed by Karen Cavanaugh; HIV/AIDS, family planning & reproductive health, and alternative development activities were reviewed by Lindsay Stewart; and infectious disease activities were reviewed by Susan Bacheller. Ben Zinner provided general support for the review team and coordinated the production of the team document.

The findings and recommendations contained in this report are based on the team's review of documents and interviews with key informants. In the time allotted, we were not able to review in depth every document or meet with everyone we would have liked to who was a potential key informant. The report therefore may include some areas that are not fully substantiated. For any errors, we ask your forgiveness.

The assessment team wishes to thank the USAID/Peru Mission staff (Richard Martin, Susan Thollaug, Jaime Chang, Lucy Lopez, Edgar Ramirez and Luis Seminario of the Health Team, and Deputy Mission Director Susan Brems) and the many representatives of Peruvian and international agencies who took so much time from their regular schedules to meet with us and provide valuable insights into health in Peru and the Mission's role in the present and future. The list of those we met is found in Appendix 3.

Executive Summary

Peru has experienced many changes in its health care system in recent years, celebrating a number of notable innovations in the delivery and promotion of health care. Signs of this progress include gains across the board in reproductive health indicators, and a 71% rate of assisted deliveries according to the 2004 DHS. This report explores some of these successes, and also some of the key opportunities that lie ahead for improving access to quality health care and information for all Peruvians.

Through this strategy period, USAID has shown its ability to adapt to a changing and often unpredictable environment in which shifts in U.S. foreign policy, changes in the Peruvian government, and other external factors have changed the context of health assistance. The conclusions and recommendations in this report recognize the key role that USAID can continue to play in supporting key reforms in the Peruvian health care system. Recommendations are made with an eye toward the marked declines in the Mission's health budget in recent years, and the importance of ensuring that approaches are strategic, sustainable, and maximize USAID's comparative advantages; and that instruments, partnerships, and management approaches are responsive and effective.

As USAID moves toward eventual phase-out of population assistance, which currently encompasses nearly $\frac{1}{4}$ of its annual budget resources in health, USAID/Peru will need to work strategically to consolidate past gains and leverage remaining resources to achieve the most sustainable impact possible. This process should include the development of a clear strategic plan for phase-out that takes account of past results and lessons-learned, identifies remaining gaps, and sets out a prioritized plan of action for moving out of USAID assistance in this area.

Institutionalizing family planning will involve working with the MOH to identify next steps in the context of decentralization and health sector reform, and these steps also should be included in the phase-out plan. USAID has worked successfully with the MOH through the Cobertura con Calidad program, assisting it in the development of regulations that are now being disseminated nationwide. The ReproSalud project appears to have been successful in the geographical areas where it has worked. Women and community empowerment techniques developed by its parent organization MMR also appear to have been successful, but on a small scale. A thorough evaluation of both programs should be conducted to clearly identify impact, lessons learned, and future directions. The review of ReproSalud's program should be conducted immediately, before any decisions are made regarding the future of the project. The Mission also should consider taking steps to further strengthen the sustainability of MMR beyond the end of USAID assistance.

Due to political sensitivities surrounding family planning in Peru, USAID Peru should look at how to best assure the continuation of clear and transparent compliance by reviewing efforts to date and weighing them against possible alternatives. One such alternative may be to include compliance as a component in already-established surveillance mechanisms.

Ensuring future contraceptive security in Peru will be a key component of the phase-out process. This should involve working closely with the MOH to address issues related to budgeting, effective targeting of subsidies, and identifying barriers to offering a comprehensive mix of family planning methods, including VSC. The private sector is an essential component in assuring a secure contraceptive supply, and the mission should evaluate current efforts to strengthen private sector involvement and explore ways to increase future sustainability through the private sector.

USAID/Peru has a strong program of health systems strengthening activities, and should continue with successful elements of this program. By taking advantage of short-term opportunities in support of clear, long-term objectives, USAID is helping to build credibility as a partner in reform. Field support mechanisms have been used effectively and have provided technical assistance that has been viewed as credible and neutral. The presence of full-time, field-based regional coordinators for *PHRplus* has also helped build successful relationships with local counterparts, and there may be options for reducing the cost of this support if it becomes necessary. Additionally, field work in Lambayeque and La Libertad has been successful for developing national models, and should continue at least until certain benchmarks are reached.

Despite uncertainty in the upcoming political transition, there seems to be consensus that the decentralization of the health system has become too institutionalized to turn back. We believe this has implications for future health systems assistance. One priority for the Mission should be to support the transition of the MOH from direct service provision into a role of oversight, regulation, and performance tracking, and to help build capacity at the decentralized level. The Mission should also consider efforts to keep health on the political agenda through the transition.

Building administrative capacity at all levels of the health system, both within and outside the government, has been a comparative advantage of USAID assistance and will be increasingly important as new reforms are rolled out. Peru has much to offer in the way of skilled care providers and system managers, and USAID needs to exploit opportunities to increase networking between local health management communities and their national, regional, and global peers. Capacity-building should include exploring sources for increasing the use and creation of technical assistance capacity through local partners, such as PROGRESA. Civil society also has a key role to play, and USAID should consider carrying out sustainability planning with local NGOs to ensure their continued participation in the national health dialogue.

Another aspect to systems strengthening is increasing the quality and availability of information for decision-makers. One opportunity is to advocate for an inventory/assessment of private sector health capacity and activities outside of Lima to inform government and donors. The Mission should continue to strengthen Peruvian capacity to track health spending and attract additional public investment in health, and may also consider helping regions to carry out burden of disease studies. The Peruvian experience with regional health accounting contains some key lessons learned, and we

suggest they be written up and presented at the National Health Accounts Symposium in Barcelona in July, 2005.

Throughout all systems-level activities, it will be important to continue to look for opportunities to improve equity – such as through improved targeting of the Integrated Social Insurance (SIS) – and to work toward achieving a more comprehensive health financing solution. Increasing coordination with other donors in Peru will also be highly valuable through the upcoming transition, and we recommend a reconstitution of the informal networking arrangement previously embodied in the “donor breakfasts”.

USAID/Peru’s flagship experiment in developing a private sector model to serve the poor, MaxSalud’s future remains uncertain. Faced with permanent structural budget deficits, there are a number of options that should be explored more carefully for reducing expenses, increasing revenues, increasing investment returns, or finding alternative sources of subsidies. Above all, it is clear that MaxSalud needs urgent technical assistance to explore these options and to develop a viable plan for sustainability. One challenge to be overcome will be to foster a greater sense of ownership among both MaxSalud’s own advisory board and local leadership in Chiclayo. MaxSalud’s experience as the first and only private sector provider for the SIS may be its key lesson thus far, and this should be fully monitored, documented and disseminated.

APROPO’s model for getting contraceptives to remote pharmacies via distributors who can turn a profit from doing so may be a valuable lesson in private sector models. In supporting these kinds of initiatives in the future, USAID might consider acting as a broker instead of a financing agent, and assist such ventures in obtaining financing through the private sector. This would allow the market to assess the viability of the business model and create more of a sense of ownership among project stakeholders.

Beyond MaxSalud and APROPO, there are signs that a variety of innovative ideas and potential for improving health care for the poor exist in the Peruvian private sector, both within the health care industry and in the business sector. Besides carrying out the aforementioned inventory of private sector providers outside Lima, USAID should consider engaging in a dialogue with private sector partners on the ideas put forth in “The Fortune at the Bottom of the Pyramid” (see Appendix 4), and on the role of the private sector in meeting social objectives in health. USAID should also be sure to document its experiences with private sector models such as APROPO’s local condom distribution scheme, as they may be worth wider dissemination.

As USAID/Peru’s field work increasingly concentrates in the 7-region alternative development focus zones, there are a number of issues that will require close attention by the Office of Health. While results have yet to be rigorously evaluated, activities to date appear to be having a positive impact on health, and also seem to support goals of democracy and community development by strengthening local organizations and investing in infrastructure. The Mission may be able to further capitalize on health’s contribution to democracy by strengthening links between local government and civic organizations and their regional and sub-regional counterparts, and this may also help

increase the sustainability of these activities. The Office of Health should further explore opportunities for enhancing coordination between health and other Mission sectors working in AD. Enhancing program monitoring and evaluation to capture health's contributions in other sectors may help facilitate this process.

The contribution of health activities to coca eradication targets is not clear, however, and health activities will likely be under increasing pressure to directly integrate coca eradication messages. The implications of further integration must be carefully scrutinized. The review team noted a perception of tension between the USG alternative development policy and the promotion of health and education. If integration comes at the price of USAID's no longer being perceived as a legitimate and transparent partner, then alternative development goals may be better served by focusing on the implicit contributions of health activities. Further integration could also place additional risk on USAID and contract health staff working in these regions, and the Mission must examine the degree to which this is a reality and, if so, the degree to which it is acceptable.

The high cost of these interventions must be taken into consideration, along with the degree to which this will make scale-up difficult. The mission should explore the links between activities within and outside the seven-region focus area, as well, as we believe there are strong rationales for continuing work in other regions. Building health systems capacity at the regional level, for example, may contribute to long-term AD goals by effectively expanding functional state presence. And infectious diseases, after all, know no borders.

In the area of infectious diseases, USAID's VIGIA project has made important contributions in malaria, surveillance and prevention of hospital-acquired infections, and other infectious diseases. The review team recommends that USAID/Peru focus additional efforts in a number of areas. One priority area for the USAID/Peru Office of Health should be to continue and increase its active engagement, and that of VIGIA, to support the National TB Program (NTP). The NTP now possesses capable leadership and has the strong support of the Minister of Health. The NTP needs to make up ground lost in TB control over the last four years, and the Mission should be especially vigilant in assuring that USAID FY05 TB funding is used to support the NTP's needs and priorities.

There are a number of specific opportunities to strengthen the engagement of the GOP in ID efforts. USAID may consider offering technical assistance to the NTP in preparing a proposal for the next round of the Global Fund. Given the problems with stock outs, USAID might provide TA to strengthen TB drug and lab supply procurement and management in the MOH at the national and decentralized levels. Another opportunity is to help the NTP re-establish a reserve of anti-TB drugs, and to build staff capacity in working with priority programs such as Malaria and TB in the context of health reform. Work with VIGIA and the NTP also should explore opportunities to expand DOTS support in civil society.

With VIGIA, USAID should hold regular meetings with VIGIA, the INS, and MOH counterparts to monitor progress. Ensuring the effectiveness of future TB funds may involve exploring alternative implementation mechanisms for programming these funds if problems with VIGIA cannot be resolved, and this decision should be made as soon as possible. The Mission also should take additional steps to ensure that FY04 TB funding is used for activities in accordance with the Agency CSH guidance.

Technical assistance is needed to continue strengthening laboratory capacity for AMR testing in hospitals with infection control activities, and the experiences and impact of regional Sanitary Intelligence programs should be documented. USAID also should consider focusing the priorities of operations research funded through the MOH-supported “Fondo Concursable” so that this research supports infectious disease research priorities as identified by control programs.

With respect to HIV/AIDS, several priority areas should be at the forefront of the Mission’s attention. The Mission needs to complete a USAID strategy for HIV/AIDS, ensuring that adequate attention is paid to key issues such as TB co-infection, and developing a more focused monitoring and evaluation plan for its work. Activities to monitor existing studies and identify additional studies needed for the strategy will be important, and that information should also be disseminated to national decision-makers. Additional care should be taken to ensure that prevention – including promotion of ABC and behavior change communications – gets appropriate attention in the USAID strategy and in the Peruvian health community.

Several steps can be taken to increase the active engagement of both the GOP and the donor community in developing a strong, multi-sectoral national HIV/AIDS strategy. USAID should work with other partners, including the MOH, VIGIA, UNAIDS, PAHO and CARE to help strengthen national leadership in this area, and to integrate new partners into the dialogue. The causes of VIGIA’s pipeline problems need to be carefully investigated, and if appropriate, another funding mechanism should be found to speed up funding and results.

Support was generally noted among informants for USAID’s moves toward a concentrated HIV/AIDS program in Ucayali. The evaluation team feels that the design should be given at least three years to prove its effectiveness, and stresses that adequately monitoring, evaluating and documenting this experience will be essential. USAID should also continue to work with people living with HIV/AIDS (PLWHAs) and ensure that they are well represented at the upcoming international meeting of PLWHAs to be held in Lima in October, 2005.

As USAID/Peru moves into the second half of its strategy, there are a number of crosscutting issues that should be kept in mind across the health portfolio. The upcoming presidential elections and political transition will be of tremendous relevance to future health programming, and USAID should remain focused on creating political will for health in general, and for health sector reform in particular. Though work with the MOH has not always been easy, long-term sustainability depends on USAID continuing to

support the MOH in identifying issues and priorities, strengthening its management capacity, and to rationalize its changing role in a decentralized health system.

The Mission's mix of field support and local procurement has been effective in the health program and, as several field support programs come to and end over the next two years, the Mission will have a good opportunity to more fully evaluate experiences with these mechanisms. The Mission needs to evaluate its processes for monitoring and evaluating all of its processes and activities to ensure that barriers and lessons learned are readily identifiable, and that information is properly used for decision-making and onward planning.

In planning for the future, the mission should continue to seize short-term opportunities to achieve clear, long-term impact, and take care not to dilute efforts by stretching its health portfolio too thinly. Activities planning should be done with awareness of past lessons learned, and of USAID's comparative advantage in supporting (but not necessarily launching) the development of new innovations. At the same time, building the sustainability of successful programs needs to be an ongoing theme of the Mission's health programs.

We feel there is a clear place and need for USAID health assistance in Peru in the foreseeable future, and USAID needs to continue to support the Peruvian Government, private sector, and civil society in providing and promoting good quality health care. Many of the findings and conclusions in this document should help the Office of Health prepare for its next strategic planning period. As USAID funds for health programming in Peru diminish, increasing emphasis must be placed on ensuring maximum sustainability of interventions, and that complementary funding from other donors is strategically leveraged. Programming should be planned with an increasing vision of the legacy that USAID will one day leave behind.

I. Family Planning & Reproductive Health

For the thirty plus years that USAID has supported family planning and reproductive health in Peru, the country has experienced great success in all reproductive health indicators, and in ensuring government and civil society support for family planning. Even during the recent tenures of two Ministers of Health who were not advocates of family planning, the government program has continued and, as of 2004, the government took responsibility for all contraceptive supplies. USAID/Peru should be very proud of all it has achieved to ensure that family planning information and services are widely available and practiced in Peru and that the government has accepted its responsibility for this important health program.

A working group in USAID/W has been developing criteria for graduation from family planning programs that include such indicators as total fertility rate and contraceptive prevalence. Countries, such as Peru, that have achieved success as measured, for example, by TFRs of 2.5 or less and contraceptive prevalence of 50% or more will be targeted for graduation from population/FP support. This has been a participatory process, with USAID Missions and any other USAID staff interested providing input. USAID/W expects to provide new guidance on graduation from family planning programs within the next few months, with the expectation that Missions will have enough notice of expected graduation dates to plan strategically for it.

Because of its notable success, and reduced funding for population programs in LAC, Peru is on the list of countries for Near Term Graduation, i.e., it is to be phased out of population/family planning support within the next three to six years. The LAC region and USAID/GH are available to help the Mission develop a phase-out strategy that will consolidate the gains already made in this area and ensure that they are sustainable over time.

Vulnerabilities Surrounding FP/RH Programs

Because of the human rights abuses committed under the Fujimori government in the 1990s, especially those related to the degree to which family planning activities were voluntary, USAID/Peru (which was not involved in any of those abuses) has been under special scrutiny by the U.S. Congress and others to ensure that its population/family planning program clearly and transparently complies with all U.S. regulations. This includes compliance with such policies as Helms, Mexico City and Tiahrt.

Both USAID/Peru and USAID/Washington have taken steps to ensure this compliance and to keep any such human rights violations from happening again. USAID/Peru has supported the national ombudsman (the Defensoría del Pueblo) and a woman's rights group (Red Nacional de Promoción de la Mujer), while at the same time building civil society awareness of and support for their family planning rights, including knowledge of how to report any abrogations of those rights.

At the same time, USAID/Washington has taken a number of steps also to ensure compliance with these policies. These include:

- Conducting a joint USAID/Washington/Peru analysis of compliance in October 2004;
- Training USAID/Peru partners in the policies (also October 2004); and,
- Working with the USAID Mission to investigate any complaints received.

According to all the work done to date, USAID/Peru appears to be in full compliance with all the USG policies related to population/FP. Given the sensitivities of this issue, and the focus various US-based groups, including Congress, put on Peru's compliance with the rules, it is important for USAID/Peru to continue paying special action to ensure it continues to be in full compliance.

Contraceptive Security

Over the past few years, USAID/Peru has been successful in raising awareness of population/family planning as a human right, increasing the government's recognition of these rights and its role in complying with them, and strengthening civil society's continued involvement through its role as a watchdog. USAID needs to assure that these successes are built on and that they continue beyond the life of USAID/Peru's population funding, and this should be included in a phase-out plan. It is important to note that, as part of this effort, USAID is working with the MOH to strengthen the FP, logistics and quality of care components into the recently developed model of Integrated Health.

Ensuring contraceptive security is key to a successful phase-out of the USAID population/FP program in Peru. USAID/Peru has taken this very seriously and has been working on ensuring contraceptive security as part of the implementation of the current strategy. With the assistance from the LAC Bureau and its contractors (POLICY II and DELIVER), USAID/Peru carried out a contraceptive security assessment of the Peru situation (September 2003), and a secondary analysis of the DHS 2000 (December 2003) which served to create awareness within the MOH and other interested audiences of the need for market segmentation and targeting of services to those who can least afford to pay.

Likewise, with its Peru-based partners, including the MOH, APROPO, PRISMA, POLICY II and The CATALYST Consortium/Pathfinder, the Mission has worked on various issues related to contraceptive security, including logistics and increasing private sector involvement in providing contraceptives.

In 2004, USAID/Peru turned over contraceptive procurement to the MOH. While there is some indication that the MOH's program could do better, especially in terms of avoiding stock-outs in clinics, this is an important first step to ensuring contraceptive security in Peru. The major issue, beyond what the Mission is already doing, is to consider the extent to which political will exists to implement some of the recommendations from the

Peru Contraceptive Security Assessment and others. Some areas of concern are, for example:

- The MOH's policy of providing free contraceptives to all has undercut competition in the private sector and resulted in the decreasing involvement of the private sector in contraceptive provision. Consolidating contraceptive provision into a single provider, the MOH, places contraceptive security at risk.
- The MOH's failure to segment and target the market for free contraceptives has resulted in a fairly substantial part of the MOH's contraceptives going to people in the top three wealth quintiles who, presumably, could pay for those supplies relatively easily.
- Continuing growth of the fertile-age population, and the resultant increasing demand for contraceptives, has not been accompanied by increases in MOH funding for contraceptives. This likely makes the current policy of free contraceptives for all impossible to continue. While recent MOH norms show the GOP's intention to target subsidies to the neediest (through the SIU and SIS, for example), it is not clear that the political will exists to cut certain segments of the population off of free contraception, i.e., those in the higher wealth quintiles.
- The Ministry has just recently been involved in updating its Family Planning Norms, which include reviewing the certification process of service centers for providing voluntary surgical contraception. This process has meant that many centers which previously provided permanent contraception are not allowed to do so until they are re-certified. This means that VSC is less available than in the past for those who wish to end their fertility.

These findings point toward the need for the Mission to put its emphasis on helping the MOH face these issues during the phase-out period and assisting the Ministry to ensure contraceptive security well beyond the life of USAID funding.

Cobertura con Calidad (Coverage with Quality)

Cobertura con Calidad, a nine-year bilateral grant agreement with the Ministry of Health, is scheduled to end in September 2005. This project aimed at improving the capability of health service staff to provide quality family planning/reproductive health services, working directly with the MOH, in defining norms and standards of quality health care, strengthening information systems, management and organization; and supervising its implementation in 10 regions (including the seven focus geographic areas) where medical equipment was provided.

The MOH's goal to improve the conditions of birth attendance and decrease maternal and perinatal mortality and morbidity was fully supported by Cobertura con Calidad in the last four years. New regulations in this regard will be disseminated nationwide as one of the last activities of this project. Funds from other donors, such as the World Bank, the EU, and UNFPA are being leveraged to further the national application of these norms and regulations. USAID is considering a no-cost extension to the end of FY2006.

ReproSalud

ReproSalud, a nine-year cooperative agreement with the Peruvian NGO Movimiento Manuela Ramos (MMR), is scheduled to end in September 2005. At the time of our visit, we were told that USAID/Peru was considering the possibility of providing MMR with a two-year no-cost extension with the approximately \$3 million left in the ReproSalud budget. Subsequently, however, we were informed that this project can not be extended beyond the ten year mark.

ReproSalud aims at promoting sexual and reproductive health and rights and respecting indigenous cultures by integrating modern health knowledge with traditional knowledge and practices that are not harmful to health. It is committed to gender equity and women's empowerment as well as to participatory processes that put community members in charge.

Beside these objectives, ReproSalud is also supposed to contribute to the institutional development and sustainability of its parent organization, the Movimiento Manuela Ramos. It appears that ReproSalud has succeeded, in the geographical areas where it has worked, in increasing the knowledge and use of contraceptives, as well as the use of prenatal care and the numbers of institutional births - all part of its objectives.

A number of concerns were noted with the institutional stability of Movimiento Manuela Ramos, specifically regarding its management and long-term sustainability. These concerns now become especially acute, given the shorter time frame available to improve the management and sustainability than had been anticipated. There is also some concern about the economic sensibility of MMR's plans for constructing a new building. Pathfinder has been working with MMR to address some of these concerns, but it is unclear whether they can be tackled sufficiently in the short time frame remaining.

Voluntary Surgical Contraception (VSC)

Following the scandals related to lack of informed consent for some voluntary surgical contraception during the Fujimori regime,¹ the subsequent GOP responded by cutting back on the offer of VSC services. This has resulted in a decrease in the prevalence of female sterilization from 12.3% of all methods in 2000 to 10.4% in 2004 (ENDES, 2004, Resultados Preliminares). Male sterilizations have stayed constant over the same period at 0.5%.

Also in response to those scandals, USAID worked with the MOH to develop VSC norms in order to ensure full, informed consent and quality of care. However, it appears that the availability of VSC services is still less than the existing demand for VSC through the currently available public services. This is in part because the MOH has to certify each place where VSC is to take place and this process has been somewhat slow. In order to ensure a complete method mix of contraceptives it is important that VSC be included, with all the appropriate safeguards in place to ensure full informed consent.

¹ USAID did not support the GOP's VSC program during the time these abuses occurred.

It is clear that the MOH needs to do a number of things to further institutionalize family planning into the future, something essential to protect it from the vicissitudes of changing governments and individual beliefs or whims. This includes addressing a number of the issues mentioned above, such as contraceptive security and surgical contraception, as well as others such as logistics and decentralization.

Recommendations

In light of these observations, the review team makes the following recommendations to USAID/Peru regarding population and family planning assistance:

1. **Develop a clear population/family planning phase-out strategy that includes, at a minimum, the following components:**¹
 - A review of the results, lessons learned and impact achieved in current and recently completed projects;
 - An analysis that identifies the reasons for recent indications in DHS statistics and other data that use of modern contraceptives is lower and that use of traditional methods has increased. For example, it should explore whether these trends are related to stock-outs of supplies and/or other factors (including decreased availability of VSC), and what, if anything, USAID/Peru might do to increase the use of modern contraceptives before phase-out is complete.
 - Identify the highest priority areas still needing completion before the end of USAID population/FP funding in Peru. This should especially focus on optimizing gains made and ensuring sustainability beyond USAID funding in the country;
 - A plan of action and time frame to carry out high priority activities, including contraceptive security, that identifies appropriate partners and defines clear results expected in the two to three years available.
 - A framework for building on past successes in raising awareness of population & family planning as a human right among both government and civil society.

2. **Take steps to determine how to best assure continued full compliance with all USG policies related to population and family planning, including:**
 - Review the work done to date and its effectiveness in ensuring compliance with the various USG policies related to use of population funds.
 - Analyze the cost-effectiveness of the methods used to date to ensure compliance.
 - Identify possible alternatives and their potential cost-effectiveness.
 - Determine whether it is necessary to continue funding special measures to ensure compliance and, if so, which one(s) make the most sense. An alternative might be to discontinue funding for special programs to ensure

¹ USAID/W is available to provide assistance to the Mission in designing this phase-out plan if the Mission desires.

compliance, and focus on thoroughly investigating any complaints received.

- Include compliance as a component in the already-established mechanisms of surveillance, for example, through the Ombudsman monitoring system that displays cases on its web page.
- Assist the GOP to ensure the sustainability of such local watchdog organizations as the local ombudsmen so that vigilance to prevent family planning abuses continues after USAID phases out of it population/reproductive health program.

3. Work to strengthen contraceptive security through the MOH as well as in the private sector, and include this as a priority in the phase-out plan.¹ Specifically, USAID/Peru needs to:

- Identify how it can work with the current and future MOH (i.e., with the current and new governments) to help them ensure contraceptive security with all temporary and permanent methods within the current and projected future budget. We understand that future MOH budgets are not projected to increase appreciably for contraceptives, and this may mean helping the GOP understand that, even if politically unpalatable, they may have to restrict the provision of free contraceptives to those in the lowest wealth quintiles.
- Work with the MOH to develop cost studies and projections that will provide information for decision-making on contraceptive security;
- Evaluate current efforts to increase the availability of contraception through the private sector to identify the results to date, future possibilities, cost-effectiveness, sustainability and possible alternative ways to expand private sector involvement in contraceptive security to make it sustainable over the long run. This includes efforts via social marketing, through pharmacies, bodegas and other outlets, and through work with midwives and physicians in private practice.² (See section III of this report for more on working with the private sector.)

4. Evaluate Cobertura con Calidad either upon or near its completion to determine: its impact, the degree to which it has been scaled up nationally and institutionalized, the extent to which these activities will continue without USAID support, lessons learned, extent to which new norms and regulations have been implemented in the field, and future steps recommended.

5. Explore the possibilities for scaling up the women's/community empowerment techniques, which appear to have been successful in ReproSalud, to other programs and settings. Before such a scaling up of

¹ The LAC Bureau contractors and USAID/W are available to continue working with USAID/Peru to ensure contraceptive security before the population/FP program is phased out.

² This includes MaxSalud's plan to replicate in other parts of the country the REDPLAN work with private midwives carried out in Lima-Callao by INPPARES under USAID funding which ends mid-2005.

activities is planned, USAID needs to ensure there is clear documentation of what ReproSalud has done, how it has done it, lessons learned, and the cost of doing so.

6. **Conduct an evaluation of ReproSalud prior to the official end of project activities (scheduled for June 2005), and prior to deciding on whether to give ReproSalud its final tranche of funding and directions on how to use it.** To be as useful as possible, this evaluation should be conducted in May or June of this year and should concentrate on the following areas:
 - What we know about the effect, impact, cost-effectiveness and sustainability of the intervention;
 - Lessons learned from the intervention that might be applied to future actions during both the USAID/Peru phase-out period and beyond; look especially at what has been learned about women's empowerment and how that might be applied beyond this project, e.g., to the Alternative Development (AD) program;
 - How this type of activity can be scaled up and become sustainable over time, including looking at:
 - What has happened when funding has been withdrawn (e.g., to what extent have the activities continued once ReproSalud has pulled out of a geographic area, and what has made that happen or not happen?)
 - The extent to which it is possible to continue this type of activity at the local level, rather than running it out of Lima. For example, whether this methodology can be transferred to local institutions/NGOs which would in turn be expected to provide follow-up and support to women's activities.
 - The prospects for sustainability if local authorities take it on.
 - Other avenues for achieving sustainability.
 - What still remains to be done to strengthen Manual Ramos as an institution to make it sustainable once this major project ends?
7. **Consider short-term activities to strengthen the management and sustainability of MMR** through Pathfinder or others. This could include helping MMR to develop a business plan for its future sustainability, and evaluating whether constructing or purchasing a building makes economic sense.
8. **Increasing the availability of voluntary surgical contraception should be a priority for the MOH, and USAID should consider steps to:**
 - Work with the MOH to:
 - Identify the extent to which the current VSC norms are known and applied throughout the public health system;
 - evaluate the current availability of VSC throughout the country and identify barriers to a more comprehensive offer of it;
 - Identify what needs to be done to make it more readily available to those who cannot afford to get it in the private sector;

- Identify what, if any, is USAID’s role in ensuring the available of a wide range of method mix, including VSC; this might include training on the latest VSC techniques;
 - Include in the phase-out plan any next steps for USAID to ensure that VSC is increasingly available in the MOH services and that its voluntariness is protected.
9. **Work with the MOH to identify the steps needed to institutionalize family planning into the future**, especially in a time of health sector reform and decentralization, and include a clear delineation of the steps to be taken by USAID to institutionalize family planning within the MOH in the phase-out plan.

II. Support to the Ministry of Health and Health Sector Reform

Peru is a middle-income country that has made tremendous progress in both health service provision and in health outcomes in the last decade. For example, according to preliminary results from the 2004 DHS, assisted deliveries have risen nationwide to 71% from 55% in 1996. Even in rural areas, assisted deliveries have risen from 15% to 44%, and in urban areas, assisted deliveries are now practically universal at 88%. These changes likely stem from a combination of factors, including increasing urbanization, expanded health care infrastructure, and new social health insurance arrangements that tackle some of the financial barriers that have kept the poor from using services.

In general, USAID's work to advance health system reform is carried out through POLICY, whose focus is on strengthening capacity in civil society, and PHR*plus*, which works to strengthen public sector capacity. In the PROGRESA education program for health sector managers, USAID taps POLICY, PHR*plus* and CATALYST.

USAID strengthens health system capacity by working at the national and regional levels to improve the effectiveness of social spending, increase the viability of health sector decentralization, improve accountability, and develop national experience with private insurance and management contracting by:

- Increasing local capacity to prepare for assuming health functions in the decentralization process (APTO Salud, Health Decentralization Map);
- Building the capacity of regional governments to track health spending (regional health accounts);
- Improving the availability of local health management expertise (PROGRESA);
- Improving the responsiveness of regional and provincial health plans to civil society (*consulta ciudadana* and Foro Salud);
- Organizing local Ministry of Health service delivery facilities into integrated service delivery networks (red Trujillo);
- Introducing the technical basis for the mandatory insurance of traffic accidents (SOAT);
- Establishing the basis for targeting of public social sector health spending (SIU--user identification system);
- Improving the management capacity of public hospitals (GalenHos); and
- Expanding the voice of civil society in setting health priorities (Foro Salud).

Developments in the Peruvian Health Sector

In a context of frequent and unpredictable political change, Peru has experimented with a number of approaches in the health sector, including the transformation of the Peruvian Social Security Institute (IPSS) to ESSALUD, and the opening up of ESSALUD to private sector participation through the EPSs. The GOP has also been able to expand the number of health centers and posts with support from the Social Development Fund

(FONCODES), and has introduced a model of community-managed government health centers (CLAS).

Recent innovations in the Peruvian health sector include the introduction of Integrated Health Insurance (SIS), designed to subsidize health services for the poor, and the introduction of mandatory insurance for traffic accidents (SOAT). Management contracts have also been introduced between national and regional governments as the basis for resource allocations, increasing the level of autonomy of public hospitals. The practice of relying on competitive selection of hospital managers is increasing, and the mobilization of civil society in health has improved, thanks in part to USAID-supported initiatives such as *Foro Salud*.

Gaps in Health Sector Reform

In the context of these recent innovations, a number of important reform measures have been surprisingly absent or underexploited. The transformation of the public sector continues to be hampered by the lack of a civil service and the resulting frequent and unpredictable movement of government personnel at all levels.

Health service delivery and financing continue to be addressed in a patchwork fashion, with the MOH, ESSALUD, NGOs, and private commercial providers continuing to duplicate efforts and suffer the effects of uncoordinated delivery. The MOH continues to finance its service delivery network on the basis of inputs rather than results (the SIS is a mix of both systems), and the GOP has yet to partner with the private sector for health service administration and delivery (such as through state contracting to the private sector).

One of the most notable gaps in the public sector, especially in the context of increasing pushes for decentralization in the health system, is the lack of progress in transforming the Ministry of Health from a service provider to a regulatory and advisory role. Despite large gains in decentralization efforts at the regional level, the Ministry of Health is ill-prepared to oversee a decentralized health system with multiple providers, and has yet to form a line unit to prepare for decentralization. Another gap has been in the institutionalization of certification of health professionals and accreditation of public and private health facilities.

While health sector participants are notably better informed about what is going on elsewhere in the country, they seem less integrated into regional and global knowledge networks and communities of practice than would be expected given their high educational and skills levels and the widespread availability of internet and telecommunications technology.

The GOP's lack of progress in regulating the private health market also leads to certain distortions. For example, providers and financing agents face strong incentives to avoid providing services or serving client groups that are not profitable. Even in the absence of effective regulatory capacity, however, positive changes are possible wherever the

interests of providers, clients and insurers align. In the large health care market of Lima, for instance, private providers have excess installed capacity, low marginal costs to expand the volume of care, and very limited opportunities for growth in the existing privately-insured or ESSALUD/EPS-insured population. The only way they can grow their businesses is to develop products that cater to lower income clients who are able to pay something for care.

This highlights another key gap in health reform – the absence of a comprehensive health financing solution. Health insurance coverage is limited, a large share of the population pays for health services out-of-pocket, and there has been little progress in the development of prepayment or insurance programs for low income and non-formal sector workers. This will also lead to problems at the decentralized level. For example, the Regional Hospital of Trujillo has been entering into multiple contracts with third parties for specialized, high cost services, such as CAT (computed axial tomography) scans and magnetic resonance imaging. With public budget resources that do not meet hospital costs, hospitals are under heavy pressure to find sources of revenues and to deflect poor patients away from their facilities.

The extent to which public sector financing can change the terms of health care delivery is demonstrated in the recent experiences of the SOAT (Mandatory Traffic Accident Insurance) and the SIS (Integral Health Insurance). The introduction of these mechanisms has prompted private hospitals to actively compete to care for traffic accident victims that they previously would have deflected to MOH facilities. Ministry of Health hospitals now provide care to the poor more readily than before, knowing that the SIS will reimburse at least their marginal costs.

USAID Contributions

USAID has comparative advantage in developing viable technical approaches that others can finance, as well as in working directly with field partners in local government, civil society and private sector, and has achieved notable successes in both of these areas:

- The User Identification System (SIU) is now being applied by MEF with World Bank financing in Lima and 30 of Peru's largest cities as basis for all targeted social programs.
- Regional governments in La Libertad and Lambayeque have taken ownership of the process of tracking regional health accounts, creating new awareness of the importance of household out-of-pocket spending that should improve the focus on equity.
- Civil society, which at beginning of this strategy was completely absent from public dialogue on health, is now more effectively organized and mobilized through *Foro Salud*.
- Regional governments in Lambayeque and La Libertad are now well prepared for transfer of responsibilities for health from the central government. The USAID-pioneered methodology of mapping health functions has been adopted by all other

sectors in La Libertad, and is also being adopted by all other regional health directorates.

- Mandatory traffic accident insurance (SOAT) is now universal, and is building national experience in public/private contracting and insurance. As a result, both public and private sectors should be better prepared to participate effectively in any future national health financing scheme.
- Regional health directors nationwide organized into a network that can jointly represent regional perspectives in dialogue on decentralization with the MOH.
- Several regions have experience in participatory health planning through *Consulta ciudadana*. This serves as a model for replication by other regions and in other sectors, and also generates the basis for increased local government accountability to civil society.
- Through PROGRESA, a network of health management specialists is now available in the local university system to provide technical assistance as decentralization rolls out.

USAID Instruments

In order to assess the validity of USAID's strategy in health reform, it is useful to consider the likely cause for each health system problem. System problems can be broken down into three broad categories – those that stem from a lack of resources, those that stem from a lack of know-how, and those that stem from a lack of political will.

Each type of problem calls for a different kind of solution. If the problem is a lack of resources, solutions may include increasing financing, brokering arrangements between those who need resources and those who have them, and technical assistance to enable institutions to generate or solicit resources. If the problem stems from a lack of know-how, it may respond to technical assistance, studies, improved information, pilot programs and/or observation of successful experiences. If the problem is a lack of political will, different approaches will be needed, such as advocacy and communication, alliances and network building, empowerment strategies, creating pressure for change and/or introducing new incentives.

In posing the question of whether USAID is using the right instruments and using them effectively in the area of health reform, it is helpful to assess how good a match exists between the source of the problem and the instruments being used to address it.

As a middle income country with well-educated health care providers and capable health system leaders, Peru has less need for direct external technical assistance in getting things done and more need for help in making national, regional and global contacts, setting up networks, and tapping into available resources. For example, health regions benefit from the direct support of individual advisors who catalyze their efforts and keep them focused on core priorities. In addition, these regions benefit greatly from the opportunity that USAID-sponsored gatherings have provided for them to network with their colleagues in other regions. They would also benefit from increased networking with their peers in other countries in the region facing similar issues.

For instance, participants in the PROGRESA program – jointly implemented by PHRplus, POLICY and Catalyst – find the program highly useful in part because it links academia and public sector practice to address issues of decentralizing health care oversight. They see its value as creating change agents within the health system. PROGRESA brings together people from different regions and people at different levels within the same region. Participants value the practical emphasis on learning by doing through the implementation of projects.

The use of field support mechanisms has certain advantages in the area of policy reform. Actors can enter the arena without the tag of being either civil society NGOs or representatives of the government. In Peru, the use of field support has provided partners with neutrality, flexibility, credibility, and overall ability to become agents of change. They are perceived as accompanying the process rather than as competition or opposition.

Strategic Focus

USAID has carried out its work in an environment of change, unpredictability and instability. In this environment, USAID has correctly focused its efforts on high-impact interventions with the best prospects for sustainability. As this environment of uncertainty is likely to persist, it makes sense for USAID to continue to establish clear objectives and to regularly anticipate and assess which opportunities will enable USAID to advance those objectives. In the area of health reform, particularly at the regional and local levels, USAID's ability to accomplish its objectives depends on local perceptions of USAID as a reliable and consistent partner. For this reason, it is important for USAID to make multi-year commitments and maintain a longer-term perspective. Given widespread sentiments among governmental and non-governmental actors that decentralization efforts have gained enough momentum to last well beyond the upcoming elections, maintaining a long-term perspective will be especially vital in seeing that gains are further institutionalized and that reforms are effective.

USAID's approach of having full time regional coordinators for PHRplus in each of the four regions appears to be a sound one. The local coordinator is able to develop the credibility and relationships with local counterparts that enable him/her to work as a trusted advisor. The regional counterparts are very pleased with the on-site support. When asked about other sources of support, they perceive those that do not have a local representative as being sporadic whereas they perceive the activity with a permanent staff member as being their partner. They refer favorably to the fact that they signed an agreement with the PHRplus project.

While working to build capacity in the public sector, largely through PHRplus, USAID has also wisely maintained a parallel focus on building civil society, working largely through POLICY, that has achieved notable success. The POLICY project has achieved results in fostering *Foro Salud*, mobilizing a civil society proposal for a drug policy, working on a child feeding regulation, working on oversight of Congress and getting local PLWHA groups to incorporate women and youth.

USAID works with local partners in La Libertad, Lambayeque, San Martin and Ucayali to develop regional and provincial capacity to manage the health sector. Together these four regions provide a laboratory for the development of innovations for national application. Through direct field presence in La Libertad, Lambayeque, San Martin and Ucayali, USAID's PHRplus project has fostered the development of a dynamic network of local health authorities in the *Macroregion Norte* that includes the USAID alternative development focus region of San Martin and Ucayali.

By piloting innovations in the less conflict-ridden areas of La Libertad and Lambayeque, USAID is developing models that alternative development focus regions can adopt. USAID also is contributing to the integration of these alternative development focus regions into sustainable macro-regions. Innovations that have been developed in La Libertad and Lambayeque and are spreading throughout the country – including all the alternative development focus regions – include regional health accounts, the APTO Salud planning tool for mapping the transfer of functions in health, and the local health planning process (*Consulta Ciudadana*).

USAID currently undertakes and supports actions on several fronts that will help Peru meet the Millennium Challenge Account expectation of increased public investment in health as a share of GDP. One barrier to increasing public spending on health is a lack of information about what the GOP currently spends and the lack of benchmarking practices to compare this spending level with those of other countries. USAID tackles this barrier by working with national and regional governments to carry out health accounting. Another barrier to increasing public spending on health is the low priority that health can have in the policy agenda.

USAID is working to elevate the importance of health in the policy agenda by fostering “*consultas ciudadanas*” in several regions and by working to ensure that the upcoming electoral process focuses attention on the importance of adequate and effective public investment in health. USAID also works to build the capacity of regional governments to assume responsibility for health services, and the process of tracking regional health accounts. As experience from other countries shows, the transfer of responsibility for health to decentralized levels often leads to increased public investment in health as local governments respond to their electorates by investing in the health services that the public expects.

Donor coordination

Through their jointly-funded health reform project PARSALUD I and the PARSALUD II project under development, the World Bank and the InterAmerican Development Bank command the resources and the attention to influence the Government of Peru's health policies and plans.

USAID has a strong comparative advantage in developing and piloting viable technical solutions that can then be scaled up with financing from PARSALUD, a World Bank

project. This is already taking place, as evidenced by the PARSALUD roll-out of the targeting methodology (SIU) developed by PHRplus in Lima and 33 other cities nationwide. USAID programs also can benefit from information sharing with other Peru health sector partners including PAHO and JICA, among others. The health sector partners' breakfast club that used to operate provided a very helpful venue for informal networking and information sharing among health sector partners, and by not actively coordinating, USAID and other donors may be losing out on opportunities to send clear messages to the GOP. For example, there was no reaction from donors to a recent law to convert CLAS physicians into civil servants effective December 2004.

Recommendations

Based on these observations of ongoing work with the Ministry of Health and to strengthen the Peruvian health system, the review team makes the following recommendations to USAID/Peru:

1. **Continue with successful elements of the current program, including:**
 - a. *Taking advantage of short-term opportunities that support clear long-term objectives.* Short-term opportunities should be pursued in conjunction with continuing to make multi-year commitments and the maintenance of a long-term perspective. Setting clear goals is necessary for advancing an integrated health systems agenda, and opportunities that arise in the short term should be evaluated based on their potential to contribute to those goals.
 - b. *Continue using field support judiciously for a credible, neutral role in health reform.*
 - c. *Continue to support the presence of full-time, field-based regional coordinators in San Martin, Ucayali, La Libertad, and Lambayeque.* If USAID needs to reduce the cost of on-site support, one way might be to scale back on office rental or equipment, although these complementary inputs appear quite reasonable in scope. Another might be to share one advisor between two regions. Another option might be to cut down on external consultants and instead link local authorities through peer groups with people who can provide outside advice.
 - d. *Continue work in Lambayeque and La Libertad.* For the development of national models and as demonstration sites for the alternative development regions, it is advisable to continue the on-site field presence in Lambayeque and La Libertad, at least until these regions reach certain benchmarks that should be made explicit and agreed upon formally. These could include:
 - the development of implementation plans to respond to the *consulta ciudadana*;
 - functional public sector health service delivery networks;
 - local sources of technical assistance in health sector management (e.g., through the universities participating in PROGRESA); and

- operational agreements between the national and regional governments for transfer of responsibilities in health.
2. **Work to move the MOH from direct service provision and into a role of oversight, regulation, and performance tracking, and work to move health financing toward a more comprehensive system.** The design of activities in this area should be based on a clear assessment of the nature of the principal barriers to progress, and the extent to which they stem from a lack of resources, a lack of know-how and/or a lack of political will.

USAID is in a unique position to help the Ministry transition into this new role in a decentralized system, as well as to help strengthen functional and strategic planning capacity at regional and local levels.

3. **Look for opportunities to improve equity.** For instance, look for ways to improve the targeting of the SIS, to advance opportunities for private sector contracting with SIS, etc. New awareness of the importance of household out-of-pocket spending through national and regional health accounts can also help advance this goal.
4. **Advocate for an inventory/assessment of private sector health capacity and activities outside of Lima to inform government and donors.** One possibility that could be explored is that of co-sponsoring an assessment with the World Bank as part of their PARSALUD II preparation (USAID could prepare the terms of reference [TOR] and the World Bank could finance implementation, for example). The Mission also should consider contacting the company that publishes the Peru's Top 10,000 Companies report to see if they could assist in this task.
5. **Work to keep health on the political agenda through the upcoming transition.** Despite uncertainty in the upcoming electoral process, consensus exists that both decentralization and the *sistema de seguro integral* are too engrained in public expectations to suffer reversal under the democratic transition. The mission may consider working to educate media and get them to focus attention on health through the upcoming election and transition.¹
6. **Exploit available opportunities for networking both within the Peruvian health management community and with their national, regional, and global peers.** Networking among health managers both within Peru and regionally is not as strong as it could be (for example, on issues such as health accounting, decentralized management of health care, organization of integrated public health service delivery models, and on building health management capacity). Local health officials and local government representatives in nearby countries including Brazil, Bolivia, Chile, Colombia, the Dominican Republic, Mexico,

¹ The Global Health Bureau's TASCII project has a Media & Communications IQC that, besides specializing in behavior change communications, would be well-suited for this kind of activity.

Nicaragua and Venezuela have many lessons to share. USAID/Peru should take advantage to the greatest extent possible of opportunities to enable Peruvian health authorities to network with their peers.

Some opportunities worth exploring include the World Bank health reform flagship training and the World Bank training in public policy for enhancing private sector participation in health, the LAC Regional Health Sector Reform Initiative events, regional and global workshops on national health accounting (such as the NHA symposium this July in Barcelona), and the biennial EUROLAC meetings jointly sponsored by the World Bank, the InterAmerican Development Bank and the Pan American Health Organization (to be held next in 2006).

The PROGRESA program should be linked with REDSALUD and INTEC in the Dominican Republic. PROGRESA should also be linked with the Global Health Bureau's QA/WD approach to quality collaboratives.¹

7. **Explore sources for increasing the use and creation of technical assistance capacity through local partners** (universities, consulting firms) to limit use of more expensive field support only to those services not available in-country. One idea would be to support the formation/growth of local consulting capacity in health financing and management through PROGRESA.

In light of the ongoing need that regions have for technical assistance in capacity building in light of decentralization of the health system, it seems sensible for the local universities participating in PROGRESA to explore setting up arrangements that would allow them to provide health management consulting services. If there proves to be interest in such an idea, USAID could support the universities in the development of business plans for providing consulting services.

8. **Carry out sustainability planning with NGOs at the local level to foster sustainability of civil society participation in health.** Despite recent progress, the organization of civil society needs further consolidation to achieve long-term sustainability.
9. **Continue to strengthen Peruvian capacity to track health spending and attract additional public investment in health.** This includes support for the scaling up and institutionalization of national and regional health accounts, and continued work with the MOH and regional governments on citizen participation in health planning.

Furthermore, USAID/Peru should consider carrying out reproductive health accounts based on the recently completed contraceptive security study, and building on Peruvian capacity to carry out national health accounts.

¹ More information is available from Tom Bossert, Harvard University.

10. **Consider helping regions to carry out burden of disease studies.** At least one USAID counterpart in La Libertad received training and is interested in doing this.¹ USAID should explore the necessary inputs to enable regional teams to carry out this exercise, and the possibility of providing any necessary additional support. This would be a good complement to regional health accounts, citizen consultations, and local health planning.
11. **Write up a case study of regional health accounting and present it at the July 2005 Barcelona NHA symposium.**
12. **Reactivate the informal networking arrangement (previously “donor breakfasts”) with other health sector partners.** This would be highly worthwhile, and could be done either by encouraging the PAHO representative to convene meetings or by tasking one of USAID’s health CAs with organizing and paying for these breakfasts. From limited informal checks, it seems like other donors would welcome the revival of the breakfast club. This seems particularly timely as Peru enters the electoral period and USAID and the Banks develop new programs.

¹ Dr. Segundo Cruz of the Belen Hospital in Trujillo participated in a training session in Spain.

III. MaxSalud and Private Sector Business Models

USAID set up MaxSalud as a pilot program to see whether/how the private sector could provide high quality basic health services to people with low incomes in a sustainable way. MaxSalud is organized as a non-profit non-governmental organization with a board of directors, an advisory board, and an administrative and service delivery staff. It runs 5 clinics (4 in the region of Lambayeque and 1 recently-opened in Cajamarca). Discussions with MaxSalud leadership suggest that it has been influential in the Chiclayo area in driving down the fee schedules of other private sector providers.

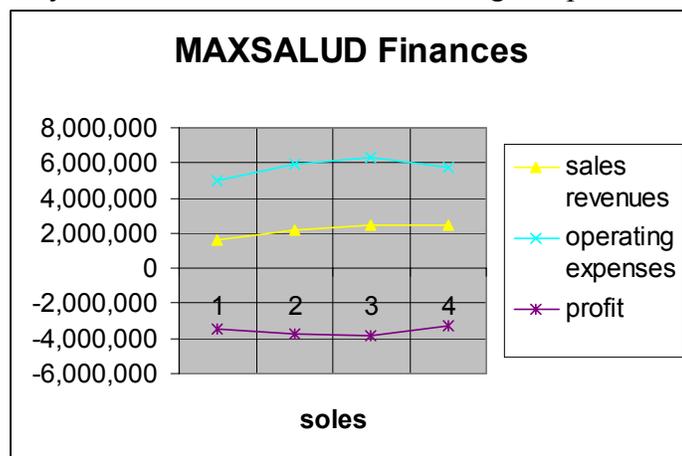
From 2001 to 2004, the gap between the sales revenues from medicines and health services and total operating expenses has remained in a state of deficit of over S./ 3 million (over \$1 million). With a capital fund of S/. 11.2 million and funds from USAID that cover a large portion of its personnel costs, MaxSalud has nonetheless been able to keep its doors open, and recently celebrated the opening of its fifth clinic in Cajamarca.

USAID project support is planned to continue for 18 months, after which, if the gap between operating costs and sales revenues remains constant, MaxSalud will consume its capital fund in less than 3 years. This means that the remaining 18 months are a critical period for developing a solution to the gap between revenues and expenses that would make MaxSalud financially viable.

MaxSalud is currently managed as an NGO rather than as a cost-minimizing business, and at the current time, is not financially sustainable. It also lacks a clear game plan for achieving financial sustainability after USAID support ends. The lack of a plan for financial sustainability threatens its future commitment to serving the poor, as this will cease to be in their best economic interest.

The options for increasing MaxSalud's viability include reducing expenses, increasing revenues, increasing return on capital, and/or securing

alternative sources of subsidies. Since the initial objective of MaxSalud was to provide a viable model of health services for low income Peruvians, the only appropriate options would be those that protect this aim.



Reducing Expenses: Since the largest share of MaxSalud's costs comes from personnel expenses, this is the most likely area for reducing expenses. One way to change personnel costs is to change the contracting arrangements from salary to a share of revenues, as MaxSalud has already begun to do, and expenses could be

further reduced by avoiding tying up its capital to purchase unnecessary supplies, such as large stocks of medicines.

Other less desirable options for reducing MaxSalud's expenses would be to reduce the quality of facilities and services, or to close out services or clinic sites that operate at a loss. Since the aim of the model was to provide high-quality services to low-income people, it would be regrettable for MaxSalud to be forced into either one of these options, or into any scenario that would detract from serving the poor.

Increasing Revenues: A number of options may be available to increase MaxSalud's revenues, some of which it is already exploring. Recent efforts have included introducing optical services, increasing the volume of its pharmacy business (which is a profit center), and selling basic services to the public sector through the SIS in Cajamarca. Nonetheless, efforts to date have been unable to pull MaxSalud out of its permanent state of deficit.

Other options have yet to be explored. For example, MaxSalud might try marketing pre-paid services and/or insurance programs to exploit underserved segments of the health market, such as non-formal sector workers or the employees and/or customers of large businesses. One possibility would be for large businesses to pay MaxSalud a fee to run promotions offering some MaxSalud health service(s) as a bonus with the purchase of another good or service (such as supermarket promotions that offer coupons for restaurants).

MaxSalud also has explored the idea of increasing revenues by opening new clinics. This would only be a viable solution if new clinics reach profitability within the next 18 months to contribute to the NGO's overall financial sustainability (this is important to keep in mind even with the new clinic in Cajamarca).

Increasing Investment Returns: One useful option is to attempt to increase the return on its capital fund, and MaxSalud is currently recruiting a financial analyst for just that purpose. Other options also could be explored. One would be to purchase the services of a professional investment advisor on a fee basis to review its investment portfolio and recommend changes. Another would be to use the capital fund either to invest in expanding its own profit centers or to diversify into additional profitable lines of business. Conversations with members of the business community in Chiclayo generated ideas as far fetched as investing in cemeteries, which are said to be quite profitable ventures.

Finding Alternative Sources of Subsidies: Another option for MaxSalud would be to find alternative sponsors to subsidize the gap between expenses and revenues. Perhaps the local government could offer financial incentives to local businesses that support MaxSalud in the form of tax write-offs. Another bilateral donor might be interested in supporting MaxSalud in its social mission. Other possible funding sources would be local, national or external foundations. To explore these options,

MaxSalud needs to begin conversations with possible donors immediately to determine whether and how this might be possible.

Fortunately for MaxSalud and USAID, the past several years have yielded valuable experiences in financing sustainable models of private health service provision. One key lesson is that linking resource transfers to results rather than inputs provides managers with incentives to find low-cost effective solutions. USAID has moved from providing NGOs with financing for inputs (such as salary reimbursements for MaxSalud) to providing them with payment for achieving service delivery or impact targets.

The USAID/Haiti experience with HS2004 shifted USAID funding for NGO service delivery over the course of several years from paying on the basis of budgets to paying on the basis of service delivery to the target population. Likewise, USAID's PROSAMI program in El Salvador paid NGOs to provide services to the poor on the basis of production. Another similar experience is the IDB-funded CEAS program that paid NGOs on a capitation basis to provide basic health services to underserved populations in Guatemala. USAID's work in many countries with national family planning associations also provides rich lessons on how to help health organizations with a mission to serve the poor become financially viable.

Private hospitals in Peru, especially in Lima, have developed new management approaches to compete for a very limited direct pay client group and develop financially competitive prepayment, insurance and customer loyalty discount programs, and also to provide services through the mandatory traffic accident insurance (SOAT). They may be able to share some of these experiences with MaxSalud.

Considering the variety of options available to MaxSalud, including lessons learned in Peru and other countries, the assessment team recommends several immediate actions for moving forward with MaxSalud:

1. **MaxSalud urgently needs expert technical assistance on sustainability planning, and to help them explore the various options mentioned above.** One source for such assistance might be the recently-awarded Global Health Bureau Private Sector Program which follows on from the Commercial Market Strategies project. Other sources of this expertise might be locally available as well.
2. **Fully monitor, document and disseminate MaxSalud's experience as first and only private sector provider for SIS.**
3. **Take steps to foster a greater sense of ownership of MaxSalud's future among its advisory board, and among local leadership in Chiclayo.** The local community in Chiclayo pays attention to MaxSalud and has suggestions about what it should do and how it should proceed. However, they also do not feel a sense of ownership nor consider its future to be their problem. The local leaders in the business community and on MaxSalud's board seem to view the situation

as a USAID problem about which they can provide advice. They need to move into a more central role where they see this as their community's institution and take direct responsibility for finding a solution.

In the search for solutions to make MaxSalud more financially viable, it will be especially important to get Chiclayo's local leaders to take ownership of this challenge. After all, if the organization fails in three years, the people of Chiclayo ultimately will be the losers.

APROPO: A New Approach to Sustainability

APROPO has developed an interesting and successful approach to getting contraceptive supplies to remote pharmacies by setting up distributors who can earn a living doing this. APROPO has expressed interest in future USAID financing to explore the viability of a primary care voucher system.

USAID might consider switching from acting as financing agent for contraceptive social marketing (e.g. APROPO) to acting as broker, for example by working with APROPO to establish a for-profit arm. USAID might do better to encourage partners like APROPO to face market risks to ensure that they have fully vetted the viability of their ideas. If donated financing protects stakeholders from business risks, they have reduced incentive to ensure that their business model is viable under real market conditions.

Instead of providing supply side financing to develop such a firm, USAID could assist APROPO in obtaining commercial credit in order to allow the financial market to assess the viability of the business model. Along those lines, it may be helpful in the short term to find out what the company that produces "Gents" condoms thinks of APROPO's model for "OK" condoms.

USAID might explore whether the Development Credit Authority would be an appropriate financial backer for APROPO in such a venture. USAID should find out what banks think of APROPO's business model. If it is not possible for APROPO to get commercial credit on its own, USAID might use its funds as a credit guarantee rather than as a direct source of capital.

Future Prospects in the Private Sector

The Peruvian private sector wields promising ideas for business models that will provide services to and improve the health of the lowest income segments. Private hospitals, at least in Lima, recognize that their business growth opportunities lie in serving the large number of relatively poorer people who can afford to pay something for health care. They are innovating models of care with operational and financial success that still have very limited prepayment or insurance elements. The mandatory traffic accident insurance (SOAT) provides a preliminary experience with a public-private subsidy, and MAXSALUD may provide another if it can effectively negotiate an arrangement for funding from the SIS in all of its clinics.

It is not clear that the central government has the capacity for effective oversight of the private sector. The MOH does not have, nor is it developing the capacity to effectively regulate private sector health service delivery. The private health insurance market is small and growth is stagnating, and is increasingly consolidating into the hands of only a few insurance companies, with Rimac and Pacifico essentially covering 70% of all insured. It also remains unclear whether the *Superintendencia de Seguros* has the capacity to effectively regulate the private health insurance market.

In response to these trends, private health care providers in Lima are organizing into informal health provider networks to serve low-income clients who can pay something (e.g., Cadena Protectora's¹ providers who see enrolled clients for S./10 per outpatient visit). The Clinica Stella Maris runs the Sagrado Corazon health center in Vitarte with outpatient consultations at S./3 and specialist consultations at S./ 5. The Clinica Ricardo Palma runs a pre-paid service for outpatient care in Comas. The Clinica San Pablo's Los Olivos clinic in San Juan de Lurigancho is more financially successful than its Surco site.

There seems to be a broader community of private businesses that realize their own potential as catalysts for improving health, and the importance of promoting a stronger culture of preventive health care. In a meeting with the private sector in Chiclayo, the discussion turned to finding innovative ways to deliver health messages and practices to hard-to-reach, poor populations. Several entrepreneurs recognized their ability to reach large numbers of people and expressed interest in using their businesses to disseminate such messages. One representative of a group that operates 100 rice mills in the area employs a total of over 12,500 workers. Another represents a distribution business that reaches over 28,000 small *bodegas*, and someone else pointed out that 34,000 households can be reached through gas cylinder distribution sites as well.

Within these private sector networks are also ideas for increasing access to health financing options for the poor. SUNAT has expressed interest in finding insurance for its workers. PetroPeru, the Ministry of Finance and the mines currently self-insure, but might be interested in other options. Falabella is exploring the concept of selling pre-paid vouchers for health services to its retail clients.² The Ministry of Labor is interested in exploring health insurance options for small and micro-entrepreneurs.³ SABSA (the *sistema alternativo de beneficios en salud*) is a recent innovation of Hector Begazo Dongo (tel. 372-5910) to provide health care packages to the uninsured. PROMPEX is exploring the business potential of exporting medical services, particularly elective and cosmetic services, to foreigners.⁴

Signs that the private sector wields a variety of innovative ideas and vast potential for improving healthcare for poor Peruvians are promising. Besides the aforementioned

¹ This is organized by Carlos Peñalosa of CJPR and he can be reached at 221-0750.

² Contact Gonzalo Vilchez to explore further

³ Contact Ricardo Perez Luyo at 446-4509 (PYME) to explore

⁴ Contact is David Ederly Muñoz at dedary@prompex.gob.pe

recommendations with respect to MaxSalud, we recommend that USAID/Peru consider the following in its search for a successful private sector model:

1. **Consider carrying out an inventory/assessment of private sector health providers and activities outside of Lima** (see report section on health reform).
2. **Shift future USAID incentives for private sector participation in serving the poor to results-based rather than input-based financing** (explore models of El Salvador PROSAMI, Haiti HS2004, Guatemala CEAS for example).
3. **Engage in a dialogue with private sector partners on ideas put forth in “The Fortune at the Bottom of the Pyramid”.** Through its CA networks, USAID may be able to help mobilize some of the creativity, talent, installed capacity and financial resources of Peru’s private sector (both within and outside the health sector) to develop service models in the future. USAID must find ways to contribute to their efforts in ways that will ensure partnerships are dynamic and that a sense of local ownership is a central theme.
4. **Consider initiating a broad dialogue about the role of the private sector in meeting social objectives in health.** Interest is likely to be high among the private health sector, private enterprises and employers, and other donors such as the World Bank and the IDB.
5. **Consider developing case studies on key aspects of USAID’s experiences in the private sector.** For example, if APROPO’s local condom distributors are able to earn a consistent living delivering condoms to isolated, low volume rural pharmacies, this seems worthy of sharing more widely.

IV. Integrating Health and Alternative Development

A major emphasis of USAID/Peru is its Alternative Development Program, which aims at helping Peruvian families in seven coca-growing regions of Peru to transition from growing coca to having a licit lifestyle. These seven regions are characterized by high food insecurity, mainly caused by extreme poverty, and drug trafficking, which is sometimes coupled with guerrilla activity. Health indicators in these areas are notoriously poor¹, and the state has in many cases abandoned social and production infrastructure, making lawlessness common.

USAID's Alternative Development Program (AD) is a multi-sectoral effort to support the transition into a licit economy and includes health, education, democracy and governance, and economic development activities. As the Mission's 2005 Annual Report states:

"The Mission's operational approach over the last year centered on integrating sectoral interventions in common geographic locations, and prioritizing investments from all sectors in the specific communities where voluntary eradication was taking place. Although there were some notable successes in integrating health, education and economic growth with alternative development activities over the past year, there were limits in the degree and consistency with which this was possible based on the structure of implementation mechanisms, security considerations, and whether the preconditions for success in a given sector were in place. USAID will continue to promote complementarity and joint efforts where feasible, supplemented by more in-depth coordination and information-sharing among partners on common themes (e.g. decentralization, legitimate livelihoods) and working in common geographic areas."

USAID/Peru's health sector has accepted its mandate to work in the Alternative Development areas and has shifted most of its field activities to the Mission's geographic emphasis zones in order to complement AD activities. It has charged Catalyst/Pathfinder and its sub-contractor, PRISMA, to carry out health activities included in the Alternative Development program of the Mission.

This partnership has resulted in the development of the "Healthy Municipalities and Communities" and "Healthy Schools" programs in the target geographic areas. These programs aim at promoting healthy lifestyles and environments, and empowering individuals and communities by working at the local level with families, community leaders, local governments, schools and health centers, and with the Ministry of Health and the Ministry of Education through their local counterparts. These activities promote the overall health of the people by helping communities identify basic needs which can be satisfied through community work and a small sum of money from the health program.

¹ For example, chronic malnutrition is found in about 41% of the population, reaching levels of up to 55% in some communities, and severe malnutrition averages 22%, reaching up to 30% in some communities. This increases the morbidity-mortality of children aged 12 to 24 months who suffer from frequent infections due to the lack of access to drinkable water and basic sanitation. (Healthy Municipalities and Communities in Alternative Development Zones project proposal)

Communities have been especially interested in improving water, sanitation, nutrition, and bettering schools and health centers. PRISMA's health promotion covers such things as education about hand washing as a way to prevent disease (including diarrhea) among children and their parents, family planning, and increasing maternal-child survival via appropriate pre-natal care and professionally-attended births. PRISMA also works to improve the quality of and access to health services in the target areas.

Contributions to Alternative Development

These health and education programs are tied into other AD activities in a number of ways. They contribute to consolidating democracy by working with local government structures, actively engaging local leaders to become involved in health improvement activities, and by strengthening civic participation in community organizations. They also directly contribute to local development through investments in latrines and other infrastructure. Efforts to institutionalize health promotion by incorporating it into the agenda of local governments work to both further health goals and strengthen local government structures and processes.

Prospects for the sustainability of these actions are based on relating these local efforts to communal and regional development processes, generating capacity in participants in the social sector to detect and respond to local conditions, especially in health and education, and promoting the formation of a social net that promotes its continuity.

In March, 2004, a rapid assessment of the PRISMA work in the alternative development areas made a number of notable observations:

1. People are very interested in improving health and receiving food donations (available through USAID's Title II program through 2008), both of which are seen as important to alleviate poverty and to partially compensate people for the loss of income resulting from their eradication of coca.
2. Community authorities feel that the support for health is important.
3. There was no evidence that the PRISMA work served to open up communities to the AD program (i.e., to coca eradication).
4. PRISMA had not been able to get its field staff to incorporate the AD message other than its health-related components.

PRISMA is working to improve results on the latter two observations, and to ensure continued support for the first two. While the direct contribution of these programs to coca eradication remains unclear, activities do appear to be having a positive impact on health, as indicated by a declining maternal mortality in the AD geographic areas. This is surely due in part to the increase in institutional births from 47% to 65% recorded between 2000 and 2004, respectively, which is likely attributable to USAID efforts (2005 Annual Report).

Recommendations

The recommendations that follow illustrate and explore some of the issues detected by the review team surrounding the integration of health into the alternative development program:

1. **The Mission needs to consider the effect of integrating coca eradication messages with health programs on the perception of USAID as a legitimate and transparent partner.** The Mission will need to consider how to productively deal with the perceived tension between the USG alternative development policy and the promotion of health and education. Several informants interviewed for this report, including representatives of NGOs and the GOP, spontaneously noted that they fear that USAID health and education programs are tainted by their link to coca eradication. There also appears to be a perception that this program is linked to USG needs, not Peruvian needs.

Efforts to further incorporate AD and coca eradication messages into health programs should be carefully planned, and take into consideration their potential effects on the perceived legitimacy of USAID health activities among target populations, as well as among civic and government actors throughout Peru. USAID's success in working in these areas is inextricably linked to its being perceived as a legitimate and transparent partner in social and economic development. If linking health activities to coca eradication is detrimental to this spirit of accompaniment and cooperation in working with local counterparts – and we suspect that it may be – then alternative development goals may be better served by focusing on the implicit contributions of health promotion activities.

The Mission should also keep several fundamental questions in mind about linking health and coca eradication:

- What are the risks and benefits to USAID of using health as a carrot and stick to coca eradication?
 - Does the community perceive the need for improving income in the coca eradication areas as outweighing anything that could be accomplished by health, i.e., is health one of the most important factors in AD from the community point of view?
2. **Carefully evaluate and minimize the risks to staff in further integrating coca eradication messages into health programs.** Further integration of coca eradication messages into health activities could place additional risk on USAID and contractor staff of being targeted by violence from drug traffickers and/or guerilla groups. Working in these regions carries an inherent risk for USAID staff, and past reluctance of PRIMSA staff to incorporate AD messages into programs may be due, at least in part, to their perception of this risk.
 3. **Strengthen links between local government and civic organizations and their regional and sub-regional counterparts.** Several aspects of the Healthy

Municipalities and Communities and the Healthy Schools programs have the potential for secondary effects that could serve to support coca eradication goals. For example, limited state presence in coca-growing regions is a pillar for the success of an illicit economy. By working with local officials and civic organizations to engage them in the improvement of community health and sanitation, USAID programs are effectively helping to strengthen state capacities at the local level and helping communities become more responsive to adverse conditions around them.

USAID may be able to further enhance both the sustainability of these interventions and their link to health activities in other areas of the country by fostering cooperation between newly capacitated local government and civic organizations and their regional and sub-regional counterparts. Strengthening these relationships could further increase the ability of local entities to address needs in their own communities. It could also create a clearer connection between USAID's work in national and regional health policy and its work in the geographic focus areas by bringing nationwide decentralization efforts to the local level. Institutionalizing these health programs through such local and regional structures would also be a way to increase their sustainability over the long term.

- 4. Explore the links between activities within and outside the seven-region focus area, and the rationales for continuing health activities in other regions.** The AD health program is working only in the seven AD areas and, other than working on national health policy, the Mission is increasingly restricted to working only in those areas. Beyond the aforementioned potential to more effectively link health activities in the AD zones to the decentralization process, the assessment team believes that other convincing rationales exist for continuing health activities outside of the geographic focus area.

As the USG policy of focusing field activities on advancing coca eradication continues, it may be increasingly important for the Mission to explore these rationales and effectively make the case, when warranted, that health activities in the focus area share numerous linkages with activities throughout the country.

One such rationale is that infectious diseases know no borders. With the large volume of cross-migration of people from the coca-growing regions to other areas of the country, there are myriad risks of the spread of infectious diseases to other regions. Due to the fragility of the AD programs and the difficulty of implementing new activities in those regions due to external factors, there is a case for piloting health programs first in other regions, where health needs are great but where conditions are more conducive to successful USAID interventions.

Activities to strengthen health systems capacity at the regional levels through regional governments and civic organizations – for example, the work of PHR*plus* and POLICY in Lambayeque and La Libertad – are also key to extending

effective state authority to remote regions of the country. Enhancing capacity of local governments to address health and other community concerns in the coca eradication zones by strengthening their interactions with regional authorities also entails having strong regional counterparts to interact with. And, as discussed previously, USAID seems to have a comparative advantage in this kind of capacity-building, as is evidenced in Lambayeque and La Libertad.

- 5. Consider the cost implications of scaling-up current efforts relative to their contribution, and ways to reduce the overall cost of the intervention.** The health work in the seven regions is very small scale, reaching about 370 communities at the present time, and is also very costly. Further evaluations will be necessary to determine the effects of this work in changing health indicators and advancing the AD effort. If the goal of the program is eventually to scale up activities throughout the seven regions, then the mission should also consider the extent to which this will be possible given the decreasing amounts of health and AD funding. Possibilities for lowering the cost of the intervention and for leveraging contributions should be explored.

At the present time about half of the operating budget for Health AD is for staff salaries to do the labor intensive work with communities. USAID might want to explore the possibility of providing technical assistance, ensuring such things as distance learning and computer technology for marketing alternative products are available, and having the communities and municipalities pay the recurring costs of this program.

- 6. Explore opportunities for enhancing coordination between health and other Mission sectors involved in AD, and enhance program monitoring and evaluation.** USAID should carefully examine how to better coordinate between the health sector and other Mission sectors working on alternative development, and how to facilitate that coordination to ensure maximum advantage is taken of the USAID-funded programs in the AD areas. More explicitly tracking and reporting on the links between the Mission's full portfolio of health activities and their potential secondary effects in other sectors (such as democracy and alternative means for income generation, and in turn, to sustainable coca eradication) may help advance such coordination by better informing other sectors of the health contribution.

Placing greater emphasis on the links between health work and activities in other sectors will entail a broader focus in monitoring and evaluation activities. Specifically, the Mission will need to consider how the health program complements alternative development and vice versa, and how health activities contribute to other AD goals such as increasing citizen participation and keeping girls in school. In the short term, future monitoring and evaluation activities should also seek to more clearly identify the short and medium-term impacts of this program on health indicators in the seven health regions.

V. Infectious Diseases

In 2001, USAID/Peru developed a Mission strategy for the years 2002-2006. Strategic Objective #3 in that strategy was “Improved Health for Peruvians at High Risk.” Contributing to the achievement of this strategic objective were three intermediate results: IR 3.1 “quality services accessible and utilized;” IR 3.2 “people practicing healthy behaviors;” and IR3.3 “health sector policies and programs more responsive to health needs.”

USAID/Peru infectious diseases (ID) activities have contributed to the achievement of all three intermediate results. Important investments have supported the achievement of the following sub-IRs in particular:

- 3.1.1 – Services are responsive to client needs and rights;
- 3.1.2 – Health providers have competencies required for quality service;
- 3.1.3 – Management systems in place to improve the performance of Frontline Health Workers;
- 3.1.4 – Adequate infrastructure, supplies and equipment in place;
- 3.2.1 – People have improved knowledge;
- 3.2.2 – Community structures in place to facilitate health behaviors;
- 3.3.2 – Policies and programs are information based.

While the infectious diseases programs may have contributed to the achievement of IR 3.2.2, we were unable to identify specific activities that contributed to this IR during the review. Also, while the USAID mission strategy states that USAID is not primarily responsible for IR 3.1.4, and this was indeed the case for the infectious diseases activities, USAID did, nevertheless, contribute to the achievement of IR 3.1.4 through support for computer equipment, laboratory supplies (particularly in the case of laboratory supplies needed for specific applied research) and some laboratory renovation. These investments though limited, were targeted, strategic, and indeed appropriate.

Intentions and Expectations for Infectious Diseases Activities in Peru

In 1998, the US Congress directed USAID to ramp up infectious diseases activities by including an infectious diseases directive in the CSH account. USAID Washington prepared an Agency infectious diseases strategy which became what is known as the health Strategic Objective 5 (SO5) with the objective to “Reduce the threat of infectious diseases of major public health importance.” This initial directive was subsequently followed by an earmark for infectious diseases beginning in the FY 2002 appropriations bill, with earmarks for Tuberculosis (TB), Malaria, and other infectious diseases (including antimicrobial resistance – AMR, surveillance and response) in descending order of budgetary support.

The Agency ID strategy focuses on four priority areas: TB, Malaria, antimicrobial resistance, and surveillance and response. By focusing on TB and Malaria, USAID has

been able to ramp up activities related to malaria and to initiate programs to control TB, thereby tackling two important diseases of poverty that are a threat to the health and well-being of families and individuals in developing countries. By investing in measures to contain antimicrobial resistance, USAID's ID program contributes to the success of key child survival and maternal health interventions by aiming to preserve the effectiveness of antimicrobials that are essential to the treatment of infections such as pneumonia, diarrhea, and post partum sepsis. Finally, by improving surveillance and response, USAID is able to assist countries to identify disease outbreaks, assess epidemiological trends, and to use surveillance data for priority setting, decision making, planning and action.

USAID/Peru seized the opportunity presented by S05 and the accompanying financial resources to develop a comprehensive infectious diseases program. To my knowledge, USAID/Peru is one of very few missions that has taken a truly "strategic approach" in the implementation of their infectious diseases program. The result was the creation of the VIGIA program – a bilateral program with the MOH.

The goal of USAID/Peru's infectious diseases program is to "Improve the health of the population at high risk of suffering from emerging and re-emerging infectious diseases." VIGIA would contribute to the achievement of the following results:

- A reduction in malaria incidence of 50% or more;
- Stabilize and/or reduce transmission of sexually transmitted diseases, including HIV/AIDS;
- A reduction in the incidence of pulmonary TB from 150.5 to 107 per 100,000;
- Continued decreases in the annual incidence of cholera, maintaining a lethality rate below 1%;
- 50% coverage of hepatitis B vaccine in children under the age of 5 that live in moderate or high endemic areas;
- 80% coverage of yellow fever vaccine in endemic areas, in migrant populations, and in areas of migration;
- 100% coverage of anti-rabies vaccine in areas where people are at risk for contracting rabies selvatica.

The overall objective of the VIGIA program is to "Strengthen the ability of MOH to effectively identify, prevent and control emerging and re-emerging infectious diseases." The program focused investments and activities toward the achievement of the following indicators and targets:

1. MOH will have surveillance systems and control measures for the most important infectious diseases in Peru and in the region.
Target: 9 surveillance and control systems for emerging and re-emerging infectious diseases (EREID).
2. MOH will monitor infectious diseases, drug resistance patterns and risk factors associated with EREID.

- Target: MOH will monitor infectious diseases, drug resistance patterns and risk factors associated with 10 prevalent EREIDs.
3. MOH will substantially reduce inadequate prescription of antimicrobial drugs used to treat EREID.
Target: MOH will reduce inadequate prescription of antimicrobial drugs to 40% in patients hospitalized with EREID.
 4. MOH will apply IEC strategies and involve communities in the prevention and control of EREIDs.
Target: MOH will apply 4 strategies for IEC and 2 participatory community strategies for EREID using priority interventions.
 5. The laboratory network will have the ability to provide valid and timely diagnosis of 100% of outbreaks, as an indicator of an efficient system.
Target: 24 reference labs implemented
 6. MOH will have two centers of investigation of EREID in accordance with international standards.
Target: 2 new biosecurity level 3 and 4 laboratories will be constructed.

Given the limited time available to conduct this review and the relatively “unstable” situation in the national TB program (as compared to other infectious diseases programs such as malaria), in consultation with the USAID health office (Drs. Susan Thollaug and Jaime Chang) it was decided that this assessment and recommendations would focus on tuberculosis, surveillance and response and other infectious diseases, and broader strategic and management issues related to the VIGIA project. HIV/AIDS will be covered in the following section of this report.

USAID Achievements and Contributions

The VIGIA program has made an important contribution to infectious diseases control in Peru. It was impossible to evaluate the impact of these interventions on malaria or TB incidence, for example, or to assess yellow fever and hepatitis B vaccination coverage rates given the time limitations of this review. While TB incidence in Peru has decreased since VIGIA was initiated, for example, it was impossible and it would be unreasonable to attribute this decrease directly to interventions supported by VIGIA. Many inputs such as training, supervision, an adequate supply of anti-TB drugs and laboratory supplies (which have been largely supported by MOH) contribute to prompt diagnosis and effective treatment of TB, resulting in a reduction in TB transmission and incidence.

A number of key results and outcomes have been achieved, and are summarized below along with the health strategy IR that they contribute to:

- Improved malaria treatment in Peru and the Amazon sub-region: Malaria drug resistance surveys resulted in the adoption of an evidence-based malaria treatment policy for the use of SP-artesunate combination therapy. Peru was the first country in the sub-region to carry out such studies and to use the study findings as the basis for the adoption of an effective malaria treatment regimen. The Peru experience served to catalyze other countries in the sub-region to carry out their

- own anti-malaria drug resistance studies, and created a foundation from which the Amazon Malaria Initiative (AMI) was designed and launched.¹ (IRs 3.1 and 3.3)
- Monitoring the effectiveness of the new malaria treatment policy: Applied research on SP-artesunate combination therapy adverse drug reactions has demonstrated safety and tolerance of this regimen in Peru. This is also an activity being undertaken by the AMI. (IR 3.1)
 - Establishment of the Sanitary Intelligence (SI) program – By the end of 2002, 11 DISAS had SI in place (the target was 10 by 2006). This activity subsequently expanded nationwide and all DISAS now have SI in place. (IR 3.1)
 - Introduction of rapid malaria diagnostic - Operations research on use of rapid malaria diagnostic lead to the introduction of a rapid diagnostic for use in Peru. (IR 3.1 and 3.3)
 - Advances in hospital infection control – By 2002, staff in 70 hospitals had been trained and provided tools to implement hospital-acquired infection surveillance and control activities. 2000 hospital staff were trained in hospital infection control, and 26 hospitals received new laboratory equipment for detecting infections. During 2004, a “self-assessment” of progress on hospital infection control was conducted in 43 of the 70 hospitals and found that: 100% had copies of norms, guidelines and manuals; 68% had formed infection control committees; 88% had incorporated an epidemiologist into their committee; 28 hospitals had prepared plans during 2004; 14 of the 28 hospitals had incorporated infection control plans into the overall operational plan for their respective institutions during 2004. VIGIA has also worked with the MOH to apply the various tools and materials to improve infection control for Tuberculosis. In one Lima hospital visited during this review, the incidence of wound infections decreased from 12% in 2002 to 2% in 2004, and hand washing improved by 30%. (IR 3.1)
 - Rational use of antimicrobial drugs - 39 hospitals evaluated antimicrobial prescribing, use and adverse reactions, and developed plans to improve the use of antimicrobials. Progress has also been made toward improving antimicrobial prescribing practices. (IR 3.1)
 - Support for lab infrastructure strengthening – In 2004, VIGIA supported new laboratory equipment to 23 regional labs and the national reference lab. Support for laboratory strengthening is helping to decentralize TB drug resistance susceptibility testing to include 5 regional labs. This is an important investment that will help reduce the time between collection of a sputum specimen and the availability of drug resistance test results, thereby leading to the provision of an appropriate treatment regimen more quickly to patients with drug resistant TB. Ultimately, this will contribute to a reduction in the transmission of drug resistant strains of TB. Construction is underway on a level 3 bio-security lab in Iquitos. (IR 3.1)
 - Introduction of yellow fever vaccine – Studies to evaluate strategies for use of the yellow fever vaccine led to the introduction of mass yellow fever vaccination in 2004. (IR3.1 and 3.3)

¹ AMI is a joint initiative supported by USAID/LAC/RSD, USAID/Peru, and USAID/Bolivia that targets these countries as well as Brazil, Guyana, Suriname, Venezuela, Colombia, and Ecuador. Partners include the participating countries, as well as PAHO, CDC, and MSH/RPM Plus.

- Strengthening the national TB program – Support was provided for a number of studies including the economic impact of TB and socio-anthropological issues related to TB, and KAP studies mentioned below, and studies of TB-HIV/AIDS co-infection and TB drug resistance are underway. In the area of biosecurity, technical assistance was provided to design and implement biosecurity measures in health facilities (including an isolation manual for hospitals), a training manual was prepared and disseminated, and training in the prevention of nosocomial transmission of TB was conducted. Training in laboratory biosecurity and quality control was also supported, and certification of bio-security cabinets was carried out (these cabinets are used for the preparation of TB sputum cultures). This creates a safer work environment for laboratory technicians and helps to improve the morale of these personnel who handle highly infectious samples of sputum on a daily basis. (IRs 3.1 and 3.3) Substantial support was provided for TB IEC materials and messages (see below).
- Information, Education and Communication (IEC) – Studies on knowledge, attitude and practice were conducted related to Dengue (in the community), hospital-acquired infections (among health personnel in hospitals), health (among primary and secondary students, and rapid malaria diagnostics (among health promoters). Studies on the socio-anthropological aspects of TB and yellow fever were also conducted. The findings from these studies were used to develop a variety of educational materials and campaigns such as:
 - Dengue – a video on Dengue Control in the Community, materials to promote dengue control practices targeting families, students and health workers, and radio and television spots;
 - Youth health - materials to support “healthy youth” programs in schools, including the prevention of sexually transmitted diseases and HIV/AIDS;
 - Malaria – materials to promote malaria prevention targeting families, communities and health workers, radio and television spots, and educational materials for health promoters to promote and improve the use of rapid malaria diagnostics;
 - Tuberculosis – Materials about Multi-drug resistant (MDR) TB, a counseling guide about TB and MDR TB, and a campaign to combat stigma against persons with TB - “TBC y no me contagié,” including print materials and television and radio spots, and workshops/technical assistance to develop a strategic plan for IEC in Lima Este and Cusco;
 - Yellow fever – a communication plan, materials, video, and radio and television spot to launch and support the yellow fever vaccination campaign. (IR 3.2)
- Operations or applied research – Through the decentralized and competitive “Fondo Concursable,” researchers are able to apply for and obtain funding for research projects. Since 2003, the INS has provided 50% of the funding for studies that have been selected for support. The “Fondo Concursable” stimulates interest in research, motivates health workers and researchers, and provides resources for research that can be used to address questions that are relevant to the local context.

USAID's Strategic Approach

The USAID/Peru infectious disease program implemented through the VIGIA project is an appropriate mix of interventions that are consistent with the Agency infectious diseases strategy and are appropriate for the Peruvian context. Malaria, TB, dengue, yellow fever and other diseases are leading causes of infectious diseases-related morbidity and mortality in Peru. Furthermore, VIGIA focus areas directly support the achievement of USAID/Peru SO3 results and objectives. Surveillance provides information for decision making, planning and response (IRs1 and IR3); operations research provides the evidence base for policy reform, and improves understanding of program performance challenges and issues (IR3); investments in prevention and control programs, as well as capacity building and laboratories, helps to support the implementation of policies and technical interventions for disease prevention and control and to improve access to, and quality of services (IR1). In addition, the “Fondo Concursable” stimulates local operations research activities to help address local infectious diseases problems and to identify solutions that are appropriate to the local context (IR1).

In reviewing project reports and plans, it appears that the early years of VIGIA (1998 to 2001) were more focused on applied research, and that support for implementation, prevention and control, capacity building, IEC, lab strengthening, etc. increased between 2001 and 2004. This shift seems appropriate in that key research activities were needed early (malaria drug resistance studies, for example) and were crucial to the adoption of an evidence-based malaria treatment policy, for example. In the case of TB, 1996 to 2000 represented a period of consolidation for the national TB program (NTP). Thus, focused studies such as the economic impact of TB and socio-anthropological issues provided useful information to help refine and support an already successful TB program.

During the initial years of USAID/Peru's infectious disease (ID) program, funding and activities were largely focused on malaria, AMR, surveillance and response and other IDs under the Child Survival and Health (CSH) account. Very little funding for TB was provided to USAID/Peru. This ID funding “mix” in the initial years was appropriate given the needs in malaria and other IDs, and the fact that by the year 2000, Peru had what was considered to be one of the best national TB programs in the world.¹

Peru's successful DOTS program, however, suffered serious setbacks between the years of 2001 to 2004. A number of factors contributed to these setbacks. First and foremost was the loss of strong leadership in the NTP. Since 2001, there have been four directors of the NTP with an average tenure of just eight months each. Some of the directors lacked commitment to the successful DOTS strategy (Directly Observed Treatment Strategy Shortcourse) or were not experienced in TB, while others lacked the necessary leadership skills. Weak leadership at the national level created a vacuum at the same time as there was a huge infusion of funds (approximately \$40 million) from the Gates

¹ Peru graduated from the list of 22 High Burden TB Countries in 2001 as documented in the impact of DOTS on TB incidence in Peru.

Foundation to a grant to Partners in Health for Multi-Drug Resistant TB and DOTS Plus in Peru. The result was a distortion in priorities in the national program. This distortion was further exacerbated when parties outside of the NTP prepared an application to the Global Fund (GF) which focused on DOTS Plus, increasing the involvement of civil society in DOTS, and prisons. While the above areas are all important and need attention in the TB program in Peru, almost none of the resources (one contact interviewed estimated that less than 10%) approved in the Global Fund TB grant to Peru were provided to support the basic functions of the NTP such as training, supervision, and monitoring.

Second, persons responsible for program management, including integrated services in a decentralized system, lacked the necessary planning and management skills in “reforming health.” There was virtually no training or supervision carried out by the NTP for three years, and when training and supervision activities were undertaken in the second half of 2004, these activities were supported by the GF grant. Finally, “corruption paranoia” in the post-Fujimori period was pervasive in the MOH, leading to a failure to carry out timely bids and purchases of key commodities, leading to stock outs of first line anti-TB drugs, lab supplies, and sputum collection cups.¹

As a result of the setbacks described above, there has been a measurable decline in effectiveness of the NTP in Peru. The detection of TB suspects decreased by 6% leading to a decline in the smear positive (SS+) case detection rate from 87% in 2000 to 81% in 2003. This has led to a pool of approximately 7,388 “undiagnosed” cases of infectious smear + pulmonary TB between 2001 and 2003. The default rate in new smear positive cases of TB increased from approximately 2% in 2002 to 4.2% in the 3rd trimester of 2004, with two areas of Lima-Callao reporting default rates of 8 – 10%, potentially contributing to the development of future cases of drug resistant TB.

These findings should not be interpreted as suggesting that the program collapsed - indeed, that was not the case. But, had it not been for the fact that the NTP had created a solid base with norms in place and with health personnel largely trained in DOTS, the program might have collapsed. Strong, consistent leadership in the NTP, and support by MOH will be needed in the coming months to ensure that the above declines in performance are reversed, and to further consolidate and strengthen various elements of the NTP.

A positive development was the July 2004 resolution signed by the Minister of Health creating National Sanitary Strategies (which includes TB). Consumables such as lab supplies and drugs are part of the NTP program budget, procured centrally and provided to the DISAS, which will help guarantee that funding is available for these crucial inputs even in a decentralized program. This resolution led to the creation of two committees:

¹NOTE: According to the TB advisor in the PAHO office in Peru, the NTP has not yet “recovered” or reestablished a reserve of anti-TB drugs.

the technical committee (on which VIGIA is represented) and the consultative committee (which includes patients, NGOs, universities and other stakeholders). The new NTP director, Dr. Cesar Bonilla sees both of these committees as a real opportunity to strengthen the NTP. Regional TB program supervisory positions which had disappeared have now been restored.

The new NTP director appears to possess the appropriate technical and leadership skills that are needed at this time. He is a pulmonary disease specialist, an epidemiologist with experience in the NTP, and he is committed to DOTS. He stated that he has strong support from the Minister of Health.

A five year strategic plan for the period of December 2004 – December 2009 has been prepared that directly addresses the performance problems mentioned above, as well as other challenges including Multi-Drug Resistant (MDR) TB and TB-HIV/AIDS. The NTP plans to establish a STOP TB partnership in Peru, and to apply to the Global Fund in round five, focusing that proposal on TB-HIV/AIDS. The NTP expressed their gratitude for the support that USAID has provided through VIGIA, and identified several areas where they would welcome support from USAID and VIGIA:

- Strengthening DOTS in the following departments – Loreto, Ucayali, Madre de Dios, Piura, Tumbes, Moquegua, Tacna;
- Expanding DOTS plus outside of Lima-Callao (Ica Arequipa, Lambayeque, La Libertad and Ancash;
- Capacity building and supervision, focusing on strengthening decentralized training and supervisory capacity;
- Operations research, especially at the local level;
- Infection control in health facilities;
- Improving access to DOTS in indigenous populations.

Dr. Bonilla also mentioned that he needs one additional person in the NTP national team (a physician with a background in research and epidemiology) and believes that the Minister of Health will assign a person to fill this gap in his team.

USAID Mechanisms

VIGIA is a bilateral program whose principal technical counterpart is the MOH as well as various divisions of the MOH - INS, DIGESA, DIGEMID, OGE, and DGSP. The INS serves both an administrative role - by carrying out the procurement of goods and services, and a technical role - by reviewing and approving technical activities (in partnership with other MOH divisions).

The role of INS as a technical partner ensures MOH buy-in for activities, facilitates the transfer of research results into policy decisions, and helps to ensure the application and use of tools and approaches supported by VIGIA. In addition, VIGIA personnel are “seconded” from the MOH, thereby helping to increase MOH capacity when these persons eventually return to positions in the MOH. In terms of technical implementation

VIGIA's partnership with INS and MOH has been generally successful as evidenced by the results cited above.

The challenge for VIGIA has been timely execution of activities. A steering committee/board ensures consensus on priority activities supported by VIGIA. Scopes of work (SOW) or terms of reference for products or consultancies are agreed upon by the MOH, including the INS and the appropriate or relevant division of MOH, as well as VIGIA, and USAID. Delays in the review or approval of these SOWs have sometimes slowed project execution. The biggest problem, however, has been delays due to the slow and cumbersome procurement processes at INS. This has been a chronic problem with VIGIA, resulting in a pipeline of \$1,012,365 (February 17, 2005). Alternative administrative arrangements are currently being considered that would remove the administrative functions from the INS.

In addition to VIGIA, FY04 ID funds were provided to the following activities - POLICY, Measure, CATALYST, MaxSalud, Pop/Sup, and Promotion. The Mission plans to provide FY05 ID funds to the following activities - POLICY, Measure, Pathfinder, New Proyecto, MaxSalud, Buen Inicio and Promotion (*See Appendix 2, Graphs A & B*).¹

As the USAID/Peru funding for TB has increased, the provision of TB funding to VIGIA as a percentage of the Mission's total TB funding, has decreased (*See Appendix 2, Graph C*). In fact, of the \$500,000 of TB funding in the USAID/Peru FY 04 budget, only \$35,000 was obligated to VIGIA. This is of serious concern since it is highly doubtful that the other programs mentioned above that received FY04 TB funding possess expertise in TB. Furthermore, Dr. Jaime Chang indicated that it was doubtful that these projects are implementing ID activities that are in keeping with the USAID guidance on the use of CSH – ID funds. The Mission indicated that the provision of ID funding to these projects is due to the large pipeline in the VIGIA project.

Donor and Partner Coordination

USAID and VIGIA coordinate with the MOH, Partners in Health, the AMI initiative including priority countries and AMI partners such as CDC, PAHO, RPM Plus, USPDQI, CONAMUSA and a variety of other local partners in Peru. Coordination between USAID/Peru, VIGIA and AMI has been extremely effective as the VIGIA malaria activities and AMI activities in Peru directly complement each other. The program for South America Infectious Diseases Initiative (SAIDI) is still developing a work plan; thus it was not possible to evaluate USAID/Peru and VIGIA coordination with that program at this point in time.

Obvious synergies exist between the objectives and activities of VIGIA, and the LAC Infectious Diseases Initiative (IDI). The latter has focused on surveillance of antimicrobial drug resistance in selected pathogens, including common pathogens

¹ Time constraints prevented the team from interviewing key informants or reviewing workplans from these projects with respect to ID activities.

associated with hospital acquired infections, and promoting the rational use of antimicrobial drugs. Peruvian counterparts have participated in numerous workshops supported by the LAC IDI, and applied tools in Peru (such as the protocol for studying the cost of hospital acquired infections) that were developed by the IDI. A working group was formed in Peru to adapt the regional guideline for antimicrobial drug use to the Peruvian context, but this work has not yet been completed. VIGIA provided training in the application of a protocol to study antimicrobial drug prescription focusing on hospitals that are already involved in hospital infection control activities. Baseline information from 21 hospitals demonstrated that the prevalence of antimicrobial drug prescription is high (61.9% as compared to the target of 40%) and that only 63.1% of antibiotic prescriptions were “adequate” as compared to the target of 80% proposed by DIGEMID.

Time constraints did not allow further investigation into the degree to which tools developed by VIGIA, such as tools and training materials for hospital infection control, have been used or applied by other health partners in Peru, including USAID partners focusing on improving primary health care and reproductive health services.

Some partners expressed optimism that CONAMUSA could be an effective mechanism for improving programs and coordination in Peru, particularly with regards to strengthening the NTP and DOTS. The inclusion of a wide variety of partners, including NGOs that have not previously been engaged in TB, represents an important opportunity to broaden civil society involvement and support for TB control and DOTS.

USAID’s Comparative Advantage in Infectious Diseases

USAID support for key research through the VIGIA project has been crucial for adoption of evidence-based policies (malaria, yellow fever vaccination, hepatitis B vaccinations, etc.) to name a few. With adequate evidence, USAID/Peru has been able to advocate for key policies at the Ministerial level. The provision of technical assistance – by USAID staff, project staff of VIGIA, and through consultancies funded by VIGIA, has been timely and appropriate. Furthermore, through AMI, USAID/Peru and the MOH have had access to specialized technical expertise in operations research and epidemiology (CDC), drug use and drug management (RPM Plus) and drug quality (USPDQI). Support for “implementation” - training, laboratory strengthening, and IEC activities, etc., has enabled USAID to assist MOH to implement new tools and approaches and guidelines that were developed or supported by VIGIA.

Recommendations

Based on these observations, the review team recommends that USAID/Peru take the following actions:

1. **Continue and increase the active engagement of USAID/Peru office of Health, and VIGIA, in TB to support the NTP in Peru.** This would include:

- a. Susan Thollaug and Jaime Chang should meet with Dr. Cesar Bonilla as soon as possible to discuss NTP needs with the new NTP director, and to identify priority activities for USAID/Peru mission support;
 - b. Focus TB funding on support for implementation (training, monitoring, supervision, lab strengthening, etc.) as well as operations research to improve program performance;
 - c. USAID/Peru and VIGIA should become engaged in the creation of a STOP TB partnership in Peru;
 - d. Provide support to the NTP national-level program team, including possible support for human resources if necessary.
2. **Ensure that USAID FY04 TB funding is used for activities that are in accordance with the Agency’s CSH guidance on the use of TB funding.** This is especially important given the fact that TB funds are an earmark and there is strong interest in Congress in the appropriate use of these funds. Activities should contribute to the objective of reducing TB incidence in Peru by helping the NTP to achieve the objectives described in their 5 year strategic plan. Specifically, USAID/Peru should:
- a. Review the work plans of all USAID non-VIGIA partners that are receiving TB funding, and provide recommendations on appropriate use of TB funds to these partners;
 - b. Provide a copy of the USAID guidance on use of CSH funding to all USAID/Peru partners that are receiving TB funds, and ensure that these partners understand how TB funds can be used;
 - c. Recommend that non-VIGIA partners working at the DISA or DIGESA level meet with regional NTP program supervisors to identify needs and priorities;
 - d. The USAID/Peru ID advisor should meet with the CTOs of all non-VIGIA partners who received FY04 TB funding to provide them guidance on the appropriate use of TB funding.
3. **Ensure that USAID/Peru FY05 TB funding is used to support the needs and priorities of the NTP.** If the VIGIA pipeline is not reduced by May of this year, the Mission should explore alternative mechanisms for programming FY05 TB funds (instead of “sprinkling” TB funds into a variety of USAID/Peru partners that possess no expertise in TB and who are unlikely to use TB funds appropriately). USAID/Washington can provide information on Global Health Bureau mechanisms that would be appropriate if necessary. Failure to program USAID/Peru FY05 TB funding in a way that will support the priorities of the NTP would be a tremendous lost opportunity given the new and capable leadership in the NTP, the apparent strong interest of the Minister of Health in the TB program, and the need to “recover” ground in TB control that was lost in the past 4 years.
4. **Offer technical assistance to help the NTP develop and prepare a proposal for round 5 of the Global Fund.** This could be done through VIGIA. If a

consultant is contracted to assist with this, be sure that the consultant is familiar with all rules and procedures for preparing a Global Fund grant proposal.

5. **Hold regular meetings (monthly for a minimum of 6 months) of VIGIA, INS and the relevant MOH counterparts** for the purpose of monitoring implementation and project execution, including the procurement of goods and services.
6. **Make a decision about an alternative administrative mechanism to INS as soon as possible.**
7. **Orient or train staff working on priority programs such as malaria and TB regarding how to engage in the health reform process.** Some of the problems that were encountered in the transition between governments and in the process of implementing reforms could have been mitigated had program management staff been better prepared to engage in the process, and to assume new or changing responsibilities.
8. **Strengthen program management capacity in the MOH, including the capacity to manage and procure health commodities such as drugs and lab supplies.**
9. **Explore measures to help the NTP try to “recover” or “re-establish” a reserve of anti-TB drugs.** Should the NTP face the next presidential election with an inadequate reserve of anti-TB drugs and supplies, the lives of TB patients and the public health of the population of Peru will be at stake.
10. **Continue strengthening laboratory capacity for antimicrobial drug resistance testing in hospitals that are carrying out hospital infection control activities.** This would be a logical, strategic and appropriate investment that would complement and support current activities related to rational antimicrobial drug use and hospital infection control.
11. **Roll-out/introduce hospital infection control tools and training to a wider audience,** including facilities caring for PLWHAs, prison TB control activities, NGO service providers, and at a minimum, all USAID health program partners that are involved in improving the quality of health services.
12. **Work with VIGIA and the NTP to explore opportunities to expand civil society support for DOTS,** including involvement of CONAMUSA partners that may be more historically linked to HIV/AIDS.
13. **Document the impact and lessons learned of SIs,** including how these units have responded to specific disease outbreaks or helped to strengthen the performance of priority programs.

14. **Consider focusing operations research funded through the “Fondo Concorsabile” on a more specific set of research priorities** that are agreed to by MOH, VIGIA and USAID.

VI. HIV/AIDS

Peru is a non-focus country under the President's Emergency Plan for AIDS Relief (PEPFAR). USAID/Peru's budget, therefore, has been straight lined by the Office of the Global AIDS Coordinator (OGAC) at \$1 million a year since 2003, with little chance that it is going to increase in coming years. Peru has a concentrated epidemic, and while the estimated prevalence is 0.4% in the general population, it is much higher in the most vulnerable populations who include men who have sex with men (MSM) and their partners (including women), sex workers and their clients, and men in prisons. Women are increasingly infected, with the national ratio of male to female infection currently at about 2:1. There are also various geographic "hot spots" identified with rapidly increasing HIV/AIDS prevalence, including the jungle cities of Iquitos and Pucallpa and the tourist center, Cusco. The Lima-Callao area has the highest numbers of people living with HIV/AIDS (PLWHAs) in Peru.

USAID Strategy and HIV/AIDS in Peru

USAID has pursued an HIV/AIDS strategy of primarily working through national institutions to strengthen Peru's response to the epidemic, while also working at the community level. USAID sees its role as instigating action and complementing what others are doing. Major efforts include:

- Improving the political environment for addressing HIV/AIDS;
- Improving surveillance, including behavioral surveillance so that activities can respond to the evidence base; for example, the second HIV/AIDS PREVEN survey will be carried out by the Cayetano Heredia University by the end of FY05;
- Strengthening the Peruvian Country Coordinating Mechanism (the CCM is known as CONAMUSA) in its successful application for Global Fund money for HIV/AIDS treatment, as well as to monitor the implementation of the Global Fund grant;
- Strengthening country capabilities to provide anti-retroviral treatment (ART) including training health care providers and laboratory technicians, and providing equipment to expand and improve the quality of HIV/AIDS testing, care and treatment, thus complementing the GF efforts;
- Working through various community programs – including peer-based programs with MSM, SWs, and people living with HIV/AIDS (PLWHAs) – and schools, as well as local/regional governments, to prevent the spread of HIV/AIDS by focusing on the ABC approach, and to improve the political environment for addressing AIDS and the rights of PLWHAs;
- Planning a new comprehensive HIV/AIDS prevention and treatment initiative in the Alternative Development focus region of Ucayali, with most activities to be centered in the capital city of Pucallpa, where recent surveys have shown an HIV/AIDS prevalence of among adult men of 2%, and where the regional government has made HIV/AIDS a priority;

- Working with the only other USG agency working on HIV/AIDS with a presence in Peru – the National Medical Research Center Detachment (NMRCDD) – to develop a joint country strategy, as will be required by OGAC in the not-too-distant future.
- Supporting the involvement of PLWHAs in the effort against the HIV/AIDS epidemic.

Also, with population funding, USAID supports a social marketing campaign, APROPO, which, among other things, promotes condoms as a method of dual protection, i.e., against pregnancy and STIs, including HIV/AIDS, and STI treatment supplies. This effort has succeeded in expanding the market for high quality condoms (and other products) throughout Peru via inter-personal and mass media communications, as well as training of pharmacy staff and private doctors and midwives. It is not clear whether USAID is currently using APROPO as well as it might to promote the prevention of HIV/AIDS. If it is not taking full advantage of the synergy of efforts in this social marketing program, it should do so as soon as possible.

Because it receives \$1 million a year, USAID/Peru is required to develop a strategy for its HIV/AIDS program, which it has not yet done. OGAC will soon be issuing guidance, measures and other information. This will include requiring that this strategy be a USG one (i.e., including NMRCDD). To date, USAID has only developed a first draft of its strategy.

A number of studies on HIV/AIDS have been done in Peru, and more are being done, that have not necessarily been made available to those who need them for decision-making. Identifying additional studies needed should be an important ongoing role of USAID, and should be included in its new strategy. USAID should also be applauded for its support for a number of important studies, including the rolling DHS, the PREVEN HIV/AIDS studies, the mapping of HIV/AIDS services and of those working with PLWHAs, and the study currently underway on HIV/AIDS stigma and discrimination among health care providers.

Working with PLWHAs is key to preventing further transmission of HIV/AIDS, ensuring testing, treatment, adherence and care reach the right people, and that stigma and discrimination, a major driving force of the epidemic can be diminished.

Co-infection with TB is a concern to Peru, a country with a high burden of TB. It is important that USAID ensure that it recognizes this in its new strategic plan and develops actions to ensure that those who are co-infected have available appropriate testing, treatment and care. This means that people attending HIV/AIDS counseling and treatment centers should be offered TB tests and those attending TB centers should be offered HIV/AIDS counseling and testing.

USAID's approach is beginning to concentrate efforts in one region, Ucayali, while continuing to press for national-level policies and programs. Ucayali appears to be a good choice for a number of reasons. The Regional Government has made HIV a

priority, and the Regional Health Forum, which incorporates PLWHAs on its directorship, has also made HIV/AIDS a primary theme. Pucallpa, the capital of Ucayali, is one of the HIV/AIDS “hot spots” in the country, with a number of indicators that put its population at risk, including: early age of sexual debut, a young and mobile population, a high rate of STIs, multiple sex partners, considerable male to male sex¹ and a substantial use of sex workers². As a result, the HIV/AIDS prevalence rate is about 2% in adult men, considerably higher than the national average. USAID is in the process of refining data for the area and developing a participatory plan of action to provide targeted technical assistance in Ucayali. Among other things, that plan will focus on strengthening the local health centers to provide prevention, counseling, testing, and ART. A number of the informants interviewed by the assessment team, including those at VIGIA, support USAID’s moves into this area, and believe that ensuring good monitoring and evaluation of the experience is very important. Some also noted, though, that the HIV/AIDS situation in Ucayali and the experiences under this new strategy, will probably only be applicable/adaptable to other jungle regions of Peru – not to the rest of the country.

HIV/AIDS is a disease with a social/cultural basis, and this requires that it be confronted on a multi-sectoral basis. The multi-sectoral planning session on HIV/AIDS planned for April 2005 offers an opportunity not only to consolidate a multi-sector approach, but also to lay the groundwork for a more comprehensive national strategy. The MOH, VIGIA and CONAMUSA all need to take a major role in this, but new partners also need to be included, such as religious groups and the business sector. USAID needs to work with those putting together this multi-sectoral strategy, providing technical assistance and other support as appropriate.

It is unclear what results USAID is getting for its investment in HIV/AIDS. USAID needs to review its current strategies and plans of action with an eye to identifying what’s working well and what’s not. This includes identifying the strengths and weaknesses of its current partners and using this entire analysis in its future HIV/AIDS strategy.

GOP Efforts

USAID has put its primary emphasis on working with VIGIA, the infectious disease part of the Ministry of Health and USAID’s main GOP contractor, rather than working with the MOH directly. VIGIA has been slow to spend its grant, something it attributes to the money going through the very inefficient MOH. This has resulted in a large pipeline and a slower than expected roll-out of VIGIA’s HIV/AIDS activities. VIGIA has asked USAID to seek another funding mechanism, such as PRISMA, for example, so that it can move more speedily to implement its program. USAID needs to provide more technical

¹ 46% of men in Pucallpa report having had sex with another man at least once, while 13% report having had sex with another man within the last twelve months according to the PREVEN situation analysis of Ucayali. 70% of the MSM report not having used condoms with same-sex partners.

² According to the same study, 55% of men in Pucallpa report having had sex at least once with sex workers, 60% of them without using condoms. Three percent of women reported that the last time they had sex, it was in exchange for money or goods.

leadership and pro-actively identify the problems in moving this program forward and find rapid solutions to resolving those problems.

VIGIA strongly supports developing a multi-sectoral national HIV/AIDS plan. It has begun establishing the base for this by working with POLICY to map the more than fifty organizations working on HIV/AIDS in Peru, including those working with PLWHAs, asking the Ministry of Education to map HIV/AIDS programs in schools, with parents and teachers, developing a national STI policy, acting as the permanent technical advisor on HIV to CONAMUSA, and promoting HIV/AIDS within health education programs,

The Ministry of Health's HIV/AIDS program has been downgraded in status and staffing¹ during the current administration, something that is part of an overall weakening of the MOH. As a result, the MOH has not been taking the leadership role in HIV/AIDS policies and activities that should be expected of them. If the Ministry doesn't take that leadership, USAID needs to work with other donors, such as UNAIDS², to help build that leadership either within the MOH or, if that is not possible, elsewhere. This includes working with the MOH, VIGIA and others to develop a strong national strategy on HIV/AIDS.

The MOH receives technical assistance from PAHO/WHO to improve surveillance, improve laboratories' ability to produce valid test results, and improve the technical skills of MOH personnel.

Prevention of further HIV/AIDS cases should be a major emphasis of the GOP's program. The MOH has recognized this by including prevention in its norms. However, the Ministry appears to have taken little effective action to prevent the spread of the epidemic. By not doing so, it risks having to provide ever more people with ARVs and having to cover the cost thereof. Effective prevention work focused on those most at-risk would not only help stabilize or decrease the epidemic, but also help make the program sustainable over time.

The Global Fund

Peru was awarded a grant from the second round of the Global Fund (GF) for HIV/AIDS activities, primarily for treatment. CARE is the principal recipient (PR) for this grant. USAID participated in developing that project proposal, by supporting the Country Coordinating Mechanism (CCM), known as CONAMUSA in Peru and developing a manual of procedures. Unfortunately, USAID does not have sufficient funding to support a CONAMUSA staff person to act as general secretary, something it appears would help move the HIV/AIDS program forward more speedily. In accepting this grant, the GOP committed to meeting certain targets for treatment. However, it has fallen short. This has put it in danger of losing further GF money unless it is able to renegotiate the targets,

¹ Presently, the MOH has only 3 staff members plus one volunteer working on HIV/AIDS.

² UNAIDS has a new country representative in Peru, so this might be a good time for USAID to work with UNAIDS on this major issue of a developing a national strategy that looks beyond the Global Fund.

which it is in the process of trying to do. The GF is expected to evaluate the Peru project in June of this year.

The GOP has also pledged to take over virtually all the costs of ART by 2008. This may be difficult since the current projected budget is not sufficient to meet that commitment. USAID has been working with CONAMUSA and others to help renegotiate the terms of the GF to ensure that the funding continues. At the same time, the scale-up of ART beyond Lima appears to be occurring much more slowly than had originally been anticipated, due in part to the need to upgrade staff skills and health infrastructure to enable it to deal with HIV/AIDS, as well as to ensure an adequate supply chain for ART, laboratory equipment, etc. In addition, public pressure needs to be mobilized to get the Ministry of Finance to include sufficient funding for ART in its budget.

CONAMUSA has focused on obtaining and monitoring Global Fund monies, and needs help looking at the bigger picture, including: 1) ensuring country-level HIV/AIDS strategies, policies and programs are developed consistent with the evidence base of the epidemic; 2) identifying what will happen when the Global Fund ends; and (3) making the Peruvian response more multi-sectoral (for example by including the business sector, faith-based organizations, professionals groups and others). USAID could assist CONAMUSA to move more pro-actively in these directions.

With the emphasis on treatment through the Global Fund money, it also appears that prevention may be getting short shrift in Peru's HIV/AIDS program. Prevention work is essential to stemming the epidemic. This is especially important as there are indications that the Peruvian epidemic is becoming more generalized, with the ratio of male to female infections reaching close to 2:1.

Recommendations

Considering these observations, the assessment team recommends that USAID take the following actions with respect to its HIV/AIDS strategy:

1. **Finalize Development of a USAID/Peru Strategy for HIV/AIDS.** USAID needs to complete its strategy and submit it to USAID (and, if required by that time, to OGAC as well) for consideration and approval.¹ It should be based on available evidence of the Peruvian epidemic and pay adequate attention to such things as TB co-infection.

It is unclear what results USAID is getting for its investment in HIV/AIDS, and the development of the new HIV/AIDS strategy offers an excellent opportunity to review this issue and identify the means needed to achieve optimal results, and develop a more pro-active, strategic program. In this process, USAID needs to review its current strategies and plans of action with an eye to identifying what's working well and what's not. This includes identifying the strengths and

¹ USAID/Washington is available to assist the Mission to complete this strategy.

weaknesses of its current partners to determine whether they should continue being the partners or whether others might offer more bang for the buck.

At the same time, USAID needs to develop a more focused monitoring and evaluation plan for its work, using the M&E both to assess its progress as well as to identify problems as they arise and taking rapid action to resolve them.

2. **Work with other partners, including the MOH, VIGIA, UNAIDS, and CARE to help build national leadership in HIV/AIDS and develop a strong, multi-sectoral national strategy.** In consolidating national leadership in HIV/AIDS, USAID needs to consider how to most effectively help the MOH and VIGIA take on the leadership role required of the government in this epidemic. One such opportunity is the multi-sectoral planning session on HIV/AIDS planned for April, 2005. USAID should be prepared to support the development of a multi-sectoral strategy with technical assistance and other support as appropriate, as well as to support the integration of new partners such as religious groups and the business sector.
3. **The design for the concentrated program in Ucayali needs to be given at least three years to prove what it can do, and needs to have strong monitoring and evaluation** built in, as well as the means to identify lessons learned along the way and document the experience so others can learn from it.
4. **Ensure that prevention – including promotion of ABC and behavior change communications – gets appropriate attention** in USAID’s own HIV/AIDS strategy and that it is an important part of the programs of the other major actors on the HIV/AIDS scene in Peru. Those actors include the MOH, NGOs, the Ministry of Education, APROPO, the media and others who could be co-opted into helping with the prevention effort.
5. **Investigate why VIGIA’s money is not moving and, if appropriate, whether another mechanism might be appropriate to speed up funding and results.** USAID needs more information to determine whether the problem lies solely with the MOH, or whether there are other issues that need to be identified and dealt with. If appropriate, PRISMA or some other entity may offer an alternative administrative mechanism.
6. **Actively monitor studies being carried out and identify additional studies needed in the new strategy.** USAID should make sure that studies are made available to all those involved in HIV/AIDS so that policy and program decisions can be based on evidence.
7. **Ensure that good monitoring and evaluation is built into the national strategy, USAID’s strategy, the GF and all other HIV/AIDS programs so that the impact of all interventions can be measured and used by decision-makers to make program adjustments as necessary.**

8. **Work with PLWHAs to make sure they are well-represented and have prominent places on the agenda at the PLWHA meeting in October, 2005 meeting, and ensure that the findings and recommendations of this meeting are utilized for onward planning of its work with those groups.**

VII. Overall Comments and Findings

Over the course of investigating and discussing the findings of this report, the review team identified a number of issues and opportunities that cut across various parts of the health sector. The following is a discussion of some of these crosscutting themes.

Preparing for Presidential Elections

- Presidential elections are scheduled for April 2006. The Mission has been working to institutionalize a great many health policies and programs so that they will survive a change in government, something to be applauded. The team suggests that, in addition to the work it is already doing to improve the MOH's policies and functions, it needs to manage the political transition to ensure continued success. Creating political will needs to be a continuing Mission theme. One way of doing this, for example, is for the Mission work with civil society to press each political party and candidate to make improving health and health systems a part of their platform.

The Ministry of Health

- Working with the MOH has not been particularly easy during parts of the current administration. Repeated changes in personnel, changes in policy and other matters beyond the control of the USAID program have resulted in a diminished MOH and the loss of strong professionals in many areas. Nonetheless, ensuring long-term sustainability requires USAID to work with the MOH on policies and programs, something it seems to be doing quite well. The Mission needs to further evaluate its work during the existing strategy, its results and problems, identify lessons learned and use them for planning the next strategy, both with the new government as well as with the next Mission strategy. It also needs to provide the Ministry with the tools needed to take the leadership role it is not currently taking in such areas as TB and HIV/AIDS. We suggest that the Mission work with the MOH to identify its strengths and weaknesses and develop and implement plans to improve its overall effectiveness. The Mission also needs to determine what problems have led the Ministry to under-spend its USAID budget so that those problems can be corrected and money properly expended to advance program goals. At the same time, the Mission needs to continue working with the MOH to improve its management capacity in such areas as commodities, logistics, and its changing role with health sector reform, especially in terms of ensuring that decentralization works.

Implementation Mechanisms

- The Mission has used a combination of field support and local procurement during this strategy, something that appears to have served the health program well. As a number of the field support and local mechanisms end within the next

year or two, this offers the Mission an opportunity to review the experiences to date with each mechanism, the advantages and disadvantages of each, to ensure that the best mechanisms are chosen for the future. At the present time, the Mission has a large portfolio and a large number of partners. As money becomes scarcer, it may make more sense to have fewer partners. The Mission will have to review this as well.

Impact of the Program

- It is not clear to the team what the Mission is doing to evaluate the process and impact of its programs. That may be because we did not have the time during our two-week visit to look into this issue enough. However, we suggest that the Mission evaluate its own processes of monitoring and evaluation, barriers to obtaining more impact, what it needs to do to solidify the impact it has had, all in order to ensure that it is getting maximum benefit from its M&E and is using the data obtained from that M&E for decision-making and onward planning.

Sustainability of Programs

- To date, the Mission has worked to obtain health impact in its policy and program activities. It does not appear to have paid sufficient attention to program sustainability. As some projects are now coming to an end, the Mission is now realizing that it may not have done enough to ensure the sustainability of certain programs and institutions. In the future, especially as USAID/Peru health funds diminish, the Mission will need to pay greater attention to ensuring that programs and key institutions are sustainable. This can be done by ensuring their incorporation into the MOH or others' ongoing programs, with budgets to sustain them through the sale of goods and services, through cost savings, through support from other donors, and other means.

We recommend that the Mission pay much closer attention to this issue in the future so as to avoid such sustainability issues as are currently being experienced with MAXSalud and Manuela Ramos. This will require a change of mind-set within the Mission to make sustainability a priority. It may also require some outside technical assistance to conduct appropriate sustainability planning.

Current USAID Health Strategy

- USAID/Peru has been very agile in seizing opportunities as they present themselves, and making changes as appropriate. This has sometimes meant deviating from the original 2002-06 strategy, as happened notably in the Alternative Development seven region strategy. This has meant that short-term strategies have sometimes taken a front seat to longer-term planned strategies. The flexibility to take full advantage of these opportunities as they present themselves is to be admired and to date does not seem to have taken away from the many things that the Mission's health team does to ensure the long-term

impact of its actions. The team recommends that the Mission continue seizing opportunities while also working toward achieving long-term impact. At the same time, however, it may need to impose more discipline on itself so as not to overextend itself or dilute its efforts.

Innovation and Technical Leadership

- USAID has a comparative advantage in supporting new and innovative ways to help Peru ensure good health for its people. This does not mean that USAID should launch innovations. Rather, USAID should identify promising innovations in the Peruvian health system and help develop and support them. This approach ensures that USAID does not get out ahead of local stakeholders and makes local ownership and sustainability more likely. The Mission's technical leadership in health should be directed toward solidifying what's proven, applying lessons learned from previous innovations, and ensuring that appropriate policies are implemented effectively. The Mission needs to ask itself whether it is making efficient use of previous innovations and lessons learned and, if not, why not?

Rationale for Continuing to Provide Health Support to Peru

- The team believes that USAID still needs to continue its investment in the health sector for some time to come. Despite the relative ineffectiveness and disorganization of the Peruvian health sector, the MOH continues to have a large impact on the health of more than half the Peruvian population. Private sector mechanisms are not well developed. There is inadequate investment in health by the GOP and the normative mechanisms are not in place to provide a basic level of health services to the population. Therefore, at least through the next strategy period, USAID needs to continue to help the GOP take on its responsibility for providing health efficiently and effectively, with good quality ensured via the application of appropriate norms and policies, something especially important during this time of major reorganization of the health system through decentralization. This includes working to strengthen the regional and DISA entities.

New Health Strategy

- While the Mission seizes opportunities, it also needs to develop a new strategic plan for the 2007-11 period. The many findings and recommendations found throughout this document, as well as the lessons learned throughout the current strategy, should help the health sector plan for the next strategy. At the same time, the Mission needs to identify the areas where it needs to collect data, do additional evaluation, and develop cost studies and papers on critical subjects that will also help it plan for the future. How to achieve maximum sustainability of its efforts needs to be a key part of the new strategy, given that with the improved health indicators registered by Peru, there may be pressure on the Mission to close out some or its entire health program during or at the end of the next strategy

period. At the same time, successful actions may need to be scaled up, with USAID or other funding. The Mission needs to help Peru leverage complementary funding from other international agencies that are still working in Peru on health, including, for example, the World Bank, the Global Fund, and others. This should be a part of the new strategy.

- As USAID funds for Peru in general and for health in particular diminish, the Mission needs to define very clearly its key strategies and target its actions not only to increase efficiency and effectiveness, but also to ensure it leaves a clear legacy behind when Peru eventually graduates from health assistance. This means making some hard choices among different possible activities at the national, regional and community levels. It also means not entailing major mortgages. At present most of the Mission's field work focuses in the seven alternative development (AD) regions. Most of its national-level work is connected to strengthening both government and NGOs institutionally and developing and implementing effective health policies so that their health work can eventually be sustained over the long run. These issues need to be considered as the Mission plans and evaluates the remaining two years of the current strategy and while it moves forward in planning its next strategy.

Appendix 1: Questions for Mid-Strategy Assessment

Priority topics for the review were set in consultation with Mission HPN staff and the guidance of HPN Director Dick Martin and Deputy Director Susan Thollaug, who submitted two initial lists of questions to the USAID/W team before their arrival in Peru. The team used these questions as a guide for this review.

List 1

1. Reproductive Health

- Phase-out. What are the implications of being identified for phase out of population assistance? How should we restructure our activities in order to optimize benefits and get to full sustainability in the time remaining?
- Population Account. Are we comfortably within the guidelines of the USAID population account?
- Vulnerabilities. Our human rights, VSC, Tiahart, Mexico City, etc. monitoring is costly and doesn't seem to be coming up with much. Are these activities (Defensoria del Pueblo, Red Nacional de Promocion de la Mujer) the best methodology, or would some alternative be more efficient?
- Contraceptive Security. Is our strategy for switching users to the private sector strong enough to achieve our objective?
- “Cobertura con calidad” close-out. The project has moved from a “project” approach to a flexible implementation approach. Is there any inconsistency with the original objectives identified in authorizing and obligating documents? Is a final evaluation needed?
- “ReproSalud” close-out. “Manuela Ramos” is in need of an end-of-project vision. Should USAID provide the final scheduled tranche of funding? Is a final evaluation needed? Is the project on track with regard to original and amended objectives that were established in authorizing and obligating documents?
- Surgical Contraception. Is there anything short-term USAID should consider to help the MOH re-start VSC services?
- MOH. Does the MOH require further institutional strengthening to manage family planning into the future?

2. Improving Quality of Care

- Logistics. Is the MOH getting closer to a sustainable logistics system? Are we diluting the effort by including other supplies along with contraceptives?
- Accreditation and Certification. How are the prospects for long term operation of these systems? How can these activities be evaluated to document their impact on quality of care?
- MOH. Is there any way that USAID grants to the MOH (VIGIA, COBERTURA, and SOAG) can be implemented smoothly and quickly? What kinds of assistance should USAID offer the MOH in the future, and what “instruments” would work most efficiently?

- Alternative Development. How effectively is USAID’s Health Program complementing Alternative Development? Are the “Healthy Municipality” and “Health-promoting School” initiatives likely to have lasting health impact and to help consolidate coca-free development?
 - Child Survival. Should USAID support institutional strengthening in the MOH in support of sustainable Child Survival services? Why are we so frequently asked for emergency support?
 - Technology. How might USAID provide more assistance to the health sector with “cutting edge” technologies (management information systems, diagnostic equipment, etc.) that could lead to breakthrough improvements in efficiency and coverage?
 - Nutrition. What should we do about chronic malnutrition?
3. Infectious Diseases
- Implementation. Are there ways to pick up the pace and raise the visibility of these activities? Are there alternatives to MOH as the principal implementing partner?
 - Strategy. Are there additional approaches that should be considered for future activities? Do we have an optimal mix of prevention, research, surveillance, and other interventions?
 - Regional Activities. How will planned regional activities complement bilateral activities?
4. Health Sector Policy
- Decentralization. Is our big bet on decentralization going to pay off? In what ways?
 - Concentrating subsidies. Are we being politically naïve to think that subsidies to the non-poor can be withdrawn?
 - Other initiatives. Are there other reforms we should tackle, such as re-defining the role of the MOH (normative instead of service delivery) or new business models?
 - Priority for Health Sector Reform. With our dwindling budget, should health sector policy reform (with its risk of little immediate measurable impact on health indicators) receive more or less priority in the future?
 - Partners. Are our current partners efficient and effective? What are our options for the future?
 - Environment. With elections approaching, how should we prepare for a turbulent transition and a new health sector regime? Is investing in policy reform worthwhile in Peru’s unstable political environment?
 - Private Sector Models. What are we learning from the MaxSalud experience that might lead us in new directions in the future? Should MaxSalud be evaluated in preparation for close-out? Are there other “bottom of the pyramid” models we might test that could more radically reduce costs and replace public sector services?

List 2

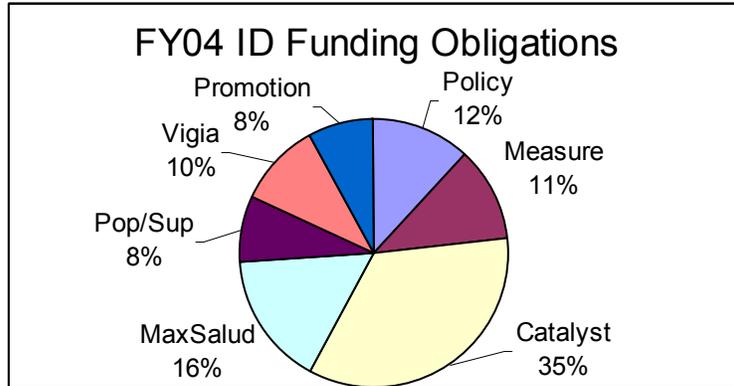
1. How is the 2002-6 Strategy Working?

- Based on 3 years' experience, do USAID's activities still appear strategically well-conceived? Were the most critical challenges in the health sector identified? As the health sector has evolved since the beginning of the strategy in 2002, are there other, different challenges that should be addressed?
 - Were activities designed in such a way that they are leveraging other resources?
 - Do our activities make optimal use of USAID's comparative advantages?
 - What rationale exists for continuing USAID investment in the health sector? At what point can USAID begin to contemplate phase down or phase out? What should our phase out criteria and benchmarks be?
 - Are we being innovative and demonstrating technical leadership?
 - Is the strategic linkage with Alternative Development working? In what ways?
 - How is our balance among different kinds of strategic approaches (policy reform, institutional strengthening, R&D)? Should we tighten our strategic focus?
 - If the USAID strategic focus is on strengthening human capital, productivity, and competitiveness, what are the strategic implications for our health portfolio?
2. What Impact Are We Getting?
- What activities show promise in terms of long-term sustainable impact? What activities are successfully producing useful short-term impact?
 - What evidence is there of impact from our health sector policy reform focus? Which elements – decentralization, subsidies, management training, etc. – appear most likely to produce permanent benefits? Are there other issues we should push?
 - What evidence is there of impact of our infectious diseases activities? Can work in this area be accelerated?
 - What evidence is there of direct impact on health conditions and indicators, especially in the USAID geographic emphasis zone?
 - What evidence is there of impact of our work with private sector health providers, especially MaxSalud? As this project ends, what should USAID do next to build on the experience?
 - What has the contribution of the ReproSalud project been so far on the Peruvian health sector? What kind of final evaluation should be designed?
 - What evidence is there of impact for our work in human and client rights – Ombudsman, Red Nacional de Promocion de la Mujer? At what level should this support continue?
 - What evidence is there of impact in the area of accreditation and certification?
3. Are We Managing Activities and Resources Well?
- Are our activities effectively coordinated with other donors?
 - Are we keeping direct and indirect costs in our implementing units under control?

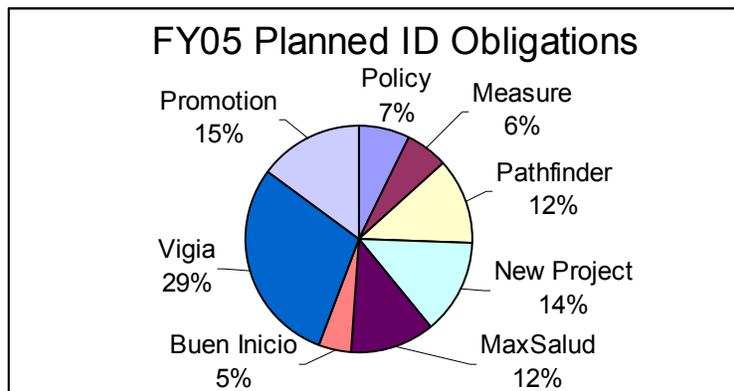
- Is our mix of instruments (Cooperative Agreements, Field Support, etc.) appropriate?
 - Are we adequately implementing and reporting on earmarks?
 - Have we effectively integrated our activities with other Mission programs – democracy, economic growth, environment, Alternative Development?
4. Do We Have the Right Partners?
- What is the cost-effectiveness of our Field Support partners – PHR+, POLICY, and Catalyst? Are their costs reasonable? What is the value to the Peruvian health sector of our teams of experts?
 - Has our reliance on Peruvian leadership in technical and policy areas been effective? Do we need more outside participation?
 - Do we have the right partners? Are we depending too much on old, experienced partners? Do we have too many partners?
 - Have the partners coordinated activities effectively among themselves?
 - Based on experience to date, what should our relationship with the Ministry of Health be?
5. How is Our Implementation?
- Have we unnecessarily sacrificed long-term development objectives by implementing quick-response mechanisms?
 - Is there any unnecessary duplication of capabilities, activities, or administrative overhead among our partners?
 - Shall we plan to rely on Field Support mechanisms after the current ones (Policy, PHR+) expire?

Appendix 2: ID Budget

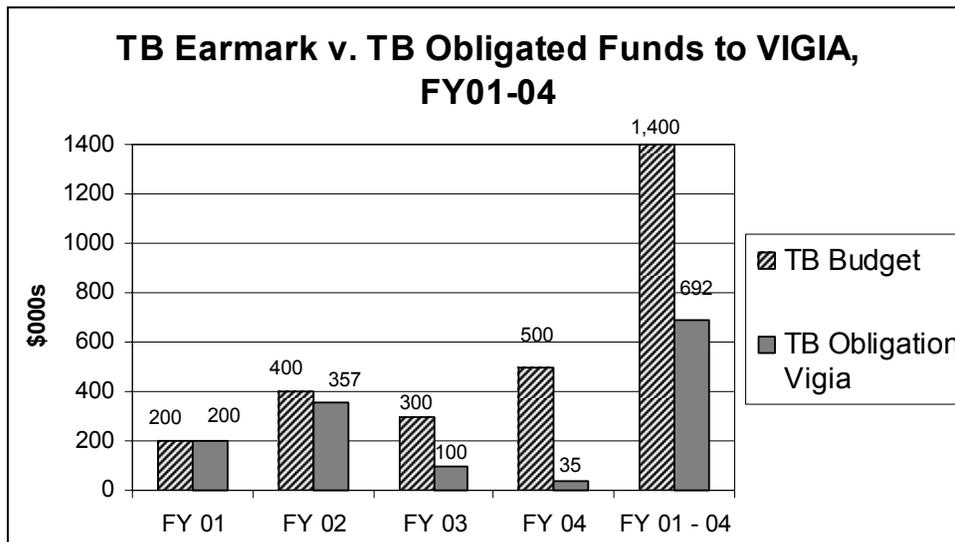
Graph A



Graph B



Graph C



Appendix 3: Persons & Organizations Consulted

Organization or Project	Interviewee(s)
APROPO	<ul style="list-style-type: none"> Malva Rosa Baskovich M., Director of Social Marketing
Belen Hospital, Trujillo	<ul style="list-style-type: none"> Segundo Cruz, Director
Development Zones Project	<ul style="list-style-type: none"> Patricia Morán, Logistics Project
Economic and Social Research Consortium, Lima	
Estella Maris Clinic, Lima	<ul style="list-style-type: none"> Jorge Ruiz Portal, General Director
Foro Salud	<ul style="list-style-type: none"> Board of Directors, Trujillo Board of Directors, Lambayeque Fanny Ruiz, Regional Coordinator
Futuras Generaciones, Peru	<ul style="list-style-type: none"> Laura Altobelli, Director
GOP: Office of the Ombudsman (Defensoría del Pueblo)	<ul style="list-style-type: none"> Walter Albán Peralta, Defensor del Pueblo Rocío Villanueva Flores, Defensora Adjunta para los Derechos de la Mujer Pilar Mazetti Soler, Ministra de Salud
INPPARES (RedPlan), Catalyst	<ul style="list-style-type: none"> Daniel Aspilcueta, Executive Director Angela Sebastiani, Program Director
INS	<ul style="list-style-type: none"> Cesar Cabezas Sánchez, Deputy Chief
International Development Bank	<ul style="list-style-type: none"> Susan Kolodin, Senior Specialist, Social Development
MAXSALUD (Bolonesia & Trujillo Clinics)	<ul style="list-style-type: none"> Miguel Vela, Executive Director Luis Noriega Arisnabarreta, Vice President, Board of Directors
Ministry of Economy and Finance	<ul style="list-style-type: none"> Javier Abugattás F., Advisor Alejandro Olivares Ramirez, General Directorate for Economic and Social Affairs Juan Pablo Silva Macher, General Directorate of Public Sector Multiyear Programming
Ministry of Health	<ul style="list-style-type: none"> Luis Manrique Morales, Advisor Eva Guerrero, Advisor to Minister Cesar Cabezas, National TB Program Director, DGSP Cesar Cabezas Sánchez, Deputy Chief, INS
MOH Health Post, Alto Trujillo	<ul style="list-style-type: none"> Attending doctor and staff

Municipal Government of Trujillo	<ul style="list-style-type: none"> • José Murguía, Mayor • Mario López, Municipal Sanitation • Yanny Aldave, Municipal Neighborhood Participation
National Council on Decentralization	<ul style="list-style-type: none"> • Otoniel Velasco Fernández, Advisor to the President, National Council on Decentralization
National Institute of Neoplastic Diseases	<ul style="list-style-type: none"> • Rosa Rosales, Infection Control Coordinator
National TB Reference Laboratory	<ul style="list-style-type: none"> • Luiz Asencios, Lab Chief
PAHO, Peru	<ul style="list-style-type: none"> • Rubén Figueroa, Infectious Diseases Advisor • Juan Carlos Millan, Tuberculosis Advisor
PAHO/WHO	<ul style="list-style-type: none"> • Fernando González Ramírez, Nacional Consultant on Health & HIV/AIDS Situation Analysis
Pathfinder	<ul style="list-style-type: none"> • Milka Dinev, Country Director
Peruvian Association of Infectious and Tropical Diseases	<ul style="list-style-type: none"> • Luis Cuellar Ponce de León, President
PHR <i>plus</i>	<ul style="list-style-type: none"> • Midori de Habich • Ada Pastor • Mary Diehl • Kathleen Novak • Oscar Bueno Valenzuela, Regional Advisor, La Libertad • Manuel Jumpa, Regional Advisor, Lambayeque
POLICY Project, Lima	<ul style="list-style-type: none"> • Patricia Mostajo, Project Coordinator • Marcela Huaita, Gender and Human Rights Specialist
PRISMA	<ul style="list-style-type: none"> • Raul Caro Palavicini, Logistics Director • Henry Espinoza Marchan, Logistics Division, Office of Reproductive Health and Medication • Delia Haustein van Ginhoven, Executive Director • Marilú Chang Echenique, Human Development Director • Edgar Medina Figueroa, Head of Healthy Municipalities and Communities in Alternative • Field Teams from “Healthy Municipalities and Communities” project
Private Sector Business Representatives, Chiclayo	<ul style="list-style-type: none"> • Carlos Delgado Tello, General Director, Abaco Corporation • Otto Zoeguer Navarro, President, SENATI, EPDYME ALTERNATIVA, Clínica Chiclayo • Luis Gasco Arrobas, COMOLSA S.A.C., Vallenorte

	<p>Arroz</p> <ul style="list-style-type: none"> • Julio Kant Elias y Marielena de Kant, Owners and Managers, Supermercados Kant & Grifos Kant • Julio Fernández Manayay, Director, Clinica Metropolitana • Juan Carlos Peramas Sánchez, General Manager, J&M Distributors • Cesar Calderon, Manager, OLTURSA • Otto Zoeger Navarro, President of Lambayeque Zone Council, SENATI
PROGRESA program team, University of Trujillo	<ul style="list-style-type: none"> • Cesar Lisa, Director of Graduate School • Jorge Neciosup, University General Secretary • Several PROGRESA program instructors
Red Hospitalaria, Trujillo	<ul style="list-style-type: none"> • Miguel Cassinelli, Planning & Institutional Development Unit • Coordinators from Microredes de Establecimientos
Regional Government, La Libertad (DIRESA, CRS, Consejo Regional)	<ul style="list-style-type: none"> • Carlos Chávez Pereda, General Manager • Regional Hospital Directors • Pedro Diaz Camacho, President of the Social Development Commission & PHR<i>plus</i> Coordinator in Regional Government • Ángel Iribari Poicón, Regional Health Director • Carlos Chávez Pereda, General Director • Jose Sanchez Ferrer, Social Development Commission • Enrique Recalde Gracey, Manager of Social Development • Marco Zegarra, Planning and Budget Manager
Regional Government, Lambayeque (CRS, DIRESA)	<ul style="list-style-type: none"> • Nery Saldarriaga de Kroll, Regional Vice President • Luis Deza Navarrete, Regional Health Director • Jorge Paico García, Regional Vice Director • Julio Ríos Souza, Regional General Manager • Eduardo Saenz Piedra, Regional Social Development Manager • Beatriz Solis Rosas, Advisor • Luis Enrique Lozano Zelada, Representative of Professional Associations of Lambayeque (Colegios Profesionales) • Carmen Gutierrez, Regional Council of Physicians Dean of Lambayeque School of Medicine • Miguel Vela López, Civil Society Organizations representative
Regional Hospital of Trujillo	<ul style="list-style-type: none"> • Raul Cantera, Director • Hospital Management Team
SIS (National Integral Health Insurance program)	<ul style="list-style-type: none"> • Moisés Acuña Díaz, Chief

Socios en Salud	<ul style="list-style-type: none"> • Jaime Bayona, Director
The World Bank	<ul style="list-style-type: none"> • Libia Benavides, Sectoral Specialist, Department of Human Development • April Harding
USAID/Peru Mission	<ul style="list-style-type: none"> • Richard Martin, Director, Office of Health • Susan Thollaug, Deputy Director, Office of Health • Luis Seminario, Office of Health • Jaime Chang, Office of Health • Lucy López, Office of Health • Edgar Ramirez, Office of Health • Marvin Dreyer, Alternative Development Officer • James Dunlap, Regional Contracting Officer • Jenny Vernooy, Alternative Development Program • Susan Brems, Deputy Mission Director
Vía Libre	<ul style="list-style-type: none"> • Robinson Cabello, Executive Director
VIGIA	<ul style="list-style-type: none"> • Luz Esther Vásquez, Director • María Pereira, Deputy Director • Luz Illescas Ruiz, Technical Advisor • Frine Salnavides, Technical Advisor, Hospital Infection Control • Lisabel Cabrera Vargas, Social Communications

Appendix 4: Documents Reviewed

APROPO.

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