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ASSESSMENT OF THREE USAID/PERU HEALTH PROJECTS

IMPLEMENTED BY THE MINISTRY OF HEALTH:

- VIGIA
- COVERAGE WITH QUALITY
- IMPROVED HEALTH FOR POPULATIONS AT HIGH RISK

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This publication was produced for review by the United States Agency for International Development. It was prepared by Stanley Terrell and David Nelson through the Global Health Technical Assistance Project.

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ACRONYMS

AMI	Amazon Malaria Initiative
APCI	Peruvian International Cooperation Agency (*Agencia Peruana de Cooperación Internacional*)
ASIS	Health Assessment Methodology *(Análisis de Información en Salud)*
CDC	Centers for Disease Control and Prevention
CwQ	Coverage with Quality
DHS	Demographic and Health Survey
DIGEMED	General Directorate for Medicines *(Dirección General de Medicamentos)*
DIREMED	Regional Directorate for Medicines (*Dirección Regional de Medicamentos, Insumos y Drogas)*
DIRESA	Regional Health Directorate (*Dirección Regional de Salud*)
FESP	Field Epidemiology Specialization Program
FP	Family planning
GAO	General Administration Office of the MOH
GH Tech	USAID/Global Health Technical Assistance Project
GOP	Government of Peru
HCM	Healthy Communities and Municipalities
HIS	Health information system
HIV	Human immunodeficiency virus
HPI	USAID/Health Policy Initiatives Project
HPR	USAID/Health Policy Reform Project
HRD	Human resources development
HS20/20	USAID Health Systems 20/20 Project
IHI	Intrahospital infections
M&E	Monitoring and evaluation
MCC	Millennium Challenge Corporation
MOH	Ministry of Health
NAMRID	Naval Medical Research Center, Lima
NGO	Non-governmental organization
PDE	Public decentralized entity
NHI	National Health Institute
OGE	Epidemiology Office of MOH (*Oficina General de Epidemiologia)*
OGCI	Office of International Cooperation
PAAG	Program for Administration of Project Support

PAR	Improved Health for Populations at High Risk project
RH	Reproductive health
RHC	Regional Health Council
RENACE	National Epidemiology Network *(Red Nacional de Epdemilogia*)
SIS	Integral Health Insurance scheme *(Seguro Integral de Salud)*
SNIP	National Public Investment Fund (*Sistema Nacional de Inversion Pública)*
SO	Strategic Objective
TA	Technical assistance
TB	Tuberculosis
UEP	Special Projects Unit of USAID Project 2000
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VIGIA	Addressing the Threats of Emerging and Re-emerging Infectious Diseases project

EXECUTIVE SUMMARY

USAID/Peru requested the GH Tech Project to assess lessons learned and best practices of three Mission-supported activities that were implemented by the Ministry of Health (MOH): Addressing the Threats of Emerging and Re-emerging Infectious Diseases (VIGIA); Coverage with Quality (CwQ); and Improved Health for Populations at High Risk (PAR). This report also assesses the management approach and administration of the activities and identifies specific project management strengths and weaknesses within the MOH. This information will be useful for the MOH (including regional health offices), which is reorganizing as it adapts to its stewardship role under decentralization; and it will also provide useful feedback for USAID/Peru as it manages current activities and designs and implements new activities that support the MOH.

The assessment is intended to

- Review and summarize project results and identify best practices and lessons learned.
- Document how the MOH implemented and managed programmatic and technical interventions within the context of health reform, decentralization, and political change.
- Examine how the programs evolved and how changes in policies and program priorities affected regional and local service delivery and programmatic outcomes.
- Identify gaps in technical assistance (TA) that USAID should consider priorities going forward.
- Describe lessons learned regarding project management and make recommendations for improving administration of future projects.
- Contribute to USAID's development experience database.

The assessment team reviewed documents provided by USAID and other documents and data collected through searches and discussions with local counterparts (Appendix B). Special attention was paid to identifying end-products ("markers") for each project and ascertaining whether they are still in use. The team used a structured qualitative in-depth questionnaire for more than 200 key informants at various levels of the health system and from a variety of sectors. Before it was validated and taken to the field, the draft structured open-ended discussion guide (Appendix D) was revised in consultation with the MOH counterpart in Lima with feedback from USAID. Versions of the discussion guide intended for regional health office personnel were adapted for local government officials and community beneficiaries.

The discussion guide sought both spontaneous and prompted responses related to knowledge of the projects and their products. Where appropriate, questions were asked about management of the programs to get feedback that was balanced in terms of the technical and the management and administration aspects of projects. The team met with some 237 people in Lima and six health regions (San Martin, Junin, Loreto, Ucayali, Ayacucho, and Cusco): USAID personnel and project staff; MOH and other stakeholders in Lima; and DIRESA and health center staff, local government, and project beneficiaries.

PROJECTS ASSESSED

Coverage with Quality (CwQ)

CwQ (1997–2007) was carried out under a limited scope grant agreement between the Government of Peru (GOP) and USAID. It was designed to strengthen the MOH to be able to

respond to the family planning (FP) needs of the Peruvian population in a very complex health care setting with high rates of maternal mortality due to numerous social, economic, cultural, and health factors in a country with a generally weak health care system.

Improved Health for Populations at High Risk (PAR)

PAR (2005–07) was intended to improve health education and healthy behaviors for families, schools, communities, and health services. It operated in the regions of Ucayali, San Martin, Junín, Cusco, Pasco, Ayacucho, and Huánuco. The initial agreement hoped to implement five components with the goal of fortifying regional and local training in health promotion within the public health system. They were methodological development and instrumentation (procedures); advocacy and political consequences of health promotion projects; training of health personnel; development of pilots to evaluate methods and strategies; and monitoring and evaluation (M&E) against indicators for health promotion activities.

Addressing the Threats of Emerging and Re-emerging Infectious Diseases (VIGIA)

VIGIA (1997–2008) was intended to strengthen national and local capacity to identify, control, and prevent emerging and re-emerging infectious diseases effectively in Peru. The goal was to improve the health conditions of populations at high risk of contracting emerging and reemerging infectious diseases by building the capacity of the MOH to identify, prevent, and control emerging and reemerging infectious diseases.

MAJOR FINDINGS

1. The team encountered hard-working, competent and dedicated personnel at all levels from the MOH down to the community, who were grateful for past and present USAID support efforts. Some of these personnel have over 30 years of service.

The three projects offered some interesting comparisons:

- VIGIA was more central and technically oriented, developing innovative solutions for infectious disease control; CwQ and PAR were more focused on improving service delivery at the regional and subregional levels.
- PAR had an unwritten additional objective of improving central and regional capacity for effective communications on a variety of health issues. At various times there was a salubrious overlap, e.g., PAR-sponsored trainings using VIGIA materials.
- VIGIA, which was financially more efficient than the other two projects, was administered by the National Health Institute (NHI) and had an effective governing board that facilitated institutionalization of its work and innovations. All the projects experienced some difficulties in executing funds, however, with PAR being the extreme case.
- All three projects were flexible in adapting to changes in both the macro political climate and health sector policy regarding reform and decentralization.

2. Most of the detectable markers of the projects were publications and testimony of recipients of training. There were also instances of donated equipment that was or had become obsolete and unserviceable. Brief trainings and ad hoc publications seem to have had limited effect because they were diluted by staff rotations, inadequate institutional structure, and lack of career paths (except NHI-VIGIA). Even though many were able to recognize the covers of project-produced publications, they did not have them at hand and in most cases could not verify that they were in use.

VIGIA products, innovations, and results were well documented. However, for PAR and CwQ it was difficult to ascertain which materials they had themselves developed since most of the manuals and guides they distributed seem to have been produced by other USAID projects (Figure 1). Although this complicated the team's ability to identify clear footprints for CwQ and especially PAR, it appears that in fact these projects coordinated well with other USAID technical assistance (TA) projects to create synergies and a win-win situation in extending the coverage of materials and guidelines developed by the other projects. CwQ in particular appears to have done a great deal to strengthen and extend FP and reproductive health (RH) services. For example, the waiting houses (*casas de espera*) for pregnant women from rural areas it helped develop and support appear to be a promising approach for increasing the proportion of institutional births, reducing maternal mortality, and bringing previously excluded groups into the health system.

3. Regional authorities interviewed consistently and emphatically requested that USAID not channel funds through the central MOH or even directly to regional directorates (*Direcciones Regionales de Salud*, DIRESAs) themselves. They cited bureaucratic delays and lack of responsiveness in Lima as a principal cause of the poor spending capacity of the projects. Even when funds, e.g., for Plus Petrol in Loreto, were directly deposited with regions, they still had serious problems with financial execution due among other things to GOP requirements.

The assessment found no mechanisms for peers to share experiences across the DIRESAs, particularly with regard to problem-solving. The regions were insistent that they do not want prepackaged projects from the Central Level, with fixed objectives and standard inputs and indicators. They are demanding flexibility so that projects respond to particular local needs. Both central and regional administrative and finance personnel expressed the concern that because they had been left out of project planning, they did not fully understand the project or their role and participated only grudgingly.

LESSONS LEARNED

Among the organizational, managerial, and technical lessons learned from these three activities were that

1. Training is best conducted within a functioning civil service system and should contribute to a competency-based career path. Many professional pre-service training programs do not prepare their students for the first level of care, where the graduates tend to be placed. Too little attention is paid to staff satisfaction and motivation at all levels, including community networks. Salaries are very low, and there is a dearth of other performance incentives. Certain professional training that responded to perceived interests and needs, as exemplified by the VIGIA-supported Field Epidemiology Specialization Program (FESP), did increase institutional competency. FESP graduates were easily identified by their peers, and most were apparently still in epidemiology-related positions, some with international organizations.

2. In terms of financial management, the team found a continuum of perceived efficiency. Least efficient was having funds deposited with and managed by the MOH General Administration Office (GAO), and the most efficient was a standalone mechanism independent of the MOH, such as the one managed by the Spanish Cooperation for a project in Loreto. Although perceived as most efficient, standalone management units do little to enhance MOH financial management. Intermediate mechanisms included the unit set up for Project 2000 (the USAID Special Projects Unit [UEP]) that for a time administered CwQ funds; the Program for Administration of Project Support (PAAG) of the MOH, which no longer exists; and a public decentralized entity (PDE), such as the NHI that managed the VIGIA funds.

3. M&E are crucial to ensure that projects remain on track to achieve their objectives. PAR and CwQ seemed to be extraordinarily weak in this area, which is one of the reasons that they

have had relatively little impact, since they functioned in a context where there were complementary projects and activities in operation.

4. There is a role for projects that support MOH activity if they are properly structured with clear objectives, M&E, and work plans to achieve clear results. These conditions contributed to VIGIA's relative success and ease of monitoring. Properly structured, these activities incorporate a participatory M&E plan that assigns an oversight role to local government and civil society and can have synergies with other USAID TA projects.

5. Decentralization, including municipal management of primary care and universal health insurance, will be the driving force for MOH reform and development in coming years. The lesson for USAID is to more fully involve other sectors in monitoring execution and spending to make it more likely that resources are spent wisely and program outcomes sustained. Principal regional needs are improving the operational ("nuts and bolts") capacities of the DIRESAs and their subunits (networks and micro-networks). Some regions seem to be having difficulties in adjusting to performance-based budgeting.

6. Civil society is starting to play a much larger role in health decisions. If projects like USAID/ Healthy Communities and Municipalities (HCM) that builds on PAR, VIGIA, and CwQ experiences are successful, empowered communities will begin to demand quality and performance from local authorities and the health system. Health insurance companies provide quality assurance and referral services in addition to financing. The universal health insurance scheme, in addition to financing MOH services, should provide these functions, which would promote alternative suppliers and ensure quality services through accredited providers, which in turn would strengthen consumer demand for quality services. However, the potential role of civil society is generally underappreciated and underutilized. Regional Health Councils (RHC) in some regions are consultative only, with no real oversight role.

7. The principal strengths of working with the MOH to manage health programs are that it builds up the MOH institutionally; reinforces its commitment to extending and implementing products and technologies developed by TA projects; and can do work plans, carry out activities, and deliver services to a large number of people as a complement to other projects. However, these strengths are compromised by such weaknesses as difficulty in adapting to USAID requirements; inefficient financial execution; M&E limitations; and geographical and cultural limitations in addressing equity and exclusion issues.

LEGACY

The team assessment of the legacy of these three activities can be summarized as follows (see also Table 4 for more details):

- Everyone contacted appreciated USAID support. Personnel that participated felt that their capacity had increased and they had been empowered to do a better job.

- There were sustained results in the form of printed norms and manuals (even though developed by other projects) bearing the MOH imprimatur. These are still available on the MOH website.

- There was recognition of the importance of information-based decision making for planning services and setting norms and standards.

- Although all three projects do seem to have supported the drive to improve quality in health services and committed individuals are still working in the regions, it is impossible to quantify the effect.

- FESP prepared competent epidemiologists who are still making contributions. CwQ implanted a capacity for and interest in quality improvement in some areas and personnel. However, there is no evidence of *sustained* capacity building elsewhere.

BEST PRACTICES

Finally, with regard to best practices used successfully by these programs that are being replicated by other donor projects or programs or by the GOP, the team identified the following:

- Quality improvement activities, situation rooms for data analysis, and quality committees in some hospitals
- Malaria and tuberculosis treatment regimens
- Malaria promoters
- Intermittent rice irrigation for malaria control
- Intrahospital infection control committees
- Rational antibiotic use surveys being conducted
- Waiting houses for pregnant women from rural areas
- Healthy schools

RECOMMENDATIONS TO THE USAID/PERU HEALTH TEAM

(Section IX contains a more extensive list of recommendations):

There is still a role for projects that support MOH execution of planned activities. The team recommends that USAID consider continuing to support them, but with a number of conditions, such as

- clear objectives based on defined a results;
- an M&E plan with indicators and a schedule for periodic measurement;
- flexibility for regional subproject design;
- efficient and transparent financial management; and
- effective MOH and USAID management and oversight teams.

The assessment team recommends that the USAID/Peru Office of Health systematize M&E for projects of this type and consider entering into a third-party M&E TA agreement that would provide for periodic evaluation over the life of the project rather than mid- and end-term visits. There would be a role for external review (a "third eye") even after the office's internal M&E capacities are built up.

In designing financial management mechanisms for future public sector support projects, the team recommends that USAID balance the concerns for administrative efficiency with concerns for MOH strengthening. The simplest and most efficient mechanism would be for USAID to incorporate MOH and DIRESA support funds into TA mechanisms. This would have the added advantage of ensuring close harmony between USAID-supported TA and MOH/DIRESA support. However, operational budget amounts would need to be fully negotiated with the MOH and DIRESA, and the counterpart should be fully empowered to program the funds through a results-based budgeting process.

The team recommends that USAID-supported TA to the DIRESAs emphasize basic administrative and management functions to identify and overcome bottlenecks. Such support could include problem-sharing and -solving networks and the transfer of lessons learned across regions through horizontal peer-to-peer communication (DIRESAs, DIRIMEDs, regional labs, etc.) via social networking and Web 2.0 technologies.

The team recommends that USAID/Peru projects continue to have a general overarching framework throughout the planning, design, and workplan development process. However, it is also recommended that USAID recognize the need for flexibility for sub-project plans and budgets to be introduced in the regions, and that DIRESA administrative and financial as well as technical staff contribute to subproject planning and workplan development to ensure that such projects function smoothly.

USAID has supported and continues to support training at a number of different levels through each of its implementing mechanisms, many of which worked with and through Peruvian training institutions. The team recommends that USAID consider working with the MOH and DIRESA on a comprehensive review of health sector human resource needs in order to deal with them consistently across projects in terms of regional salary equity and incentive systems, both monetary and nonmonetary. Health staff training, both pre-service and in-service, also merits a comprehensive approach that takes into account the high rate of turnover at the primary care level. Alternative training methods could be explored, such as incorporation of MOH norms into professional and paraprofessional pre-service training programs and more on-site mentoring, especially for clinical services. Distance learning (self-learning) could be expanded—both current Web-based efforts for those who have Internet access, and paper-based modules for paraprofessionals working in the community.

The team also recommends that USAID work with the MOH and DIRESA to see that training at all levels is integrated with and followed up by supportive supervision with incentives for successfully completing training and applying it in the workplace.

The team recommends that USAID explore working with the MOH to identify and support alternative delivery systems for extending coverage, with the public sector taking a stewardship/supervisory role. The Guatemalan **Sistema Integrado Atención de Salud** (SIAS) model of the MOH entering into performance-based contracts with NGOs to extend services, according to MOH standards and guidelines, to populations excluded by culture or geography could be considered as another way to extend coverage and ensure equity. The team also recommends that current community-based initiatives for healthy communities, schools, and families continue to be supported by USAID TA.

The national priorities of reducing maternal and perinatal mortality and chronic malnutrition are appropriate. However, if they are pursued too zealously, other key interventions, such as tuberculosis control, could be neglected. The team recommends that USAID-supported TA help regional governments more adequately balance program priorities in their planning and results-based budgetary processes in terms of the health situation in a particular region.

USAID makes a unique contribution in making available and improving the quality of FP and RH services. This assistance is highly valued by health workers and beneficiaries. The team recommends that the Mission continue working with the MOH, UNICEF, and other partners on documenting and disseminating lessons learned from the various implementations of the waiting houses model.

I. INTRODUCTION

PURPOSE

USAID/Peru requested that the GH Tech Project assess lessons learned and best practices of three Mission-supported activities that were implemented by the Peruvian Ministry of Health (MOH). This assessment also reviews the management approach and administration of the activities and identifies specific MOH project management strengths and weaknesses. This information will be useful for the MOH (including regional health offices), which is reorganizing as it adapts to its stewardship role under decentralization; and it will provide useful feedback for USAID/Peru as it continues to manage current activities and designs and implements new activities to support the MOH.

The assessment

- Reviews and summarizes project results and identifies best practices and lessons learned.
- Documents how the MOH implemented and managed programmatic and technical interventions within the context of health reform, decentralization, and political change.
- Examines how the programs evolved over time and how changes in policies and program priorities affected local and regional service delivery and program outcomes.
- Identifies gaps in technical assistance (TA), filling which should be considered priorities by USAID in future.
- Describes lessons learned about project management and makes recommendations about how to improve administration of such projects in the future.
- Contributes to USAID's development experience database.

ASSESSMENT TEAM

Dr. Stanley S. Terrell, team leader: Dr. Terrell had general responsibility for the direction and coordination of the team's activities, including drafting the work plan, choosing the assessment methodology and data collection instruments, scheduling staff visits, and preparation and final editing of the English version of the report to assure that all relevant topics, including cross-cutting themes, were covered. Dr. Terrell represented the team to USAID/Lima and local partners, such as the MOH, and was responsible for keeping GH Tech/Washington and USAID/Lima informed of progress; resolving any issues arising in the field; and meeting deadlines for deliverables.

Dr. David P. Nelson, deputy team leader: Dr. Nelson assisted Dr. Terrell in all team activities and represented the team when Dr. Terrell was unavailable. He drafted the components of the report that deal with project management, health sector reform, and decentralization.

Dr. Reynaldo Alvarado, CwQ: Dr. Alvarado had primary responsibility for aspects of the report dealing with the Coverage with Quality Project (CWQ), including reviewing the background documents, drafting the necessary data collection and interview instruments, conducting interviews with stakeholders and local partners, and drafting the CWQ section of the report. He also contributed to the articulation of the responses to general questions and cross-cutting issues; assisted other team members in collecting information on their primary assignments; and performed other tasks as needed.

Dr. Pedro Mendoza, VIGIA: Dr. Mendoza had primary responsibility for aspects of the report dealing with the Addressing the Threats of Emerging and Re-emerging Infectious Diseases project (VIGIA), including reviewing the background documents, drafting the necessary data collection and interview instruments, conducting interviews with stakeholders and local partners, and drafting the VIGIA section of the report. He contributed to the articulation of the responses to general questions and cross-cutting issues; assisted the other team members in collecting information on their primary assignments; and performed other tasks as needed.

Teobaldo Espejo, PAR: Mr. Espejo had primary responsibility for aspects of the report dealing with the Improved Health for Populations at Risk (PAR), including reviewing the background documents, drafting the necessary data collection and interview instruments, conducting interviews with stakeholders and local partners, and drafting the PAR section of the report. He also assisted the other team members in assessing communications components of their projects; helped articulate the responses to general questions and cross-cutting issues; assisted the other team members in collecting information on their primary assignments; and performed other tasks as needed.

Gabriela Torres, logistics coordinator: Ms. Torres was responsible for all logistics and administrative support to keep the team functioning smoothly, including reservations, appointments, itineraries, communications, and other administrative functions.

METHODOLOGY[1]

The team reviewed documents provided by USAID, additional documents, and data collected through searches, visits, and discussions with local counterparts (see Appendix B). Special attention was paid to identifying end products ("markers") for each project and ascertaining whether they are still in use.

The team also made visits to sites selected in accordance with the Scope of Work (SOW) and discussions with USAID and local counterparts to assure adequate coverage within logistical limits and the assessment timeline. Criteria for site selection included

- Presence of personnel who could inform the assessment;
- Level of effort and activities realized at the site; and
- Logistical feasibility.

Regions selected for visits through this consultative process were San Martin, Junin, Loreto, Ucayali, Ayacucho, and Huánuco. However, due to a general strike in Huánuco, it was replaced by Cusco. Site visits were made during the weeks of October 5 and October 12, and an MOH staff member accompanied the team on each visit (see Appendix G).

During the week of October 19, the team had follow-up appointments and interviews in Lima with USAID and various stakeholders, including telephone interviews with personnel who could not be interviewed in person. The team also had extensive discussions with USAID, MOH, and other counterparts to review preliminary findings and observations from the field visits and documents reviewed.

Primary assessment data were obtained using a structured qualitative questionnaire for informants at various levels of the health system and from a variety of sectors. The draft structured open-ended discussion guide (Appendix D) was revised with the MOH in Lima with feedback from USAID before it was validated and taken into the field. The discussion guide for DIRESA personnel was adapted for local government officials and community beneficiaries. The

[1] See Appendix A for the Scope of Work.

discussion guides sought both spontaneous and prompted responses related to knowledge of a project and its products. Where appropriate, questions were asked about management of the program to get a balance of feedback on the technical and the management and administration aspects of the projects.

Table 1 categorizes the 237 individuals contacted.

TABLE 1. PERSONS CONTACTED

Place		Number
Lima	USAID staff	8
	USAID projects	5
	Other stakeholders	29
Regions	Ayacucho	44
	San Martín	36
	Loreto	28
	Ucayali	33
	Cusco	24
	Junin	30
TOTAL		237

All were either individually interviewed or took part in group discussions. All were given an opportunity to offer input, and most did.

USAID provided a list of contacts for the projects and in the health regions that was the starting point for identifying interviewees. The list was enriched through discussions with local counterparts. Care was taken to ensure a cross-section of stakeholders and counterparts, including representatives of

- USAID
- Government (MOH, DGSP, DGPM, DIGEMID, NHI, etc.)
- Regional Health Directorates (DIRESAs)
- Regional and local government authorities
- Civil society organizations
- Health facilities
- Other stakeholders and donors providing assistance to the MOH (the Pan American Health Organization; other USAID projects – HS20/20, HPI, HCM, Quality)
- Beneficiaries (patients, community leaders, citizens)

MOH personnel from the Office of International Cooperation (OGCI) and the General Directorate of Health (DGSP) formed part of an expanded assessment team and actively participated in all phases of methodology design and instrument drafting; facilitated communications and logistics; accompanied the team to the field; and participated in extensive discussions of the findings and recommendations (see Table 2). However, structured interviews with DIRESA staff were conducted solely by GH Tech consultants, and the informants were assured of anonymity. Results

from the interviews, initial impressions and findings from the site visits, and secondary information were discussed by the expanded team in the field and upon returning to Lima and with USAID staff and other stakeholders while the draft report was prepared. The team made a PowerPoint presentation to USAID on November 9 and to the MOH on November 10 (Appendix F). The draft report was submitted to USAID for comments on November 12.

TABLE 2. MOH REPRESENTATIVES PARTICIPATING AS ASSESSMENT TEAM MEMBERS

Name	Office/Directorate
Esthela Cusco	Office of International Cooperation (OGCI)
Betty Gaviria	Personal Health (DGSP)
Rosario Zavaleta	Personal Health (DGSP)
Erika Jímenez	Personal Health (DGSP)
Yessy Ruíz	Office of International Cooperation (OGCI)
Aurelio Roel	Office of International Cooperation (OGCI)
Marcos Calle	Quality (DGSP)
Rocio Figueroa	Office of International Cooperation (OGCI)

Upon returning from the field the team conducted follow-up interviews in person and by phone to validate and enrich the findings and met with USAID and the MOH to discuss the preliminary findings before they were formally presented.

BACKGROUND

For more than a decade (1998–2008), USAID/Peru's Office of Health implemented a significant part of its work by directly funding activities of the MOH under three separate agreements: Addressing the Threats of Emerging and Re-emerging Infectious Diseases (VIGIA; *Enfrentando las amenazas de las enfermedades infecciosas emergentes y remergentes)*; Coverage with Quality (CwQ, *Cobertura con Calidad);* and Improved Health for Populations at High Risk (PAR, *Poblaciones en Alto Riesgo*). The three activities had different goals:

- VIGIA: increase local and national capacities to identify, control, and prevent emerging and re-emerging infectious diseases.
- CwQ: improve the quality of reproductive, maternal, and perinatal health services.
- PAR: improve the health of high-risk populations through health program campaigns and capacity-building in a number of priority health areas.

VIGIA had national coverage; CwQ and PAR operated in seven health regions. The projects can be summarized as follows

- VIGIA (Activity No. 527-0391)
  - Infectious Diseases
  - September 1998–June 2008 (assessment emphasis: last five years)
  - USAID: $18.8 million (M); Government of Peru (GOP): $13 M
  - Nationwide

- CWG (Activity No. LSGA: 527-0375)
  - Reproductive, Maternal, and Infant Health and Family Planning
  - September 1996–December 2007
  - USAID $6.35 M; GOP $3.5M
  - 1996 – 2002 nationwide; 2002 seven regions,[2] Piura (Border), and Huancavelica at the request of the MOH
- PAR (Activity No. 527-0412)
  - Health Promotion and Communications
  - September 2003–September 2007
  - USAID $5M; GOP $1.7M
  - Seven regions (see footnote 2)

These three activities accounted for approximately one-third of the Mission's budget for health for 2003–07.

Other UAID-supported Health Activities

During this period USAID also supported the following health activities:

- USAID/Promoting Alliances and Strategies (PRAES)
- USAID/Health Policy Initiatives (HPI)
- USAID/Health Systems 20/20
- USAID/Quality Healthcare
- USAID/Healthy Communities and Municipalities (HCM).

USAID/Peru is also implementing the Millennium Challenge Corporation (MCC) Threshold Program, which has corruption control and immunization components; providing TA through the MEASURE, POLICY and DELIVER projects; and funding other health activities through MaxSalud, ReproSalud, CATALYST, and Buen Inicio.

HS20/20 and HPI supported macrostructural reform through TA for the design and implementation of the health sector decentralization process, sector financing, sector-wide regulatory structures, and health insurance for the poor. They also supported the development of systems to strengthen human resources, pharmaceutical logistics and supply chain management, service delivery, and information systems. Although HPI and HS20/20 had ended by November 2009, many of their activities will be continued through a new USAID Health Policy Reform (HPR) project.

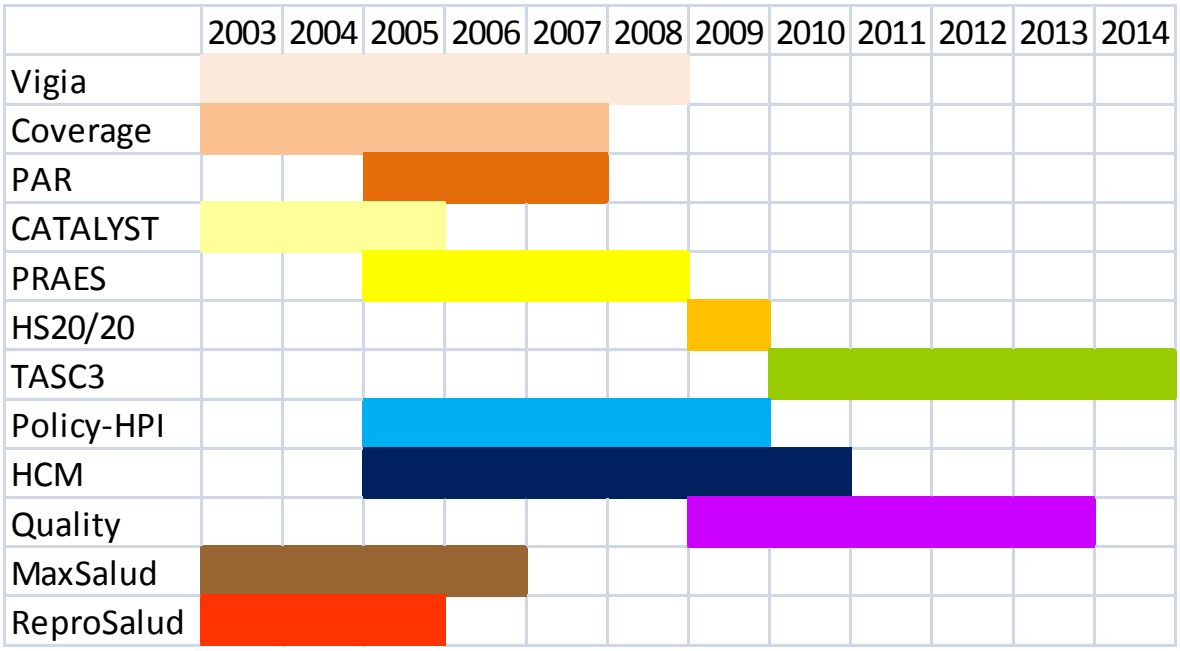
Quality Healthcare and the MCC are aimed at reinforcing key health functions at the operational level and addressing problems related to poor implementation of technical procedures and practices; they focus on the technical capacity of providers. HCM is promoting community health through a multisector approach to increase utilization of improved health care services; it continues through September 2010. Quality will continue through 2013.

[2] The seven regions were Ayacucho, Cusco, Huánuco, Junin, Pasco, San Martin, and Ucayali.

Finally, USAID/Peru will soon initiate the five-year HPR project (2010–15) with the goal of increasing the capacity of the MOH and regional and local public entities to deliver quality health services and effectively use key health system inputs. HPR will focus on five system components: governance, financing, information, the workforce, and medical products, vaccines, and technologies. The USAID-supported Amazon Malaria Initiative (AMI) and the South American Infectious Diseases Initiative (SAIDI) are also currently active in Peru, and USAID is considering a follow-up to the HCM activity.

Figure 1 shows the sequencing of past and current USAID/Peru projects in chronological relation to the three projects being assessed: VIGIA, CwQ, and PAR.

Figure 1. USAID Projects Active in Peru, 2003–14



Health Sector Reform

All health activities in Peru operate in the context of health sector reform and decentralization. On April 1, 2003, President Toledo announced that "The future of Peru is beginning to change, political and economic centralism are being left behind, and true decentralization is beginning." That same year the GOP started to transfer resources and tools, along with social development projects, to regional and municipal (provincial and district) governments. The Organic Law of Regional Governments (November 2002) defined 16 health sector organization, management, and governance functions to be transferred to the regional governments.[3]

In summary, during 2003–08 direct health sector reform was replaced by a decentralization process that redefined the roles of national, regional, and local government. The MOH was supposed to cease delivering services and take on a stewardship role, defining and enforcing standards and norms; and regional governments appointed social development directors to oversee the DIRESAs. There are 125 health competencies related to the 16 functions being transferred to the regions, which are policy; strategic planning; financial management; public sector health insurance; health promotion; institutional organization; logistics and maintenance; the provision of personal, environmental, and occupational health services; regulation of

[3] Távara Castillo, G., y Márquez Calvo, J., 2009, "Sistematización del proceso de descentralización del sector salud." Lima: Abt Associates Inc. P. 33.

pharmaceutical and other health services; environmental and occupational health regulation; management of health investments and information; human resource management and regulation; and health research.[4]

The MOH retains 11 stewardship functions, but 9 of them are shared with other levels. However, there was and still is uncertainty about which functions have been transferred and accepted, and there are also questions about the level and transparency of the necessary transfer of resources to carry out these functions, which affects capacity for effective financial management.[5]

There is also an expectation that as part of the health reform process the regions will further devolve decentralization to lower operational and administrative levels. This reform should also involve other sectors, including local governments and civil society, in decision making for and monitoring of health-related activities. Health sector reform, including decentralization and a move toward universal health insurance, is an emerging and evolving process that must be taken into account in all future projects.

[4] *Sistema de Monitoreo y Evaluación de la Descentralización en Salud*, Vol. 1, Anexo XIX.

[5] Távara Castillo, G., y Márquez Calvo, J., 2009, "Sistematización del proceso de descentralización del sector salud." Lima: Abt Associates Inc. p. 33.

II. FINDINGS AND OBSERVATIONS[6]

PROJECT PERSONNEL

The team encountered hard-working, competent, and dedicated personnel at all levels of the system, from the MOH down to the community, who were grateful for past and present USAID support. Some of these personnel have over 30 years of service.

THE THREE PROJECTS COMPARED

VIGIA was more central and technically oriented, developing innovative ways to control infectious diseases. CwQ and PAR were more focused on improving service at the regional and subregional levels. PAR also had an unwritten additional objective of building central and regional capacity for effective communications programs for a variety of health issues. At various times there were synergies between the projects, such as PAR-sponsored trainings using VIGIA materials.

VIGIA, which used its financing more efficiently than the other two projects, was administered by the National Health Institute (NHI) and had an effective governing board that facilitated institutionalization of its innovations. However, all three projects had some difficulties in budget execution, with PAR being the extreme case. Yet all three were flexible in adapting to changes in the macro political climate and in policies for health sector reform and decentralization.

PROJECT MARKERS

Most of the detectable markers of the projects were publications and the testimony of trainees. There were also instances where they donated computers and laboratory equipment, although in some cases it was obsolete and unserviceable. Much of the lower- tech CwQ equipment, such as episiotomy kits and communication radios, was still serviceable and being used.

It appears that the brief trainings and ad hoc publications had limited effect because they were diluted by staff rotations, weak institutional structure, and lack of career paths (except NHI-VIGIA). While trainees said that their personal and professional lives had been enhanced by project training, many, if not most, were performing activities unrelated to the training. Even though many of them could recognize the covers of project-produced publications, they did not have them readily at hand (predecessors had taken them to their next assignment) and usually could not verify that the documents were in use.

VIGIA products, innovations, and results were well documented, but for PAR and CwQ it was difficult to ascertain which materials they had created themselves, since most of the manuals and guides they distributed seem to have been produced by other USAID projects (e.g., CATALYST, Initiatives, Project 2000, etc.; see Figure 1). Although this made it harder for the team to identify clear footprints for CwQ and especially PAR, in fact these projects seem to have coordinated well with other USAID projects to create synergies and a win-win situation in extending the use of materials and guidelines other projects produced.

Based on key informant interviews and site visits, CwQ seems to have generated interest, capability, and commitment to improving the quality of family planning (FP) and reproductive health (RH) services and the healthcare workplace. Support for the waiting houses (*casas de espera*) is solidly based, and it is our understanding that the Minister of Health has found budgetary support for them. However, there appear to be a number of variations of these (not necessarily a bad thing), and it would be beneficial to have the lessons learned systematized. PAR

[6] See Appendix H for individual project assessments.

strengthened some individuals in health promotion, but there is a dearth of educational and promotional materials at the operational and community levels.

COMMUNICATION

During field visits it was remarkable to observe that regional DIRESAs, units of drug management (DIREMID), and reference laboratories communicated only with their Lima counterparts, not with each other. The laboratories insisted that they do use web searches for technical information but they have little if any idea of who manages the other regional laboratories, much less their contact information. Similarly, there are no mechanisms for DIRESA peers to share experiences, particularly with regard to problem-solving; thus advances and successes (or mistakes and tragedies) are not communicated horizontally, so there is no transfer of learning. Social networks for information-sharing and problem-solving can also function as mutual support systems, which could help reduce job frustration and burnout.

ADMINISTRATION AND FINANCE

The assessment team heard repeatedly that administration and finance personnel, at both the central and regional levels, were left out of project planning. As a result, they never fully understood projects or their role and participated only grudgingly. They complained that the technical staff did not understand disbursement and accounting cycles and made ad hoc demands for rapid cash allotments to pay for planned activities.

In terms of financial management, the team found a continuum of perceived efficiency. The least efficient method was to have funds deposited with and managed by the MOH GAO; the most efficient was a standalone mechanism external to the MOH, such as the one managed by the Spanish Cooperation for a project in Loreto. However, standalone management units do little to build MOH financial management capacity. Intermediate mechanisms included the special project management unit set up for Project 2000 that administered CwQ funds for a while; the Program for Administration of Project Support (PAAG) of the MOH, which no longer exists; and a public decentralized entity (PDE) such as the NHI that managed VIGIA funds.

Regional authorities consistently urged that USAID not channel funds through the central MOH or even directly to the DIRESA. Bureaucratic delays and lack of responsiveness in Lima were seen as a principal cause of the poor spending capacity of the projects. However, even when funds (e.g., for Plus Petrol in Loreto) were directly deposited with regions, there were still serious execution problems, due among other things to GOP requirements. Table 3 highlights the difficulties the public sector has with financial execution of projects. The high rate of execution for CwQ was achieved only by extending the project beyond the original five years. VIGIA had a high execution of subobligated funds but spent only about two-thirds of the funds potentially available. As Table 4 shows, PAR's financial execution began slowly and actually decreased over time.

TABLE 3. SUMMARY OF PROJECT BUDGET EXECUTION (USD)

	VIGIA	CwQ	PAR
Authorized	18.8 m	6.35 m	5.0 m
Subobligated (% authorized)	12.62 m (67%)	6.35 m (100%)	1.279 m (26%)
Executed (% subobligated)	12.238 m (97%)	6.023 m (95%)	1.279 m (100%)*

* USAID spent another $1.737 million of the amount for project management and TA.

TABLE 4. IMPORTANT LEGACIES OF THE THREE PROJECTS	
Project	**Legacy**
VIGIA	VIGIA left a number of concrete products and legacies the most important of which could have been the commitment to an evidence-based decision-making mindset, both in the development of clinical norms (malaria, intrahospital infections, HAART, rational use of medicines) and the integration of epidemiology with other management information, e.g. Health Situation Assessment (ASIS). The extensive list of products (manuals, norms, educational and communications materials) that VIGIA contributed to is well documented in their final report and a separate publication. The VIGIA-supported Field Epidemiology Support training left a cadre of well-trained and respected personnel who have largely remained in positions where they continue to contribute to health programming in Peru. Systems supported and disseminated by VIGIA such as the "Health Intelligence Units" and the INTERFASE system for collating and reporting information also continue to be important elements of the Peruvian health system. VIGIA also supported important efforts to integrate health themes into the academic curricula of the schools. The testing, documentation, dissemination, and implementation of intermittent rice irrigation for malaria control that involved the participation of the private sector is clearly a best practice that has continued post-VIGIA. Finally, another important legacy of VIGIA was that it appropriately elevated, in accordance with the epidemiological transition, the visibility of emerging and reemerging diseases within the MOH and Peru in general.
Coverage with Quality	CwQ gave a boost to the quality improvement in family planning and reproductive health in healthcare facilities through numerous courses and materials that reached over four thousand people. It supported the creation of quality units in many facilities and promoted the accreditation of healthcare facilities. This support fed into the activities that USAID carried out through other major projects referred to in Section IV.A (Chart IV.A.1) such as Health Policy Initiatives and Quality. CwQ also provided key support to the "waiting houses" (*casas de espera*) for pregnant women from rural areas that is an important part of the current MOH reproductive health strategy to reduce maternal/perinatal mortality (over 300 currently active according to MOH records). CwQ technical support and training improved commitment to quality family planning/reproductive health services and raised the self-esteem of personnel some of whom are still carrying on. CwQ also left advocates for improvement of service quality and improvement of the work place environment. CwQ also made important contributions to the transition for the MOH's assumption of the responsibility for contraceptive procurement and logistics. The equipment and supplies donated by CwQ are still operational and improved the clinical care response capacity and the donated computers and two-way radios to connect with rural health centers are still in use. The dissemination of educational materials for clinical and administrative use also contributed to improved services.
Populations at High Risk	PAR supported the development of the Healthy Schools and Healthy Communities initiative which continues to be applied through USAID/HMC The only other PAR legacy that the team was able to detect was a desire on the part of the MOH to have available more discretionary resources that could be used to support otherwise unfunded activities in the MOH work plans.

DECENTRALIZATION

The decentralization process, which calls for municipal management of primary care and for universal health insurance, will be the force driving MOH reform in coming years. The lesson for USAID is to continue to emphasize involving smaller government units in monitoring project execution and spending so that it becomes more likely that resources are spent wisely and program outcomes sustained. Empowering local communities should also contribute to local buy-in to health programs. This means concentrating on regions whose principal needs are improving the operational capacities of the DIRESAs and their subunits (networks and micro-networks). Macro policies must be informed by operational realities, capabilities, and needs. The regions were insistent that they do not want projects prepackaged at the center, with fixed objectives and standard inputs and indicators. As decentralization proceeds, they are demanding flexibility so that projects respond better to local needs.

CIVIL SOCIETY

The potential for civil society to contribute is generally underappreciated, so civil society is underutilized. Regional health councils (RHC) in some regions are consultative only; they have no real role in monitoring activities or performance against budget. However, HPI and HS20/20 have been working on change this. For example, the RHCs in San Martin and Apurimac are responsible for implementing universal health insurance.

TRAINING

Many professional pre-service training programs do not train their students for the first level of care, though that is where graduates tend to be placed. HPI has developed competency-based profiles for health units and works to have universities (e.g., San Antonio University in Cusco) incorporate into the pre-service curriculum competency-based training that is closely aligned with MOH profiles.

An overriding lesson is that training should be conducted within a functioning civil service system and should contribute to a competency-based career path. This lesson was reiterated by central and regional staff and is apparently being taken seriously by the Congress, the MOH, and some universities. Training that does not do so is less likely to lead to sustained institutional strengthening and capabilities and is an inefficient use of resources.

There is an important role for demand-driven activities and programs, such as accreditation and incentives to make competency-based pre-service and in-service training the norm. There was some evidence that professional training that responded to perceived interests and needs does increase institutional competency, as exemplified by the Field Epidemiology Support Program (FESP) training courses. FESP graduates were easily identified by their peers, and most had apparently stayed in epidemiology-related positions, some with international organizations. As universities adopt this norm, there will be new opportunities for USAID to support activities along the lines of FESP, which is being reinstituted by local universities with assistance from the Navy Medical Research Center (NAMRID) in Lima.

COMPENSATION

Inequities in salaries, living conditions, and opportunities contribute to the high rate of local staff turnover, and not enough attention is paid to staff satisfaction and motivation at all levels, including the community networks. Salaries are very low, and there is virtually no recognition for a job well done. No one says “thank you.”

MONITORING AND EVALUATION

M&E are vital to ensuring that projects remain on track to achieve their objectives. PAR and CwQ seemed to be extraordinarily weak in this area. That is one reason that relatively little impact can be attributed to them, considering that they functioned in a context where other projects and activities were operating.

GAPS

The assessment team identified the following major gaps relating to program design:

- Although all three projects seem to have supported the drive to improve quality in health services, and committed individuals are still working in the regions, it is impossible to quantify the effect of the projects because M&E was inadequate.
- The design of VIGIA, PAR, and CwQ did not incorporate external evaluation, and there were no baselines.
- Systematizing project results and materials, as was done by VIGIA, is important so that the MOH can appropriate findings and results and institutionalize project processes.

Administrative and finance personnel were not fully committed to project success; they must be involved from the beginning in project planning, development of work plans, and design of administrative and financial processes. Similarly, staffs from regional governments, DIRESAs, and municipalities were not included in local planning and operations.

III. CONCLUSIONS

MOH NEEDS

The following are among MOH needs in terms of TA, capacity-building, structural configuration, etc., to implement and manage programs more effectively:

- TA to push decentralization down to districts and municipalities
- More regional and municipal capacity to carry out or support first-level services, with links to local universities
- TA to define and formalize first-level services with norms
- Harmonization of pre-service training curricula with MOH needs, and additional training modalities (e.g., distance learning)
- Incentives for public administrators to enter health management under a comprehensive human resources development (HRD) plan
- Better understanding of performance-based budgeting (PPR)
- More participation in the National Public Investment System (SNIP).

FUNDING

Direct funding to the MOH would not be the most effective way to implement projects. However, all project activities should have clear and detailed guidelines for the MOH role and involvement (including regional and local) in specifying goals, work plans, and M&E.

WORKING EFFECTIVELY WITH THE MOH

There are ways USAID can work more effectively with the MOH to make it more likely that resources are spent wisely and program outcomes are sustained, such as:

- Better tracking of achievements by systematizing M&E for support projects.
- Support DIRESA managers to strengthen day-to-day administrative and management functions, emphasizing identification and elimination of bottlenecks.
- Place resident national advisers in the regions to work on improving regional and local management and administrative capacities. The regional advisers should also coordinate project TA to the region.
- Include DIRESA administrative and financial as well as technical staff in regional subproject planning and workplan development to ensure that subprojects function smoothly.
- Support problem-sharing and -solving networks and the transfer of lessons learned across regions through peer-to-peer communication (DIRESAs, DIRIMEDs, regional labs, etc.) via social networking and Web 2.0 technologies.

IV. LESSONS LEARNED, BEST PRACTICES, AND LEGACY

LESSONS LEARNED

The main organizational, managerial, and technical lessons learned from these three activities are that

- There is a role for MOH support projects if they are properly structured, with clear objectives, M&E and work plans, and specific goals.
- If central and regional administration and finance personnel are left out of project planning, they never fully understand the project or their role and participate grudgingly.
- USAID funds are more effective if not channeled through the MOH itself or even directly to the DIRESA. Bureaucratic delays and lack of responsiveness in Lima were seen as a principal cause of the poor project spending capacity.
- All regional directorates (DIRESAs), units of drug management (DIREMID), and reference laboratories need to communicate with each other as well as with Lima.

Lessons learned that can inform the design of future projects are that

- Decentralization, including municipal management of primary care and the universal health insurance scheme, will drive MOH reform and development in coming years.
- The principal need of the region is to improve the operational capacities of DIRESAs and their subunits (networks and micronetworks).
- Macro-level policies must be informed by operational realities, capabilities, and needs.
- The regions do not want projects that have been prepackaged at the central level, with fixed objectives and standardized inputs and indicators.
- Training should be conducted within a functioning civil service system and should contribute to a competency-based career path. Training that does not do so is less likely to lead to sustained institutional strengthening and capabilities and is an inefficient use of resources.
- Inequities in salaries, living conditions, and opportunities contribute to the high rate of local staff turnover, and not enough attention is paid to staff satisfaction and motivation at all levels, including the community networks. Salaries are very low, there is a dearth of other performance incentives, and there is virtually no recognition for a job well done.

The principal strengths of working directly with the MOH are that

- It builds up the MOH institutionally and reinforces its commitment to interventions and methodologies introduced by other TA projects, so that it can draft work plans, carry out activities, and deliver services to a large number of people as a complement to other projects.
- It is probably more cost-effective in terms of activities and service delivery than paying contractor rates and overhead, though this is difficult to quantify.

The principal weaknesses of working with the MOH are that

- The MOH finds it difficult to adapt to USAID requirements.
- Current regulations limit MOH ability to execute funds and make efficient execution of project activity budgets dependent upon vertical mechanisms.

- So far MOH M&E has been distinctly limited.
- There are geographical and cultural impediments to addressing equity and exclusion issues.

The advantages of USAID providing funds for the MOH to implement health programs are that

- It is very popular with the MOH and promotes a feeling of true partnership better than running everything through other partners, which leaves the MOH with a feeling of estrangement.
- Procurement is simplified.
- Methodologies and best practices can be extended to cover a large number of people.
- It can bring about institutional strengthening if certain conditions are met.

The disadvantages are that

- Implementation and spending capacity are limited unless the funds are handled by a dedicated project unit.
- It can perpetuate MOH hegemony over the sector if not adequately balanced with considerations for true empowerment of and incorporation of local government and civil society.

BEST PRACTICES

The team identified the following best practices that these programs may have successfully used and that are being replicated by other donor projects or programs or by the GOP:

- Quality improvement, data analysis situation rooms, and quality committees in some hospitals
- Malaria and TB treatment regimens
- Malaria promoters
- Intrahospital infection control committees and rational use of medicines
- Rational antibiotic use surveys
- Waiting houses for pregnant women from outlying areas
- Intermittent dry rice irrigation for malaria control
- Curricular modification for integrating health topics into academic themes

All these best practices are still being used primarily because individuals were trained and there is still institutional support for them. Malaria and TB treatments have been mandated by ministerial decree, waiting houses are an official strategy of the national program to reduce maternal and perinatal mortality, and intermittent dry irrigation has been officially sanctioned by the regional presidency of Lambayeque. The value of and need for information-based decision making has been implanted in the MOH, and there are clear vestiges of use of and desire for improving service quality and healthcare workplaces, some of which are being supported by other USAID projects, such as HCM and Quality.

LEGACY

Table 5 spells out the major legacies of the three projects.

TABLE 5. LEGACIES OF THE THREE PROJECTS

Project	Legacy
VIGIA	VIGIA left a number of concrete products and legacies, the most important of which may have been the commitment to an evidence-based decision-making mindset, both in the development of clinical norms (for malaria, intrahospital infections, HAART, rational use of medicines) and the integration of epidemiological with other management information, e.g., Health Situation Assessment (ASIS). The extensive list of products (manuals, norms, educational and communications materials) that VIGIA contributed to is documented in its final report and a separate publication. The VIGIA-supported Field Epidemiology Specialization Program left a cadre of well-trained and respected personnel, most of whom are still in positions where they continue to contribute to health programming in Peru. Systems supported and disseminated by VIGIA, such as Health Intelligence Units and the INTERFASE system for collating and reporting information, also continue to contribute to the Peruvian health system. VIGIA also supported efforts to integrate health themes into school curricula. The testing, documentation, dissemination, and implementation of intermittent rice irrigation for malaria control, in which the private sector participated, clearly constitute a best practice that has continued post-VIGIA. Finally, in accordance with the epidemiological transition, VIGIA appropriately elevated the visibility of emerging and reemerging diseases within the MOH and Peru in general.
Coverage with Quality	CwQ gave a boost to improving the quality of FP and RH through numerous courses and materials that reached over 4,000 people. It supported the creation of quality units in many facilities and promoted accreditation of healthcare facilities. This fed into the activities of other major USAID projects (see Figure 1), such as Health Policy Initiatives and Quality. CwQ also provided support to the waiting houses for pregnant women from rural areas (over 300 are currently active, according to MOH records) that are an important part of the current MOH strategy to reduce maternal and perinatal mortality. CwQ technical support and training improved commitment to quality FP/RH services; raised the self-esteem of personnel, some of whom are still carrying on the work; and left advocates for improvement of service quality and of the work environment. CwQ also made important contributions to the transition as the MOH assumes responsibility for contraceptive procurement and logistics. The equipment and supplies donated by CwQ are still operational and improved clinical care response capacity, and computers and two-way radios donated to communicate with rural health centers are still in use. The dissemination of educational materials for clinical and administrative use also improved services.
Populations at High Risk	PAR supported the development of the Healthy Schools and Healthy Communities initiative that continues to be applied through USAID/HMC. The only other PAR legacy that the team was able to detect was a desire on the part of the MOH to have available more discretionary resources for supporting otherwise unfunded activities in MOH work plans.

V. RECOMMENDATIONS AND FUTURE DIRECTIONS

GENERAL

USAID is now in the process of selecting an implementing partner for the new HPR project, which will run from 2010 to 2015. HPR will specify indicators to orient its policy initiatives, activities, and approaches. A similar process will occur for a follow-on to the HCM project. The assessment team recommends that USAID consider the following activities as priorities for investment in the next two to four years and beyond:

a. Push decentralization down to districts and municipalities.

b. Define and formalize first-level services and link them to municipalities and human resource formation by local universities, with special attention to harmonizing pre-service curricula with MOH norms and needs. Some informants described relative disorder due to lack of norms to classify what constitutes a first-level unit in terms of staff, equipment, and complexity of services provided. The idea is to codify a description to eliminate confusion. In addition, try other training modalities (e.g. distance learning, both paper and Web-based).

c. Provide incentives for public administrators to be active in health management, master performance-based budgeting (PPR), and the National Public Investment System (SNIP).

PROJECT MANAGEMENT AND ADMINISTRATION

USAID should continue to fund projects that support the MOH in executing planned activities, on the following conditions:

a. Projects support overall USAID and MOH strategies.

b. They have clear objectives and an M&E plan based on defined indicators that are measured at set periods.

c. They are flexible enough to allow for regional subprojects in which administrative and finance personnel are involved from the planning stage on.

d. Financial management is efficient and transparent, whether internal or external to the MOH or the DIRESA, and managers are trained in USAID and GOP procedures, including recovery of sales tax, though DIRESAs would retain control of programming the use of these funds.

e. There is effective MOH and USAID management and oversight.

The Mission Office of Health could better track achievements by systematizing M&E for support projects. At least until such time as the Mission has dedicated M&E staff, it should explore a continuing relationship with an M&E TA provider.[7] One of the values of this approach is that it provides continuing external validation of projects and Mission M&E methods and results.

The OGCI is about to be upgraded to a general directorate and has focal points in many regions. The regional governments also have their own offices of international cooperation connected to the Peruvian International Cooperation Agency (APCI). The team recommends that USAID

[7] See Toffolon-Weiss, M., Bertrand, J., and Terrell, S. (1999), "The Results Framework—An Innovative Tool for Program Planning and Evaluation," *Evaluation Review*, 23 (No.3): pp. 336–359 (http://erx.sagepub.com/cgi/content/abstract/23/3/336).

consider working with these groups to grow their capacity to prepare proposals and assume decentralized project M&E and reporting functions.

DECENTRALIZATION

The push toward decentralization will continue unabated, possibly at an accelerated pace, for the foreseeable future. The question is how best to support it so as to increase coverage with quality services and programs. The team recommends that

- USAID consider support to DIRESA managers to strengthen their capacity to handle day-to-day administrative and management functions, emphasizing identification and elimination of bottlenecks.
- Place resident national advisers in the regions for future USAID/Peru support projects. These advisers should work on improving regional and local management and administrative capacities and processes, including training the *jefes de redes* in basic management functions. The advisers should also coordinate project TA to the region, though not necessarily give TA themselves.
- While USAID/Peru projects still have an overarching general framework throughout the planning, design, and workplan development process, the team recommends that USAID recognize the need for flexibility so that subproject plans and budgets can be designed at the regional level. The team also recommends that DIRESA administrative and financial as well as technical staff be part of subproject planning and workplan development to ensure that regional subprojects function smoothly.
- Support cross-regional problem-sharing and -solving networks and the transfer of lessons learned through horizontal peer-to-peer communication (DIRESAs, DIRIMEDs, regional labs, etc.) via social networking and Web 2.0 technologies.[8]
- Expand and systematize efforts to increase the involvement of local governments and educational and other institutions. The role of the multisector RHCs should be upgraded from a consultative status to include monitoring and oversight of the execution of planned activities and budgets.

PERSONNEL AND HUMAN RESOURCE DEVELOPMENT

- The human resource issue should be dealt with comprehensively after review of regional salary equity and incentive systems, both monetary and nonmonetary. Complementary efforts of different USAID implementers could be coordinated through a strategic HRD plan.
- Health manpower training, pre-service and in-service, also merits a comprehensive approach that takes into account the high rate of turnover of professionals at the primary level. Alternative training methods could be explored, including incorporation of MOH norms into pre-service professional training programs and more on-site mentoring (especially for clinical services) rather than several-day workshops. Local institutions should continue to offer diploma-level certification for MOH technical areas. Independent distance learning could be expanded, such as current web-based efforts for professionals who have Internet access, and paper-based self-learning for paraprofessionals in the community. The team also recommends that USAID work with the MOH and DIRESAs to see that training at all levels is integrated with supportive follow-up supervision and incentives for successfully completing training and applying it. Strategies are needed for coping with the frequent rotation of personnel.

[8] See http://en.wikipedia.org/wiki/Web_2.0, and Laboratorios Regionales del Peru on www.facebook.com..

Innovative ways to make training more demand-driven (market surveys of health personnel and scholarships to personnel) should continue.

HEALTH TECHNOLOGIES AND SERVICES

- USAID should work with the MOH to explore alternative delivery systems for extending coverage, with the public sector taking a stewardship/supervisory role in addition to maintaining and where feasible even expanding its own services. One alternative to extend coverage and improve equity is the Guatemalan SIAS model of the MOH doing performance-based contracting with NGOs to extend services to populations excluded by culture or geography according to MOH standards and guidelines.[9]
- Support current community-based initiatives for healthy communities, schools, and families through TA.
- Fund TA to help regional governments balance program priorities in their planning and results-based budgetary processes in terms of health concerns within the region. The national priorities of reducing maternal and perinatal mortality and chronic malnutrition are appropriate. However, if they are pursued overzealously, other critical health issues, such as TB, may be neglected. Also, it is important to ensure that, as vertical programs, they do not undermine integrated MCH health care, which would be self-defeating in terms of achieving the intended reductions in mortality and malnutrition.
- USAID makes a unique contribution in making available and improving the quality of FP and RH—assistance that health workers and beneficiaries value highly. The team recommends that the Mission continue working with the MOH, UNICEF, and other partners to document and disseminate lessons learned from the various implementations of the waiting houses model as one alternative for increasing access to RH services.

FUTURE DIRECTIONS

Initiatives, activities, and approaches that warrant continued or additional USAID investment in the future include:

- Communication strategies for behavior change
- Closer links with training organizations, using the FESP experience as a model for developing technical careers or specializations rather than depending on standalone training events
- Drafting of plans for identifying equipment needs, procurement, and maintenance
- Assurance that funds are fully available to complete activities and acquisitions to avoid partial purchases that leave equipment and services incomplete.

Priorities for future investment by USAID in terms of TA and activities for the medium term (2–4 years) might be to

- Draw up a master HRD and support plan that can be a cross-cutting theme for all projects. Assist in review of human resource issues and plans for dealing with it comprehensively to ensure equity between regions in salaries and all types of incentives. Complementary efforts by different USAID implementers could be coordinated through a strategic HRD plan.

[9] Organization for Economic Co-operation and Development (2009), *Performance-Based Contracting for Health Services in Fragile States, Lessons Learned from Cambodia, Guatemala, Liberia* (Paris: OECD).

- Facilitate the move toward decentralization by further empowering districts and municipalities. Decentralization will continue for the foreseeable future. Provide TA to increase the coverage of quality services and programs.
- Define and formalize first-level services and link to municipalities and human resource formation by local universities; work on harmonizing pre-service curriculum with MOH needs. Test other training modalities (e.g., distance and Web-based learning) within a master HRD plan.
- Offer TA on incentives for public administrators to be active in health management, PPR, and SNIP.
- Support TA to develop approaches for manpower training, both pre-service and in-service, that take into account the high rate of turnover at the primary level, and to build on the recommendations related to personnel and HRD.
- Expand on the recommendations under Health Technologies and Services to further extend coverage to excluded populations..
- Continue to provide TA to regional governments to help them more adequately balance national and local program priorities.
- Consider more TA to control infectious diseases:
  - Reinforce work being done with intrahospital infections.
  - Reinforce work being done on TB, especially when it co-occurs with HIV.
  - Give more attention to leptospirosis.

For the longer term (5–10) years, the following are recommended as priorities:

- Continuous quality improvement, with certification of professionals and accreditation of institutions
- Expansion of coverage to excluded populations
- Universal health insurance that allows for a choice of providers as a quality determinant.

APPENDIX A: SCOPE OF WORK

SCOPE OF WORK

Final Assessment of Three USAID/Peru Health Projects

Implemented through the Ministry of Health:

VIGIA, Coverage with Quality, and Populations at High Risk

(Revised: 08-06-09)

I. INTRODUCTION: PROJECTS TO BE ASSESSED BH]

For more than a decade USAID/Peru's Health Program implemented a significant part of its work by directly funding activities through the Ministry of Health (MOH), under three separate bilateral agreements: Addressing the Threats of Emerging and Re-emerging Infectious Diseases (*VIGIA*), Coverage with Quality (CwQ) – *Cobertura con Calidad*, and Populations at High Risk – *Poblaciones en Alto Riesgo* (PAR). A snapshot of the activities is shown in the table below.

Activity to be Evaluated					
Name	Focus	Life of Activity	Life of Funding	Geographic Area	Period to be Evaluated
Addressing Emerging and Re-emerging Infectious Diseases – VIGIA: Activity No. 527-0391	Infectious Diseases	September 1998–June 2008	USAID: $18.8 million (M) GOP: $13 M	Nationwide	FY 1998–FY 2008, with emphasis on the last five years (FY03–FY08)
Coverage with Quality (CwQ): Activity No. LSGA: 527-0375	Reproductive, Maternal and Infant Health and Family Planning	September 1996–December 2007	USAID: $6.35 M GOP: $3.5 M	1996–2002: Nationwide 2002–2007: 7 regions, Piura (Border), and Huancavelica, at the request of MOH.	FY 1997–FY 2007
Improved Health for High Risk Populations (PAR): Activity No. 527-0412	Health Promotion and Communications	September 2003–September 2007	USAID: $5 M GOP: $ 1.7 M	7 regions	FY 2003–FY 2007

USAID/Peru will engage an external contractor (GH Tech) to conduct an assessment of all three activities. This assessment will address the lessons learned and best practices for each of the three activities. In addition, the assessment will review the management approach and administration of the activities, and specifically identify strengths and weaknesses in project management within the MOH. This information will be useful for the MOH, which is reorganizing as it adapts to its stewardship role under decentralization; and it will also provide important feedback for USAID/Peru as it continues to design and implement activities that support the MOH.

Note that background material on each of the three projects is found in Annexes 1-4.

II. PURPOSE OF THE EVALUATION

This purpose of the assessment is to summarize the major achievements and lessons learned of three health projects implemented by the MOH with direct funding from USAID (VIGIA, CwQ and PAR). The assessment will also address program management and will inform USAID how it can best engage and work with the MOH in the future to implement large-scale quality health programs in Peru.

The assessment will:

- Review and summarize project results and identify best practices and lessons learned. The assessment will provide an opportunity to document how programmatic and technical interventions were implemented and managed by the MOH within the context of health reform and decentralization and political change. The assessment will examine how the programs evolved over time and how changes in policies and program priorities affected service delivery and programmatic outcomes at the regional and local levels. Remaining gaps in technical assistance will be identified that should be considered as priorities by USAID going forward.
- Describe lessons learned regarding project management and make recommendations on how to improve administration of these types of projects in the future. Additionally, information on lessons learned and best practices will be used by USAID for managing support to the MOH now and in the future.

It is anticipated that this assessment will provide information that will contribute to the design and implementation of subsequent activities by USAID/Peru, the Peruvian MOH (including regional health offices) and other public and private entities. The evaluation will also contribute to USAID's development experience database.

III. SCOPE OF WORK

The assessment will cover the entire life of each project as described in the table above. Although the MOH directly implemented the three activities, different approaches to management were used. Thus, identifying lessons learned and best practices while comparing the different approaches and their results is required. The assessment will be carried out in a collaborative manner with MOH staff.

A. General Questions to be Answered for Each Project

Results and Legacy

1. To what extent did the activity meet its stated objectives? Discuss the clarity of the project objectives and the quality of the monitoring and evaluation system.
2. What were the key factors that favored or impeded the achievement of objectives?
3. What were the main unanticipated results (both positive and negative) of the activity?
4. To what extent did the activity achieve behavior change, improved health outcomes, increased utilization of health services and improved community capacity to promote health?
5. What were the best practices resulting from the activity? Discuss any technical breakthroughs (such as innovations in service delivery, new or improved methodologies, etc.) and/or changes in operations, policies, and procedures (such as the organization of health services, etc.) that helped to achieve desired results.

6. Describe and discuss how health reform and decentralization affected implementation and management of this activity.

7. To what extent were MOH managers and providers at all levels (national, regional and local) satisfied with the activity in terms of technical quality, capacity building, opportunities for professional development, etc.? To what extent were the needs of clients addressed in terms of increased access, quality and uptake of services, better health outcomes, etc.?

8. What were the most important contributions of the activity to public health in Peru? In what ways did the activity enhance the perception of US Foreign Assistance for Peruvians?

9. What are the main lessons learned (technical, managerial, and organizational) resulting from this activity?

10. What is the legacy of this activity, in terms of sustained technical approaches, organization of health services, capacity of managers and providers, policies, etc.?

Management

1. Considering the components of health systems (information systems, quality of care, human resources and staffing, managerial and administrative capacity, logistics of commodities and supplies, governance and financial oversight) what were the main strengths of the MOH in regard to implementing and managing this activity? What were its main weaknesses?

2. To what extent did the implementation of this activity strengthen the MOH's institutional, managerial, and technical capacity? What are the remaining gaps? What can USAID do to improve the capacity of the MOH to implement and manage future activities?

3. Describe USAID's approach to supporting and working with the MOH to implement the activity. To what extent was USAID appropriately responsive to the Ministry's approach to programmatic management and oversight? If a similar activity is designed in the future, what approaches and practices should USAID continue to do, and what should be done differently in the future?

B. Cross-cutting Questions Considering All Three Projects Collectively

Lessons Learned and Legacy

1. What are the overall lessons learned (organizational, managerial, and technical aspects) resulting from these three activities?

2. What are the main lessons learned from the three programs that can inform the design of future projects? Discuss any major gaps relating to program design (including M&E) that need to be addressed in future projects.

3. What is the overall legacy of these three activities in terms of sustained technical approaches, organization of health services, capacity of managers and providers, policies, etc.?

4. What best practices from these programs have been successfully used or replicated by other donor projects or programs or by the Government of Peru? Which ones are still being used and what are the factors that help sustain the practices?

Lessons Learned to Date in Working with the MOH

Considering what is known from the experience of the three activities as well from more recent information:

1. What are the main strengths and weaknesses of the MOH in regard to implementing and managing health programs? Consider all components of the health systems (information

systems, quality of care, human resources and staffing, managerial and administrative capacity, logistics of commodities and supplies, governance and financial oversight).

2. What are the advantages and disadvantages of USAID providing direct transfer of funds to the MOH to implement health programs?

3. What does the MOH need in terms of technical assistance, capacity building, structural configuration, etc. to implement and manage programs more effectively in the future?

4. What are the most effective ways for USAID to engage and work with the MOH to implement health programs? How can USAID work most effectively with the MOH to make it more likely that resources are spent wisely and program outcomes are sustained? What are the recommendations for engaging and working with the MOH to implement high-quality, large-scale health programs?

Future Directions

1. What are the key initiatives, activities, and approaches that warrant continued or additional USAID investment in the future? What should be the priorities for future investments by USAID in terms of technical assistance and activities? Recommendations should be prioritized for the medium (2–4 years) and longer (5–10 years) terms.

2. What are other potentially sustainable service delivery models or approaches not currently addressed by USAID that should be considered for future investment?

C. Project-specific Questions to be Answered for the Activity Indicated

Note: Descriptions of the three activities are found in the annexes.

Addressing Emerging and Re-Emerging Infectious Diseases (VIGIA)

1. What were the most successful technical interventions? What key factors were involved in VIGIA's successes?

Coverage with Quality (Cobertura con Calidad or CwQ)

1. Describe the history of this project in each of its phases, including the impact that MOH policies, decisions, and management approach had on the program and the changes made to the program initiated by USAID in response to programmatic implementation. Include contextual information on contraceptives and assistance during the transition from FP to RH and from vertical strategies to integrated strategies.

2. How did the changes initiated by USAID impact the program, both technically and in how the MOH managed the activity? What were the positive outcomes of USAID-initiated changes and negotiations? What were the challenges? In what ways could USAID have engaged the MOH more effectively?

High Risk Populations (Poblaciones en Alto Riesgo, PAR)

1. How did PAR improve central, regional, and local institutional capability to develop health promotion activities?

2. To what extent was PAR helpful in designing methodologies, strategies, and procedures required for the development of health promotion projects at the regional and local levels?

3. To what extent was PAR successful in developing strategies for advocacy and lobbying for health promotion projects at the regional and local levels?

4. To what extent did PAR help the MOH train regional and local health personnel to develop health promotion projects?

5. To what extent was PAR useful in testing different health promotion methodologies and strategies at the regional and local levels?

6. To what extent did PAR contribute to establishing a set of indicators for health promotion activities at the regional and local levels?

7. To what extent was PAR able to demonstrate results and improved health outcomes?

D. Methodology

To the extent practical, the assessment shall be designed and planned to capture a wide range of perspectives. To the extent possible, the assessment shall be developed and carried out with the participation of members from the MOH teams for the three activities and their partners in the DIRESAs (regional directorates), USAID staff, and other persons or institutions with important involvement in the activities' implementation.

The assessment should include a review of key activity documents (including bilateral agreements, work plans, thematic reports, and annual reports), structured or semistructured interviews with stakeholders and beneficiaries, as well as the utilization of sources of secondary information (e.g. health statistics, health programs information).

To the extent possible, data collection should be systematic and findings and conclusions should be evidenced-based.

Team Planning Meeting

The full team will have a two-day team planning meeting upon arrival in Peru. The team planning meeting is an essential step in organizing the team's efforts. During this meeting, the team will meet with USAID/Peru to review the SOW and discuss expectations and deliverables, determine roles and responsibilities of all team members, and agree on a timeline for the evaluation effort. In addition, the following will be accomplished:

- clarification of any logistical and administrative procedures for the assignment,
- agreement on elements of the draft workplan,
- establishment of a team atmosphere, through sharing of individual working styles and agreement on procedures for resolving differences of opinion,
- development of a preliminary draft outline of the team's report, and
- assignments made regarding drafting responsibilities for the final report.

Within three days following the team planning meeting, the team will develop and submit to USAID/Peru a draft workplan that will include the following elements:

- description of each team member's roles and responsibilities,
- list of the final assessment questions/guidelines for questionnaires,
- approach to data collection, methodologies to be used , and how data will be analyzed,
- data collection instruments,
- draft outline of final report, and
- assignment timeline.

The assessment will involve *field visits* to several sites outside of Lima. It is anticipated that the following sites will be visited for all three projects: Ucayali, San Martin, and Huánuco. Iquitos will be visited for VIGIA and Ayacucho for CwQ. The final list will be agreed upon by representatives of the Office of Health (OH) at USAID/Peru, the MOH, and the DIRESAs.

For the purposes of the assessment, USAID/Peru and/or MOH staff will provide the assessment team with the following resources:

- All pertinent documentation will be made available to the evaluation team in hard copies and/or electronic versions. This will include the Project Design paper, the corresponding Bilateral Agreement with attachments and their amendments, work plans, reports, selected studies, evaluation reports, and other key documents. A preliminary list of background documents is found in Annex 4.

- A primary list of stakeholders or contacts will be provided, indicating who are considered essential for interviewing purposes. The evaluation team may expand or modify the list as deemed necessary and reasonable (taking into consideration information needs, time, and costs involved, etc.).
  The following is an illustrative list of those to be interviewed by the team:

- Relevant USAID staff

- Central Government Officials (MOH, DGSP, DGPM, DIGEMID, INS, etc.)

- Regional Health Offices

- Regional and local government authorities

- Civil society organizations

- Representative number of health facilities staff

- Other donors providing assistance to the MOH (UNICEF, UNFPA, World Bank)

- Representative number of beneficiaries (e.g., patients, community leaders, citizens)

- A list of sites where the three activities worked, including information about specific activities that took place at each site, when they started and finished, and contact information for the site and/or activity that will allow the team to gather further information on the activity and its results.

IV. DELIVERABLES

A. Work Plan

The Assessment Team will submit within three days of the team planning meeting a draft workplan to USAID/Peru for approval. Any major changes to the workplan proposed by the Assessment Team will be discussed with USAID and require approval by USAID prior to implementation.

B. Draft Report

The Assessment Team will submit to the Chief of the Office of Health in USAID/Peru three copies of its draft report in English and one copy of its preliminary report in Spanish. This report shall include findings and recommendations and will be presented at a debriefing meeting at the USAID/Peru Mission. The draft report will be submitted prior to departure of the Team Leader from Peru at the end of the in-country work.

Participants in the debriefing will be OH staff and key persons or institutions directly involved in the implementation of the three activities evaluated. Attendees will have one week to provide comments and suggestions to the Evaluation Team.

Note: USAID is looking for one consolidated report containing findings/recommendations on the three projects.

C. Final Report

The Assessment Team, via GH Tech, shall deliver (within approximately 30 days of USAID approval of the draft report) five printed copies of the final report in English and three in Spanish. The documents will also be submitted in Microsoft Word and pdf formats electronically. The main body of the report shall not exceed 80 pages in length following the format below:

- An Executive Summary (3-5 pages) containing a clear, concise summary of the most critical elements of the report, including the recommendations
- A Table of Contents
- The body of the report (no more than 80 pages), which discusses the major findings and the related issues and questions raised in Section III. In discussing these findings, for each activity, the assessment shall also address the following:
  - Purpose of assessment
  - Team composition
  - Methodology
  - Findings based on evidence
  - Conclusions drawn from the findings
  - Recommendations based on the assessment's findings and conclusions, presented with sufficient detail for USAID, the MOH, and other involved parties to take action.

The Final Report will also include appendices that will include:

- A copy of the assessment scope of work
- A list of documents consulted
- List of individuals and agencies contacted
- Data collection instruments
- More detailed discussions of methodological or technical issues as appropriate
- A PowerPoint presentation on the results of the assessment.

The body of the report should be no more than 80 pages total, not including the annexes. If necessary, supporting data may be included in appendices, the length of which should be discussed and approved by the COTR.

GH Tech will be responsible for editing and formatting the final English version (which takes approximately 30 days after unedited content is approved by USAID) and for arranging for the final Spanish version to be translated from English into Spanish in Peru (after the final edited English version is approved by USAID.) The contractor will make its assessment report available through the Development Experience Clearinghouse unless there is a compelling reason to keep

the report internal (such as procurement-sensitive information). GH Tech will prepare a separate Internal USAID Memo that includes Future Directions and any recommendations that are procurement-sensitive information so that the main report can be released as a public document.

V. PERSONNEL AND LEVEL OF EFFORT

The team will consist of approximately six persons: one expatriate Team Leader, one Deputy Team Leader, one logistical support person, and three Peruvian nationals—one each to take the lead on the three projects being evaluated. All team members will participate in the team planning meeting, preparation of the work plan, and the evaluation activities, including preparing the required reports. The expected profiles for the team are provided below.

Team Leader should be an expatriate consultant, a professional in public health or social sciences and native English-level speaker. Professional experience in Peru is strongly desirable. He/she must be fluent in Spanish (Level IV) and have excellent writing, facilitation, and presentation skills. Former experience working with USAID and in providing technical assistance relating to health reform to developing countries undergoing decentralization is highly desirable. The team leader will be responsible for final editing for the English version of the report.

Deputy Team Leader should be from Peru or the nearby region, a fluent Spanish and English speaker (Level IV), and a public health professional highly skilled and experienced in evaluating health programs in the region.

Logistical Team Support:

A local team coordinator will be hired to help schedule visits and interviews and help with logistics within Peru.

Team Composition:

Each of the evaluation team members should be professionals in public health (master's degree or higher) with at least five years experience in the evaluation of health and/or social projects and expertise in qualitative research methods and analysis. The following skills are key to the evaluation: capabilities in the evaluation of IEC and behavior change interventions, health systems and reform, infectious diseases, and reproductive health/family planning. Direct experience with implementing public health programs and/or providing technical assistance to national programs undergoing health reform and decentralization is highly desirable.

All team members will have the ability to interact with people from many different levels and backgrounds. They also should possess excellent writing and presentation skills. The team will have combined skills and experience in rapid appraisal methodologies (interviews, focus groups, mini-surveys, etc.), gender analysis, institutional analysis, capacity development, decentralization of health services, implementation and monitoring, and strong knowledge of Peru's health public sector functioning and Peruvian political context. Understanding of USAID development assistance policy is highly desired. In addition, the team should have a gender balance and combined experience in the evaluated related areas, including maternal and child health, infectious diseases, and family planning and reproductive rights. All team members must be willing and able to travel to remote zones.

The Team Leader and Deputy Team Leader must speak and write in English fluently (Level IV). All of the evaluators should be fluent in Spanish and be excellent writers in Spanish. Skills in English language and writing are highly desired. Given the type of work to be undertaken, all consultants must be able to work in a team effectively, be skilled in the utilization of Microsoft Office computer programs, and have consistent access to e-mail.

USAID/Peru anticipates that the period of performance of this assessment will be approximately 62 days with 50 days of in-country work to begin on or about September 1, 2009 (the actual start date will depend on consultant availability). The following is a sample timeline and illustrative LOE table.

Proposed Level of Effort: Total LOE proposed is 218 person-days distributed as follows:

Task/Deliverable	Time Elapse (in days)	LOE						
		Team Leader	Dep. Team Lead	Team Support	VIGIA	CwC	PAR	Total LOE (days)
1. Travel to/from DC	2	2	0	0	0	0	0	2
2. Background Reading	3	4	4	0	3	3	3	17
3. Team Planning Meeting/Draft Workplan/Draft Data Collection Instruments/Scheduling of Interviews	5	5	5	5	5	5	5	30
4. Initial Data Collection (includes continued document review and finalization of data collection instruments, interviews with key informants in Lima prior to field work, travel to first field site)	6	6	6	6	6	6	6	36
5. Field Visits (travel, interviews, data gathering)	12	12	12	6	12	12	9	63
6. Post-field Work in Lima (additional key informant interviews, compiling data, team work in drafting findings, conclusions and recommendations)	6	6	6	3	3	3	3	24
7. Draft Evaluation eRport and preparation for debrief	9	9	7	1	3	3	3	26
8. Debrief with USAID/Peru and debrief with MOH and stakeholders (2 meetings on different days)	2	1	1	0	1	1	1	5
9. USAID/Peru provide comments on draft report	10	0	0	0	0	0	0	0
10. TL and DTL prepare final evaluation report in collaboration with rest of team	7	7	5	0	1	1	1	15
Total # days	**62**	**52**	**46**	**21**	**34**	**34**	**31**	**218**

*A six-day work week is approved when the team is working in-country.

VI. BUDGET – PROVIDED IN A SEPARATE COST ESTIMATE

TBD

VII. PERIOD OF PERFORMANCE

Activities, including the approval of the final report, are expected to begin on/about September 1, 2009, and end on/about December 31, 2009.

VIII. LOGISTICS

This review will be carried out by the GH Tech Project. The contractor will provide all logistical arrangements, such as flight reservations, country cable clearance, in-country travel, airport pick-up, and lodging for the GH Tech team, as necessary. GH Tech will also be responsible for arranging for office supplies, equipment, computers, copiers, printers, etc. Vehicle rentals, plane and visa reservations, and translation services are the responsibility of the contractor

The Mission will be responsible for helping to arrange site visits and meetings, as appropriate.

IX. CONTACTS

The contacts at USAID/Peru include the Chief and/or Deputy Chief of the Office of Health, respectively:

Erik Janowsky (ejanowsky@usaid.gov; 51-1-618-1260 or 51-1-998-093-475) and/or

Sarah Blanding (sblanding@usaid.gov; 51-1-618-1261 or 51-1-998-091-816).

Additional primary contact persons include the following technical staff in the Peru Mission Office of Health (to be included on communications):

Dr. Jaime Chang (jachang@usaid.gov; 51-1-618-1266) and

Dr. Luis Seminario (lseminario@usaid.gov; 51-1-618-1268).

APPENDIX B: LIST OF DOCUMENTS CONSULTED

VIGIA

- Project Design Paper, USAID.
- Bilateral Agreement for Activity 527-0391, plus annexes and amendments.
- Project Implementation Letters by which any significant changes in the agreement or its annexes were modified.
- Annual Project work plans and reports.
- Azpur y cols. (2006), La descentralización en el Perú. Lima: CIES.
- Bardalez del Aguila, Carlos (2006), La Descentralización en Salud en el Perú. Lima: PRAES.
- Castro, J. y cols (2008), Sistematización del Proyecto Vigía. Lima: MINSA. Tomo 1: Modelo de Gestión.
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- Jaramillo, M. y Parodi, S (2004), El Seguro Escolar Gratuito y el Seguro Materno Infantil. Lima: Grade, documento de trabajo Nro. 46.
- Lora, Victor, y Solis, Adela (1999), Hacia la Administración Estratégica de la Cooperación Internacional en Salud. Lima: Ministerio de Salud.
- Mendoza-Arana, Pedro (2003), "Potential of Private Practitioners to Deliver Public Health Services in Peru," in *The New Public/Private Mix in Health: Exploring the Changing Landscape.* Geneva: Alliance for Health Policy and Systems Research.
- Ministerio de Salud del Perú (1996), "Análisis de la Situación de Salud (ASIS 95)." Lima: Ministerio de Salud, Programa de Fortalecimiento de Servicios de Salud.
- Neyra, Daniel, Cabezas, César, y K. Ruebush II, Trenton (2003), "El proceso de adecuación y cambio en la política del tratamiento de la malaria por Plasmodium falciparum en el Perú, 1990–2001." *Rev. perú. med. exp. salud publica.* [online]. jul./set. 2003, vol.20, no.3 [citado 31 Octubre 2009], p.162-171. Disponible en la World Wide Web: <http://www.scielo.org.pe/scielo.php?script=sci_arttext&pid=S1726-46342003000300010&lng=es&nrm=iso>. ISSN 1726-4634.
- http://www.usaid.gov/pubs/cp97/countries/pe.htm.
- http://www.saludarequipa.gob.pe/epidemiologia/enlac/asis.htm (Consultada el 29 de Octubre de 2009)

COBERTURA CON CALIDAD (CWQ)

- Proyecto Cobertura con Calidad. 1996. Convenio de Donación de Alcance Limitado N° 527-0375. Lima: Estados Unidos de América a través de USAID y El Gobierno del Perú.
- Cartas de Ejecución. Convenio de Donación de Alcance Limitado N° 527-0375 - Proyecto Cobertura con Calidad. Ministerio de Salud-USAID. Lima, 1996–2007.
- Enmiendas. Convenio de Donación de Alcance Limitado N° 527-0375 - Proyecto Cobertura con Calidad. Ministerio de Salud-USAID. Lima, 1997–2006.
- Cartas de Implementación. Convenio de Donación de Alcance Limitado N° 527-0375 - Proyecto Cobertura con Calidad. Ministerio de Salud-USAID. Lima, 1997–2007.
- Planes Operativos del Proyecto Cobertura con Calidad. Dirección General de Salud de las Personas. Ministerio de Salud. Lima,1997–2008.
- Informes de avances periódicos de actividades Cobertura con Calidad. Dirección General de Salud de las Personas. Ministerio de Salud. Lima,1997- 2008
- Auditoría Financiera de Cierre periodo 01de Enero al 31 de diciembre 2007 Ministerio de Salud/Proyecto Cobertura con Calidad" Convenio de Donación USAID N° 527-0375. Contraloría General de la República. Lima, 2008.
- Modelo Integral de Salud. Dirección General de Salud de las Personas. Ministerio de Salud. Lima, 2004.
- Norma Técnica de Planificación Familiar. Dirección General de Salud de las Personas. Ministerio de Salud. Lima, 2005.
- Evaluación de las Funciones Obstétricas y Neonatales. Dirección General de Salud de las Personas. Ministerio de Salud. Lima, 2005.
- Estrategia Sanitaria Nacional de Salud Sexual y Reproductiva. Dirección General de Salud de las Personas. Ministerio de Salud. Lima, 2006.
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- Casas de Espera Materna. Dirección General de Promoción de la Salud. Ministerio de Salud. Lima, 2006.
- Plan Estratégico Nacional para la Reducción de la Mortalidad Materna y Perinatal 2009–2015. Dirección General de Salud de las Personas. Ministerio de Salud. Lima, 2009.
- Para la Vida. UNICEF, OMS, UNESCO, UNPFA, PNUD, ONUSIDA, PMA y BM. Nueva York, USA, 2002.
- Niños y Madres Cuentan. Informe sobre la Salud en el Mundo. Organización Mundial de la Salud. Ginebra, 2005.
- Reducción de la Mortalidad Materna. OMS, UNICEF, UNPFA y BM. Ginebra, 2006.

- Objetivos de Desarrollo del Milenio. Organización de las Naciones Unidas. Nueva York, USA, 2007.
- Determinantes Sociales de la Salud. Organización Mundial de la Salud. Ginebra, 2008.
- Salud Materno-Neonatal. Estado Mundial de la infancia. UNICEF. Nueva York, USA, 2009.

POBLACIONES EN ALTO RIESGO (PAR)

- Auditoria Financiera a las actividades del Proyecto Una Mejor Salud para Poblaciones en Alto Riesgo períodos 2007 ejecutadas en el marco del Convenio de Donación N°527-0412 Financiado por USAID. Oficio N°5947-2008-DGPS/MINSA. Ministerio de Salud del Perú. Lima, 14 de agosto 2008.
- Convenio de Donación de Objetivo Estratégico entre la republica del Perú y el Gobierno de los Estados Unidos de América para Una Mejor Salud para Poblaciones en Alto Riesgo. 30 de Setiembre del 2003. Convenio de Donación de USAID N°527-0412.
- Convenio de Donación de Objetivo Estratégico entre la República del Perú y el Gobierno de los Estados Unidos de América para una Mejor Salud para Poblaciones en Alto Riesgo. Decreto Supremo N°047-2004-RE. Diario Oficial El Peruano, Normas Legales, viernes 20 de agosto del 2004.
- Encuesta Nacional de Demografía y Salud Familiar 2004-2006. Instituto Nacional de Estadística, INEI. Lima 2008.
- Enmienda 1 a 5 del Convenio de Donación de Objetivo Estratégico entre la Republica del Perú y el Gobierno de los Estados Unidos de América para Una Mejor Salud para Poblaciones en Alto Riesgo.
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APPENDIX C: LIST OF INDIVIDUALS AND AGENCIES CONTACTED

USAID/PERÚ

Name	Affiliation
Erik Janowsky	Chief, Office of Health
Sarah Blanding	Deputy Chief, Office of Health
Tracy Herscowitz	Office of Health
Jaime Chang	Office of Health
Luis Seminario	Office of Health
Miriam Choy	Office of Health
Nelly Rios	Office of Health
Carmela Sarmiento	Office of Health

USAID PROJECTS

Name	Affiliation
Midori de Habich Rospigliosi	Jefe de Proyecto Health Systems 20/20
Patricia Mostajo	Jefe de Proyecto Health Policy Initiatives
Luisa Hidalgo	Sub-Jefe de Proyecto Health Policy Initiatives
Edgar Medina	Jefe de Proyecto Healthy Communities
Luis Morales	Jefe de Proyecto Quality in Health

OTHERS

Name	Affiliation
Ramón Granados	OPS
Fernando González	OPS
Giovanni Escalante	OPS
Guardia, Nidia	PARSALUD
Mario Tavera	UNICEF

MINSA

Name	Affiliation
Melitón Arce	Vice Ministro de Salud
Martín Clendénes	Director General de Salud de las Personas
Mónica Matayoshi Díaz	Esp. Descentralización MINSA
Andrés Polo	Esp. Descentralización MINSA
Pedro Ypanaqué Luyo	Esp. Descentralización MINSA
Erika Jimenez	DGSP
Dr. Del Canto	Coord. Adulto Mayor

Rula Aylas	Coord. Lepra (E S N de TBC)
Gladys León	Cooperación Internacional
Aurelio Roel Enriquez	Cooperación Internacional
Marcos Calle Quispe	Dirección de Calidad en Salud MINSA
Ulalia Cárdenas	ESN SSyR
Marisol Campos	ESN SSyR
Lucy del Carpio	Coord ESN SSyR
Mónica del Pozo	OGA
Luis Miguel León	Dirección de Atención Integral
José Castro Ortíz	Oficina General de Cooperación Internacional
Esthela Cuzco	Oficina General de Cooperación Internacional
Yessy Catherine Ruiz	Oficina General de Cooperación Internacional
Gladys León	Oficina General de Cooperación Internacional
Manuel Luján	OGPP / Asesor
Betty Gaviria Jimenez	DGSP – DGS
Erika Jiménez Alegría	DGSP – DGS
Rosario Zavaleta Alvarez	DOS – DGSP

JUNÍN (HUANCAYO)

Name	Affiliation
Tania Cárdenas Jumpa	Coord. Calidad DIRESAS
Zenia Villar Viebrio	Coord. Salud Mental
Simeón Oriol Palacios	Director Oficina PLANE
Raúl Urdanecchi Basurto	A R Nutrición II
Luis Fernández Cuba	Dir. Economía
Zoila Franco Payano	Resp. PIES-PROMSA
Virginia Poma Oroya	Resp. Coop. Téc. Int.
Ayde M. Vila Matos	Directora Administración
Marco Bartulo Marchena	DESP. DIRESA
Walter Angulo	Ger. Des. Social
Julio Meza	Coop. Ext. Regional
Gladys Peñaloza Córdova	PROMSA-DIRESA Junin
Gloria Mercedes Molina Vallejos	DEMID – DIRESA Junín
José Enrique Severino Broncales	Hospital El Carmen-Dpto. Gestión Calidad
Jenny Reza Villavicencio	Coord. Salud Sex. y Reprod.
Alberto Vargas	Sub Dir. Hospital El Carmen
Josefina Córdova	EPI – Hosp. Carrión
Manuel Adrián	Hosp. Carrión OBS-GYN-DIR
Margarita Chaparro	Gestión Calidad
Roque Castro	Encarg. DIR. Hosp. Carrión
Omar Orellana Díaz	Jefe Lab. de Ref.

Norma Córdova Santivañez	Resp. Alerta Resp. Epid.
Marco Bartolo	Jefe Salud de las Personas
Zoila Franco Payano	Promoción de la Salud
Tania Cárdenas	Promoción de la Salud
Rosario Linares	Área Financiera
Luis Fernandez	Área Financiera
Wilfredo Loja Oropeza	Col. Virgen de Lourdes 30733, Huaricolca, Tarma
Flor del Rio	Coord. Adulto Mayor, Red Salud Tarma, Coord. TBC 2005–06 DIRESA
Rosario Sánchez Gálvez	Comunidades Saludables

SAN MARTÍN (TARAPOTO)

Name	Affiliation
Noelia Salvador Jimenez	Direct OTEPE DIRES
Mery del Castillo Navarro	Direct. Estad. e Informática
Miguel Gonzales Vega	Direct. Ofic. Epidemiología
Loyri Gissela Contreras Bardalez	Directora Atención Integral
Mari Grandez	Director Salud de las Personas
Aneliza Arévalo	Coord. Reg. Inmunizaciones
María A. del Aguila Lozado	Directora Promoción S.
Neptali Santillán Ruiz	Director DIRESA
Lleny Luz Barta Gómez	Directora Economía – Tarapoto
Clever Macedo Pizarro	Tec. Adm. Economía
Milcoo Vela Gonzales	Tec. Adm. Economía - Tarapoto
Rubén Chong Renfigo	Director Administrativo
Rocío Villacorta	Coord. ES Regional de SSYR
Herman Saldaña Ramírez	Jefe Unidad Control Patrimonial-DIRES/ S.M.
Renee Rengifo Cárdenas	Coord. Patrimonio Red S/M
Gilda Pineo Pezo	Coordinadora Area Niño
Maribel Chávez Flores	Coord. SSyR Moyobamba
Víctor Lazo Paredes	Gerente MRU II
Luis Mendoza	Jefe Sub Región Moyobamba
Raúl Arroyo Tirado	Director Hospital Regional
Del Castillo, Mery	DIRESA San Martín
Melgar Araujo, Raul	Laboratorio Referencial San Martin
Vela Orlando, Felipe Santiago	DIRESA San Martin
Paredes Cabel, Jose	DIRESA San Martin
Olaya Alarcon, Raul	DIRESA San Martin
Saenz Piedra, Eduardo	Región San Martín

SAN MARTIN (JEPELACIO)

Name	Affiliation
Luis A. Mendoza Valera	Director, Red Moyobamba
Lauren Ramírez Pinedo	Coord. Unidad de Seguro - Moyobamba
Gladis Ilatoma Linares	Resp. ESSSR-MR Jepelacio
Saúl Adrianzén Aguirre	Odontólogo – Personal
Junely Nolasco Reyes	Tec. Enfermería
Méfida Rengifo Tuesta	Tec. Enfermería
Edgardo Rojas S.	Tec. Adm. Promoción Salud
Julio E. Alcántara Rengifo	Jefe de Microred de Salud
Alcides Pérez Coba	Beneficiario
Clorinda Silva	Usuaria, Casa de Espera

CUSCO

Name	Affiliation
Belen Alvarado Zárate	DIRESA Cusco
Hilda Robles Mena	DIRESA Cusco
Kety Quispe Blanco	Red Cusco Sur
Fernando Perez Fasabi	DIRESA Cusco
Agripina Chamorro	Tesorería
José Miguel Rueda P.	Direct. ESC
María Cáceres Cardina	Resp. DGCS
Miriam Monya A.	Resp. DMID
Maritza Castro Huajaryo	Resp. ES PC ITS VIH/Sida
Hilda Robles Mena	Directora Ejecutiva de Salud Individual
Fenando Pérez Fasabi	DEIS
Rafael Valderrama P.	Coop. Internacional Gob. Reg. Cusco
Washington Alosillo	Gerente Reg. Desarrollo Social
Edilberto Jara Luna	S.G. Planeamiento
José Rueda	Dir. de Salud Comunitaria
María Cáceres Cerdeña	Encargada de Calidad y Gestión Comunitaria
Maritza Castro	Ofic. de Calidad y Gestión Comunitaria
Victor Ramiro Gil Gonzales	Resp. De Familia y Vivienda, PROM Salud
Lida Cuaresma Sanchez	Resp. de Educación para la Salud, PROM Salud
Jesus Germán Valdez Coz	Dir. Colégio 510099 Francisco Sibiriche
	Cole. Diego Quispe Tito, Dist. de Santiago
Rondon Abuhadba, Evelyn	Hospital Lorena, Cusco
Ordoñez Linares, Marco	Hospital Lorena, Cusco
Chevarria Pacheco, Luzmila	Laboratorio Referencial Cusco

UCAYALI

Name	Affiliation

Alejandro Magno Bartro S.	Dir. Regional Ucayali
Livia Marta Arévalo	Coop. Exterior
Marco Vela	DRSP
Cayo Leveau Bartra	Dir. Epidemiología
Yolanda Silva Orbe	Dir. Prom. Vida Sana
Lleny Rodríguez Torres	Dir. Institución Educ. Educac. de Salud
Sadith Arévalo Muñoz	Dir. Lab. Referencial
Victoria Franco de Anchante	Directora Ejecutiva DIREMID
José María Florián Vargas	Dir. Hosp. Regional
Teodoro Atencio Espinoza	Responsable Epidemiol.
Roberto Marin	Coord. Coop. Externo Regional
Juan Carlos Salas Suárez	Director Ejecutivo - Hosp. Amazónico Yarinacocha
Benito Alegría	Médico tratante, Hosp. Amazónico Yarinacocha
Luz Ponce	Coord.Unid. Téc. De DDHH, Gênero e Interculturalidad-PROM Salud
Mercedes Villacorta	Coord. TBC y Estratégia de Etapas de Vida y Adulto Mayor, C.S. Nuevo Paraíso
María Cuya Ruiz	Coord. De Área Niño, C.S. Nuevo Paraíso
Julia Martinez	Coord. PAR 2006
	Direc. de Promoción de las Salud
Martha García Paredes	Coord. Regional SSR
Abner Ortiz Roca	Jefe, Servicio Gineco-Obst., Hospital Yarinacocha
Robert Panduro Vásquez	Ejecución Presupuestal DISA–Ucayali
Javier Solis Morales	Economía–Encargado de Rendiciones
Carmen Salazar Vega	Directora de Economía DIRESA–
Flor de María Manrique Cruz	Coord. SSR–C.S. Campo Verde
José A. Mercedes Garay	HRP–Médico Asistente
Román Briones Torres	P.S. Curimaná
Tania Luz Tovar Marin	P.S. Curimaná
Noemi Beraún Soplín	P.S. Curimaná
Evelia Mallea Claros	Resp. Area Materna-C.S. Monte Alegre
Dania Ramón	C.S. Monte Alegre
Luis Fernando Cahua Rocca	C.S. San Fernando- Coronel Portillo
Antonia Hinostroza	Coordinadora Regional de Calidad
Luis Gutiérrez R	Ex Director DIRESA

IQUITOS

Name	Title
Leea Cuenca Pérez	DIPROMSA (c)
Carlos R. Dávila Tello	Dirección Ejecutiva de Salud Individual
Juan M. Pinedo Shapiama	Planeamiento
Jesús E. Rivera Guerrero	Planeamiento
Carlos Cabrera Cuadros	Dirección Servicios Salud
Percy Cárdenas Claudio	Dirección Salud Ambiental
Percy A. Rojas Ferreyra	DIRESA Subdirección
Carlos Manrique de Lara E.	Director General
Luis Rodriguez Benavides	Gerente Desarrollo Social – Gobierno Regional
María Ysabel Paccojo Paima	D. Particip. Comunitaria
Mónica del Pilar Cárdenas V.	DIRESA – Economía
Luis Enrique Lazo Ríos	DIRESA - Presupuesto
Saúl Arévalo	DIRESA - ESSalud
Lucía Marilú García T.	DIRESA – Direct. Economía
Rosana Chumbe Culqui	Coord. Reg. Salud Rep.
Marlena Otrera Panduro	Jefa Ofic. Ejec. Coop. Internacional
Giovanna del C. Babilonia R.	E. PY. Ofic. Ejec. Coop. Internacional
Rosa Bethi Ramírez del Aguila	Ingeniero II – F2
Irma Isabel Domínguez León	Obstetriz – GOREL
Benzo Gaspar Reátegui Ruiz	Director Ejecutivo
James Huamán Cerrón	Presupuesto – DIRESA
Curto Chavez, Juan Ernesto	Laboratorio Referencial Iquitos
Pacaya Paima, Maria Isabel	DIRESA Loreto
Calampa del Aguila, Carlos	Hospital Regional de Iquitos
Nunez Noronha, Etsy	DIRESA Iquitos
Julio Rivadeneyra	Director Ejecutivo de Administración
Bertha Liliana Ruiz Ríos	Coordinadora de tutoría, Colegio Sagrado Corazón
Aydee Alvarado Cara	Directora de Calidad, Hosp. Regional Iquitos

AYACUCHO

Name	Title
Leyla De la Torre Poma	Directora Servicios de Salud
Natali Vallejo Toras	Responsable Calidad
Walter Bedriñana Carrasco	Director Ejecutivo de Salud de las Personas
Leandro Prado Cisneros	Jefe de Contabilidad
Julio Santiago Peña	Técnico administrativo
Nicolás Prado Ambar	Sup. Proy. Sectoriales
Alberto Quispe Zavaleta	Administrador DIRESA

Name	Title
José Carlos Navarro Zúñiga	Contador DIRESA
Amadea Huamaní Palomino	Coord. ES Regional de SSyR
Liz Gonzales Husuya	Equipo Técnico ESR SSyR
Dana M. Olivares Tineo	Equipo Técnico ESR SSyR
Armando Savatierra Lara	Comunicador
Mirtha Aguilar Palomino	Resp. de SERUMS CLAS – UCAP
Gloria E. Chuchón Martínez	Coord. Salud S.R. Huanta
William L. Janampa Villavicencio	Resp. Calidad
Marina Quispe Ruiz	Responsable Hogar Materno (casa de espera)
Paulina Luz Medina	Usuario
Hebert Nikolo Navarro Pérez	Sub-Gerente Desarrollo Social M.Distrital Luricocha
Dra. María Torrealba	Directora Regional Ayacucho
Andrés Huayanay Quispe	Dir. Planeamiento Estratégico
Fernando Medina P.	Dir. Planeamiento y Organización Institucional
Rodolfo Walde Quispe	Director Adm. Red. Hga.
Marcos Cabrera	Gerente Des. Soc. Reg.
Alberto Quispe Zavaleta	Direct. Adm. DIRESA
Mario E. León Bendezú	Direc. Logística
Humberto Nizama Avila	PARSALUD
Joel Bravo	DIREMID
Jorge Rodriguez	Dir. Hosp. Reg.
Pedro Guerra Huamán	Direc. Planeamiento. Est. Hosp. Reg. Ayacucho
José Gutiérrez Santafé	Jefe, Recursos Humanos
Gloria Peña Castro	DIREMID
Janny Casas Falconí	Jefe – Economía
Luis Edulard Gálvez Molina	Dir. Administración
Marina Cuchi Acuña	Resp. Calidad, Hosp. Reg. Ayacucho
Orlando Llactahuamán Quispe	Antrop. Calidad Hosp. Reg. Ayacucho
Ilianor Fernández Chillue	Dirección Aseguramiento Público
Walter Oré Avalos	Dire. Ejec. Promoción de Salud
Carlos A. Calderón Moreno	Director, UERSA
Karina Ruiz Quevedo	SISMED–HTA
Geovana Cisneros Soto	Responsable de Epidemiologia–Huanta
Nelly Huamani	Jefe Epidemiología, DIRESA
Carmen Losano	Jefe Epidemiología, DIRESA
Mirian Meneses	Laboratorio Regional de Referencia
Jesús López	Laboratorio Regional de Referencia

APPENDIX D: DATA COLLECTION INSTRUMENTS

Ver 5.2: 2 de octubre de 2009

APRECIACION EXTERNA DE TRES PROYECTOS USAID-MINSA
BORRADOR DE GUIA DE ENTREVISTAS DE PROFUNDIDAD CON INFORMANTES CLAVES

Identificación del Informante **(CONSIGNAR ESTA INFORMACION EN EL REGISTRO DE CONTACTOS)**.

Nombre, Cargo y ubicación, Correo electrónico, Celular

Entre 1998 y 2008, el MINSA llevó a cabo tres proyectos con apoyo del pueblo norteamericano a través de la Misión de la Agencia de Desarrollo Internacional de los EEUU (USAID) en Lima. Estos proyectos se llamaban: VIGIA, Cobertura con Calidad (CCC) y Una mejor Salud para Poblaciones en Alto Riesgo (PAR). VIGIA tuvo como propósito fortalecer las capacidades locales y nacionales para identificar, controlar y prevenir las enfermedades infecciosas emergentes y reemergentes. CCC buscó mejorar la calidad de los servicios de salud materno perinatales en zonas vulnerables. PAR tuvo como objetivo mejorar la salud de poblaciones de alto riesgo. VIGIA tuvo alcance nacional y los otros proyectos se ejecutaron en siete regiones y nueve regiones de salud respectivamente y con mayor énfasis en Ucayali, San Martin, Junín, Loreto, Ayacucho y Huánuco.

El MINSA y USAID desean conocer como fue la ejecución de los proyectos, tanto en aspectos técnicos como administrativos a través de una apreciación ("assessment") externa. El propósito de esta apreciación es resumir los mayores logros y lecciones aprendidas de los tres proyectos. Se anticipa que esta apreciación proveerá información que contribuya al diseño y a la implementación de actividades por USAID-Perú, el MINSA, las DIRESAs y otras entidades públicos y privados. Con el propósito de realizar esta apreciación externa, USAID ha contratado un equipo de profesionales que han elaborado el presente instrumento.

Preguntas específicas acerca de los proyectos. **TODA LA INFORMACION QUE USTED APORTA SERA ESTRICTAMENTE CONFIDENCIAL.**

1.	VIGIA	CCC	PAR
¿Usted ha escuchado de alguno de estos proyectos?			
¿Tuvo alguna relación con alguno de ellos? Especificar en qué fechas aproximadas (En caso de ser varias, escoger la que haya sido la principal)			
Dirección/supervisión/coordinación			
Ejecutor en áreas técnicas			
Ejecutor en áreas administrativas			
Beneficiario directo (asistente a eventos, Utiliza materiales)			
Otras			

(Nos. 2 – 7 SOLAMENTE PARA PERSONAL TECNICO DEL MINSA/ DIRESA)

2. Los tres proyectos produjeron o contribuyeron en la producción de políticas, sistemas, reglamentos, guías protocolos e instructivos. Para cada proyecto que usted conoció, mencione cuales conoció o utilizó. (Después sacar el inventario para saber si reconoce otros. Pedir ver ejemplares).

VIGIA	
CCC	
PAR	

3. Los tres proyectos produjeron materiales impresos (folletos, afiches), spots y cuñas de radio y televisión y documentos oficiales. Para cada proyecto que usted conoció, mencione cuales conoció o utilizó. (Después sacar el inventario para saber si reconoce otros y pedir ver los documentos y/o ejemplares).

VIGIA	
CCC	
PAR	

4. ¿Cómo describiría la calidad y utilidad de los materiales utilizados en su región, para cada proyecto? Favor hacer referencias a materiales específicos.

	CALIDAD	UTILIDAD
VIGIA		
CCC		
PAR		

5.a Los tres proyectos también realizaron capacitaciones. Favor mencionar las capacitaciones en que participó o conoció. ¿Cómo describiría la calidad y utilidad de las capacitaciones en su región, para cada proyecto? Favor mencionar capacitaciones específicas.

	CALIDAD	UTILIDAD
VIGIA		
CCC		
PAR		

5.b ¿Cómo se podría haberlas mejorado?

	PROPUESTA DE MEJORA
VIGIA	
CCC	
PAR	

6.De los productos y procesos técnicos que dejaron los proyectos, cuál o cuáles considera usted que están actualmente en uso. Favor mencionar ejemplos específicos.

VIGIA	
CCC	
PAR	

7. ¿Qué necesidades todavía hay para atender en el futuro en cada área técnica de los proyectos?

VIGIA	
CCC	
PAR	

(Nos. 8 – 9 SON PARA TODO EL PERSONAL

8. ¿De 1-5 cómo calificaría Ud. Los procesos administrativos y/o financieros para cada proyecto (1=muy malo, 5=excelente)? Favor explicar su razón.

	Procesos Administrativos	**Procesos Financieros**
VIGIA		
CCC		
PAR		

.

9. ¿Cuáles eran los mecanismos administrativos, financieros o instancias que dieron el resultado indicado, arriba?

	Presencia de personas calificadas (técnicos o profesionales, administrativos)			Instrumentos, instructivos o herramientas			Financiamiento oportuno		
	Siempre	A veces	Nunca	claro	Difícil	Inexis-tente	Siempre	A veces	Nunca
VIGIA									
CCC									
PAR									

	Favor dar la razón para su respuesta arriba con ejemplos específicos
VIGIA	
CCC	
.PAR	

(Nos. 10 – 13 SON SOLAMENTE PARA PERSONAL ADMINISTRATIVO-FINANCIERO)

10. Los tres proyectos requirieron acciones nuevas o adicionales en los departamentos administrativos y financieros. ¿Puede estimar, para el último año que usted recuerda, el cargo que le representaron los proyectos, en tiempo, montos, número de movimientos por mes?

	Monto mensual	**Número de movimientos/mes**
VIGIA		
CCC		
PAR		

11. ¿Recibió algún aviso previo o capacitación para poder planificar su trabajo con relación a estos proyectos? ¿Recibió algún instructivo para el manejo administrativo o financiero de los proyectos? ¿Tuvo que ajustar la organización de su departamento o el número de personal para atender los requerimientos de los proyectos? (Pedir ejemplos de guías, instructivos, manuales y formatos específicos a los proyectos.).

12. ¿Qué problemas tuvo en la implementación de los proyectos? ¿Causaron complicaciones o interferencias con sus labores de rutina? ¿Recibió reclamos de parte de USAID, MINSA o los clientes internos? ¿Qué respuesta o solución dio Ud. A ellos?

13. En su opinión, ¿que podría haber hecho el proyecto para apoyarle más en su administración y gestión incluyendo la ejecución de fondos?

VIGIA	
CCC	
PAR	

PARA TODO PERSONAL DE SALUD:

14. ¿Cómo la reforma del sector de salud y descentralización ha afectado a Ud. En el desempeño de sus funciones? Favor explicar.

15. Recibió Ud. Algún orientación y/o capacitación en las nuevas funciones y cambios de procedimientos relacionados a la descentralización? Favor especificar.

16. ¿Que se podría haber hecho para prepárale y facilitarle mejor en la transición hacía la descentralización?

17. ¿Considera Usted, que su participación en el proyecto influyo en su desarrollo personal y profesional? Favor explicar.

PARA TODOS/AS

18. ¿Tiene algo más que agregar?

Muchas gracias por su colaboración.

Ver 2: 3 de octubre de 2009

APRECIACION EXTERNA DE TRES PROYECTOS USAID-MINSA
BORRADOR DE GUIA DE ENTREVISTAS EN DE PROFUNDIDAD CON INFORMANTES CLAVES DE LOS GOBIERNOS REGIONALES/LOCALES

[THE SAME INTRODUCTORY PAGES AS IN THE FIRST INSTRUMENT]

2. ¿Cómo se fijan las prioridades en salud en el ámbito de su gobierno regional para el planeamiento del presupuesto? ¿Quienes participan y contribuyen al proceso con voz y voto y cuáles que son las bases y/o fuentes de información que se utilizan? ¿Cuál Qué es el rol y el grado de participación de la sociedad sector civil? ¿Cómo se puede mejorar el proceso?

3. ¿Cómo se desarrollan los proyectos de varias fuentes externas en el proceso de planeamiento regional y cómo se podría mejorar la integración de estos proyectos con los programas y procesos nacionales/regionales?

4. ¿Cómo se realiza el monitoreo del gasto según lo programado? ¿Existe alguna fiscalización social de la ejecución presupuestaria, tanto en su porcentaje de cumplimiento como en la adecuación del gasto?

5. De igual manera, en relación con la ejecución de actividades de los proyectos programados:
5. Igual con la ejecución de las actividades de proyectos lo programado, ¿existe alguna fiscalización social de su cumplimiento real respecto con a lo planeado y también de la calidad de las actividades?

6. ¿Cuáles son las principales los limitantes u obstáculos para la ejecución presupuestal de proyectos en su la región, tomando en cuenta su nivel de ejecución logrado en el 2008 y hasta la fecha? ¿Ha adoptado alguna estrategia para lograr un mejor desempeño de ejecución y/o logro?

7. ¿La Gerencia de Desarrollo Social/Dirección Regional de Salud, cuenta con formación información de RRHH en salud, tanto públicos como privados, en el ámbito del gobierno regional? ¿Cuentan con políticas para su distribución en el ámbito del gobierno regional?

8. ¿La Gerencia Social promueve la acreditación de universidades y/o facultades en la Región el Departamento? ¿Tiene convenios acuerdos con las universidades de la localidad para contar con capacitaciones y/o apoyo técnico en áreas administrativas, financieras o de salud pública?

9. En su opinión, ¿existen incentivos para que el personal del Gobierno Regional o de los servicios de salud se mejoren su capacidad de gestión o calidad de servicio? Si la respuesta es positiva, ¿cuáles son, de dónde provienen, y cómo se puede ampliar y/o fortalecerlos? Si es negativa, ¿cree que es conveniente instituirlas? ¿Cómo?

Ver5: 1 de octubre de 2009

APRECIACION EXTERNA DE TRES PROYECTOS USAID-MINSA
BORRADOR DE GUIA DE ENTREVISTAS DE PROFUNDIDAD CON INFORMANTES CLAVES ADMINISTRATIVO-FINANCIERO

[THE SAME INTRODUCTORY PAGES AS IN THE FIRST INSTRUMENT]

(SOLAMENTE PARA PERSONAL ADMINISTRATIVO-FINANCIERO)
2. Los tres proyectos requirieron acciones nuevas o adicionales en los departamentos administrativos y financieros. ¿Puede estimar, para el último año que usted recuerda, el peso que representaron los proyectos, en montos, número de movimientos por mes?

	Monto mensual	**Número de movimientos/mes**
VIGIA		
CCC		
PAR		

3. ¿Recibió algún aviso previo o capacitación para poder planificar su trabajo con relación a estos proyectos? ¿Recibió algún instructivo para el manejo administrativo o financiero de los proyectos? ¿Tuvo que ajustar la organización de su departamento o el número de personal para atender los requerimientos de los proyectos?

4. ¿Qué problemas tuvo en la implementación de los proyectos? ¿Causaron complicaciones o interferencias con sus labores de rutina? ¿Recibió reclamos de parte de USAID, MINSA o los clientes internos? ¿Qué respuesta o solución dio?

5. En su opinión, ¿qué faltaba en el/los proyecto(s) y como se podría haber mejorado su administración y gestión incluyendo la ejecución de fondos?

VIGIA	
CCC	
PAR	

6. ¿Considera Usted, que su participación en el proyecto influyo en su desarrollo personal y profesional? Favor explicar.

7. ¿Tiene algo más que agregar?

Ver 2: 1 de octubre de 2009

APRECIACION EXTERNA DE TRES PROYECTOS USAID-MINSA
BORRADOR DE GUIA DE ENTREVISTAS DE PROFUNDIDAD CON INFORMANTES CLAVES DE LA COMUNIDAD

[THE SAME INTRODUCTORY PAGES AS IN THE FIRST INSTRUMENT]

2. Los tres proyectos produjeron materiales impresos (folletos, afiches), spots y cuñas de radio y televisión y documentos oficiales. Para cada proyecto que usted conoció, mencione cuales conoció o utilizó. (Después sacar el inventario para saber si reconoce otros y pedir ver los documentos y/o ejemplares).

VIGIA	
CCC	
PAR	

3, ¿Cómo describiría la calidad y utilidad de los materiales utilizados en su región, para cada proyecto? Favor hacer referencias a materiales específicas.

VIGIA	
CCC	
PAR	

4. Los tres proyectos también realizaron capacitaciones. Favor mencionar las capacitaciones en que participó o conoció. ¿Cómo describiría la calidad y utilidad de las capacitaciones en su región, para cada proyecto? ¿Cómo se podría haberlas mejorado? Favor mencionar capacitaciones específicas.

	CALIDAD	UTILIDAD
VIGIA		
CCC		
.PAR		

5. De los productos que dejaron los proyectos, cuál o cuáles considera usted que están actualmente en uso. Favor mencionar ejemplos específicos.

VIGIA	
CCC	
PAR	

6. ¿Qué necesidades todavía hay (para atender en el futuro) en cada área de los proyectos?

VIGIA	
CCC	
PAR	

Favor dar la razón para su respuesta arriba con ejemplos específicos

8. Muchas gracias por su colaboración. ¿Tiene algo más que agregar?

APPENDIX E: MATERIALS AND EQUIPMENT PROVIDED BY CWQ

DOCUMENTOS IMPRESOS Y DIFUNDIDOS POR COBERTURA CON CALIDAD

A. El proyecto contribuyó con la difusión de material para capacitación en el ámbito nacional, entre ellos tenemos:

1. Tan cerca tan lejos
2. Buscando una maternidad saludable
3. El SIDA también es problema nuestro
4. Guías Nacionales de Atención Integral de la Salud Sexual y reproductiva
5. Guías prácticas clínicas para la atención de las patologías más frecuentes y cuidados esenciales del niño y la niña, con las siguientes presentaciones:

   Diarrea Disentérica

   Diarrea persistente

   Diarrea aguda y cólera

   Parasitosis intestinal

   Rinofaringitis aguda

   Faringo amigdalitis aguda

   Otitis media aguda

   Síndrome de Obstrucción Bronquial

   Asma bronquial

   Neumonía
6. Manual para la mejora de calidad continua
7. Listado de estándares de acreditación para establecimientos de salud
8. Acreditación de Establecimientos de salud y servicios médicos de apoyo
9. Estándares e indicadores de calidad en la atención materna y perinatal.
10. Normas Técnicas de Acreditación de Establecimientos de Salud
11. Sistema de Gestión de la Calidad en Salud
12. Metodología para el Estudio del Clima Organizacional
13. Plan para el estudio del clima organizacional 2008 – 2011

B. Contribuyó con la difusión de material de capacitación en las Regiones, en base a algunas adaptaciones locales de documentos nacionales.

C. Material para implementación de actividades asistenciales en los establecimientos de salud

1. Fichas clínicas de atención del niño
2. Guía para la visita domiciliaria en la atención integral de la familia
3. Carnet de control materno perinatal
4. Historias clínicas
5. Gestogramas
6. Afiches del estado de hidratación del paciente
7. Afiches tabla de Capurro
8. Afiches tabla APGAR
9. Tablas de crecimiento del niño
10. Afiches del parto seguro

EQUIPO	CANTIDAD
Aspirador de secreciones	159
Ambulancias Junín y Ucayali	2
Balanzas mecánicas pediátricas y de pie con tallímetro	264
Caja transportadora a batería para refrigeración portátil	703
Cámara fotográfica	4
Camilla o mesa ginecológica	2
Capturador de imagen: Scanner	5
Coche de curación rodable de dos cajones	6
Computadora personal portátil	43
Data display	1
Detector de latidos fetales	156
Equipo de curaciones de 9 piezas	4
Equipo de Radio Comunicaciones	127
Equipo de legrado uterino	1
Equipo multifuncional (fotocopiadora)	1
Equipo proyector multimedia portátil	41
Equipos de computo	22
Estetoscopio clínico	5
Fetoscopio de pinar	4
Grabadora para cinta de sonido	3
Impresora de inyección de tinta y laser|	12

EQUIPO	CANTIDAD
Laringoscopio para adulto y recién nacido	37
Lavador de placas	5
Letrero clave azul, amarillo y roja	1,410
Oximetro de pulso	11
Pinza para objeto de 16 y 17 cm	2
Pulsioximetro de pulso sensor de dedo	1
Resucitador manual para adulto y recién nacido	843
Set de cirugía mayor	3
Set de oxígeno terapia	147
Set para episiorafía	1,506
Software SPSS para Windows	10
Tallímetro fijo nacional	6
Tensiómetro de brazo digital, mercurial y de mesa	360
Termómetro	428
Thermos sala dilatación, camarote, cocina, mesa, ropero, sillón	21
Tijera para cordón umbilical de 10 cm	2
Tubo endotraqueal	2
Vitrina	15

APPENDIX F: POWERPOINT PRESENTATION ON THE RESULTS OF THE ASSESSMENT

USAID
FROM THE AMERICAN PEOPLE

ASSESSMENT OF THREE USAID/PERU HEALTH PROJECTS

Implemented by the Ministry of Health

Vigia, Coverage with Quality, Health for Populations at High Risk

USAID/GH Tech Project - November 2009

USAID
FROM THE AMERICAN PEOPLE

Purpose

- Review and summarize results of the 3 projects implemented by the MOH.
- Make recommendations to MOH-USAID about how to improve administration of similar projects in the future.

USAID
FROM THE AMERICAN PEOPLE

USAID/GH Tech Team

Stanley Terrell	Team Leader
David Nelson	Deputy Team Leader
Pedro Mendoza	Vigía
Reynaldo Alvarado	Coverage with Quality (CwQ)
Teobaldo Espejo	Populations at High Risk (PAR)

USAID
FROM THE AMERICAN PEOPLE

MOH Team Members

Esthela Cusco	Office of International Cooperation
Betty Gaviria	Directorate of Personal Health (DGSP)
Rosario Zavaleta	Directorate of Personal Health (DGSP)
Erika Jímenez	Directorate of Personal Health (DGSP)
Yessy Ruíz	Office of International Cooperation
Aurelio Roel	Office of International Cooperation
Marcos Calle	Directorate of Personal Health (DGSP)
Rocio Figueroa	Office of International Cooperation
Gladys León	Office of International Cooperation

General Methodology

- Review of documents and identification of markers.
- Design of key-informant, in-depth interview guides.
- Selection of sites and interviewees.
- Interviews and site visits.
- Extensive discussion between GH Tech team and expanded MOH team.

Persons Contacted

Lima	USAID Staff	8
	USAID Projects	5
	Others stakeholders	31
Regions	Ayacucho	45
	San Martín	36
	Loreto	26
	Ucayali	33
	Cusco	24
	Junin	30
	Total	237

Vigia – Context and Organization

- First phase (1997-2000): Vertical orientation
  - Vigia Organization: The Director
- Second phase (2001-2002): Decelleration
  - Vigia Organization : Uncertainty
- Third phase (2003-2008): Participatory orientation and Decentralization
  - Vigia Organization : The Directorate

Vigia – Flow of Funds

- Administration: National Health Instutute
  - A decentralized public institution with budget autonomy
- Activities:
  - Contrated technical assistence
  - Purchased goods (equipment and materials)
  - Purchased Services (consultancies, misc. services).
- Annual Operational Plan
- USAID-NIH: Advances with monthly liquidations
- NIH-DIRESA: Consignment of Funds.

Vigia - Methodology

- Twenty two in-depth interviews.
  - Director of International Cooperation of MOH
  - Ex Director and Advisors of VIGIA Project
  - Directors and Ex Directors General and Executives of Regional MOH offices (DIRESA)
  - Persons in charge of Regional Reference Laboratories
  - Administrative staff of DIRESAs.
- Meetings with USAID staff.
- Discussions among the expanded USAID/GH Tech - MOH team
- Bibliographic and physical sources.

Vigia - Findings 1

Creation in the MOH and Regions of a culture of evidence-based decision making:

- Methodology of Situational Health Analysis (ASIS)
- Changes to the Malaria treatment norm.
- Validation of High Activity Anti-Retroviral Treatment (HAART)

Vigia - Findings 2

Innovations in organization and management:

- Proposal for Health Intelligence
- Management by the Directorate

Vigia - Findings 3

- Innovations in health technology:
  - Intermittant dry irrigation.
  - Changes to the Malaria treatment regimen.
  - Introduction of rapid tests for Malaria.
  - Work on nosocomial infections
  - Work on Rational Drug Use

"before Vigía everything was work on maternal child health, no one paid attention to intrahospital infections."

Vigia - Findings 4

Innovations in training and methodology:

- Field Epidemiology Training (PREC), cross-disciplinary.
  - First stage: 850 professionals, for first level health services.
  - Second stage: 350 professionals, for second level health services.
  - Third stage: 96 professionals, for regional and national levels.
  - Forth stage: 55 professionals, who graduated as field epidemiologists.
- The INTERFASE software application (Piura)
- Curricular diversification (San Martin)
  "We do good work, we have our own PREC!"

Vigia – Financial Management (USD)

- Amount authorized: 18.8M
- Amount sub-obligated: 1998-2008: 12.6M
  (Percent of amount authorized: 67%)
- Amount liquidated 1998-2008: 12.4M
  (Execution of sub-obligated amount: 97%)

Vigia – Key Success Factors

- Organization in accordance with MOH orientation and direction.
- Team effort between MOH and USAID.
- Creation of a career oriented team committed to the life of the project (PREC).
- Development of organizational concepts that evolved.
- Joining of disciplines and the productive sectors.
- Identification and expansion of successes.
- Administration by a management unit outside of OGA-MOH by consignment of funds to NIH.

Vigia – Future Tasks

- Adjust to decentralization.
- Establish better working arrangements with educational centers.
- Further diffusion of successes and progress.
- Greater attention to administrative personnel.
- Keep administration and management separate.

Vigia - Recommendations

- Use directorates to manage projects.
- Value prior experience for recruitment.
- Strengthen cohort-group training processes.
- Build on evolutionary organizational innovations.
- Use the operational structures and functions of other agencies, as appropriate.

Vigia - Recommendations (cont)

- Promote regional successes.
- Use management units outside of MOH-OGA.
- Work more with educational centers.
- Give incentives for publishing successes.
- Greater involvement of administrative staff.

CwQ – Technical Context

- First phase (1997-1999): Family Planning
  – Availability of all FP methods
- Second phase (1999-2000): Sexual and Reproductive Health
  – Adolescents, cancer, HIV/AIDS
- Third phase (2001-2002): Safe Motherhood
  - Individual and group health
- Fourth phase (2003 – 2007): Integrated and Quality Services
  - Quality standards for maternal-perinatal health

CwQ – Stages of Funds Administration

- First Stage (1996 a 2001) : UEP2000
- Second Stage (2002 a 2005) : PAAG
- Third Stage (2006 a 2007) : OGA
- Activities:
  - Contracts for TA
  - Training and training materials
  - Procurements (equipment and materials)
  - Contracts for logistical services.
- Annual Operational Plan
- Short-term activity plans
- Monthly advances and liquidations

CwQ - Methodology

- Discussion and analysis meetings with the team, MOH staff and USAID officials
- Visits to Regions: San Martín, Ucayali y Ayacucho
- Visits to "Casas de Espera" (pre-delivery Waiting Homes)
- Twenty six in-depth interviews.
  - Coordinators and CwQ in-charge for various stages
  - Directors and Ex Directors General and DIRESA staff.
  - Administrative officials of DIRESAs.
  - Persons from other institutions related to the project.
- Review of documents and site visits.

CwQ - Findings

- Contributed to integrated and quality FP services
- Strengthened and expanded "casas de espera"
- Most interviewees had heard of the project.
- Trained personnel not working in the original positions.
- No of the educational materials found at primary level.

"you never know where you will end up so its better to take the little books with you, you can't tell when they will come in handy"

CwQ – Findings 2

- Donated equipment and materials found in primary units in working condition and in use.

  "with these little things, we can work like we´re supposed to. Patients feel good and we do, too".

- The ambulance in Curimaná was in service.

- More than 4000 people were trained.

  "*this project served me professionally and, especially, personally. I was one person before and another after the project.*"

CwQ – Findings 3

- Manuals, technical norms, brochures, posters, tables and clincal histories.

- Episiotomy kits, minor surgery sets, blood-pressure meters, thermometers, etc in primary units.

-

- 127 radio communication units.

- Administrative staff were marginalized.

  "we started every change with the motor cold " "then they stressed us, saying we were responsible for the delays".

CwQ – Financial Management

- Amount sub-obligated: 1996-2007:
  USD 6,350,000
- Amount spent: 1996-2007:
  USD 6,022,534
- Execution: 95% (with extension of LOP from 5 to 10 years)

CwQ - Conclusions

- Strengthened quality of FP services.
- Technical assistance, educational materials and training reached primary health units, improving service quality.
- "Casas de espera" now part of the National Strategic Plan to reduce maternal-perinatal mortality.
- Huge rotation of personnel, principally out of primary units.
- Equipment and materials can help improve service capacity.
- Outsourcing of logistic operations for was effective.
- There is no way to measure impact on maternal mortality.

CwQ - Recommendations

- Integrate quality maternal-child health services, from "casas de espera" up to all levels.
- Achieve national coverage.
- Bring administrators into design and planning of activities.
- Policy dialogue with political authorities and involve sectors.
- Make in-service training a permanent activity: use competency-based training to start a "professional career" path in first-level units.
- Systematize and demonstrate the CwQ experience in achieving improved services in first-level units.
- Ensure that all projects have an M/E system.

PAR – Logical Framework

- Strategic Objective: improve the health of high-risk populaitons
- Intermedite Results:
- N°1. Quality health services accessible and used.
- N°2. Persons Practice Healthy Behaviors.
- N°3. Health Sector Policies and Programs respond to Health Needs.

PAR – Flow of Funds

Amount authorized: U$ 5.0M

Expenditures by MOH:

- 2005 U$ 574,031
- 2006 U$ 420,765
- 2007 U$ 284,700

Total U$ 1,279,496

Administration and TA U$ 1.737M

PAR - Methodology

- Cuzco (7 persons, 2 schools)
- Pucallpa (5 persons)
- Junín (7 persons, 1 school)
- MINSA (3 persons)
- USAID (3 persons)

- Document review

PAR – Technical Findings

- No one knew the project objectives; it was seen as a complementary funding source.
- Materials printed for: TB, Malaria, Quality Standards, National Consultative Plan remembered.
- The complementary nature of training was well remembered (e.g. PNC, Malaria).
- Secondary processes: Seniors and Healthy Schools.
- No evidence to measure effects.

PAR - Administrative/Financial Findings

- PAR not recognized as a separate entity, confused with MOH funding.
- The greatest accounting problems were with trainings.
- Tension between technicians and adminstrators.
- USAID/RIG conducted two visits.
- MOH only executed 25% of authorized amounts.

PAR - Conclusions I

Technical:

- Contributed to many support activities that strengthened MOH technical and promotional capacity.
- There was no baseline nor monitoring system.

Management:

- Responsibility diluted between DGSP and DGPROM. The project consultant could not provide direction.
- MOH expenditures of project funds decreased yearly.

PAR - Conclusions II

Legacy:

- The Healthy Schools experience is promising.
- M&E system necessary from the project onset.

Achievement of objectives:

- Strategic Objective (persons at high risk) never had a definition.
- Intermediate Results: had excessively broad definitions and did not have quantitative goals.

PAR - Recommendations

Support for MINSA-DIRESA health promotion is a valid goal with following caveats:

- M&E system.
- Clearly defined lines of authority and responsibilities.
- Documents must be easily accessible (libraries/internet).
- Administrative/financial bottlenecks quickly resolved.
- Sustainability plan.

Funds Executed ($US)

	Vigia	CwQ	PAR
Authorized	18.8 M	6.35 M	5.0 M
Sub-obligated (% authorized)	12.62 M (67%)	6.35 M (100%)	1.279 M (26%)
Executed (% sub-obligated)	12.238 M (97%)	6.023 M (95%)	1.279 M (100%)*

* $1.737M was spent on administration and technical assistance

Conclusions

- MOH and DIRESAs cannot manage project funds efficiently.
- There is no horizontal communication between regional peers (DIREMID, laboratories, DIRESAs).
- PAR and CwQ contributed to development of HCM, Healthy Schools and "Casas de Espera".
- CwQ stimulated quality improvement.
- Vigía was successful in developing and transferring capacities and technology.

Conclusions (cont)

- Activity-support projects with MOH-DIRESA can work synergistically with technical assistance projects.
- The principle needs of the DIRESAs are:
  - Human resources
  - Basic management capacity
  - Strengthened collaboration with universities, civil society and local governments.
  - Other sources of financing.
  - Develop peer communication between regions.

Criteria for future support to MOH-DIRESA

- Aligned with USAID-MOH objectives.
- Clear objectives, logical framework, M&E plan.
- Flexible within framework (to respond to regional needs).
- Include admin/finance personnel in planning.
- Use efficient administrative-financial mechanisms.
- Joint MOH-USAID team to monitor the project.

Recommendations

- Brainstorm with current and past project holders.
- Continue supporting MOH-DIRESA activities in coordination with TA projects.
- Support basic operational capacity of DIRESAs.
- Seek innovative mechanisms to achieve equity and reduce exclusion.
- Empower local governments and civil society.
- Develop horizontal peer communication (Web 2.0).

Recommendations (Cont)

Develop a human resource strategy to:

- Coordinate efforts of all actors under a plan.
- Seek salary equity and develop incentives.
- Strengthen links to universities and incorporate MOH norms in pre-service curricula.
- Develop innovative in-service training methods.
- Provide supportive supervision.

Recommendations (Cont)

- Continue providing technical support and equipment for FP and reproductive health, focused on quality.
- Continue to support "casas de espera" based on systematization of lessons learned.
- Systematize experiences of all projects along the lines of the Vigia model.

APPENDIX G: LIST OF SITES VISITED

REGION	1 (5 AL 08 OCT)	2 (11 AL 14 OCT)	3 (14 AL 17 OCT)
LORETO (IQUITOS)		PEDRO MENDOZA STAN TERRELL YESSY RUIZ (MINSA)	
SAN MARTIN (TARAPOTO)	REYNALDO ALVARADO PEDRO MENDOZA STAN TERRELL BETTY GAVIRIA (MINSA)		
JUNIN (HUANCAYO)	TEOBALDO ESPEJO ERIKA JIMENEZ (MINSA - DGSP) DAVID NELSON		
CUSCO (CUSCO)			PEDRO MENDOZA TEOBALDO ESPEJO STAN TERRELL BETTY GAVIRIA (MINSA) ROCIO FIGUEROA (MINSA)
UCAYALI (PUCALLPA)		REYNALDO ALVARADO TEOBALDO ESPEJO DAVID NELSON ERIKA JIMENEZ (MINSA–DGSP) GLADYS LEON (MINSA - OGCI)	
AYACUCHO (HUAMANGA)			REYNALDO ALVARADO DAVID NELSON MARCOS CALLE (MINSA–DGSP/ Calidad) AURELIO ROEL (MINSA–OGCI)

APPENDIX H: INDIVIDUAL PROJECT ASSESSMENTS

VIGIA

A. Background

The VIGIA project was initiated with the Bilateral Grant Agreement ratified on September 29, 1997, between the Government of the United States of America and the Government of Peru. This agreement encompassed all project activities for a 10-year period, between 1997 and 2008. The final report was delivered on 2008. Project planning can be traced back to 1996–1997.

1. Project Timeline

TABLE H.1. KEY EVENTS IN THE VIGIA PROJECT	
Dates	Activity
September 29, 1997	Signature of Bilateral Grant Agreement establishing VIGIA project goal, objectives, structure, and implementation arrangements with duration of seven years (1997–2004)
March 12, 1998	Congress ratified agreement with RL 26932.
June 15, 1998	National Health Institute (NHI) appointed as MOH's Special Unit to provide administrative support to VIGIA (RM 214-98-SA/DM)
January–February 1999	VIGIA Strategic Planning Workshop
September 26, 2003	Addendum to the Agreement; board includes MOH General Directors.

2. Project Logical Framework

Goal: Improve health conditions of population with high risk of contracting emerging and reemerging infectious diseases.

Purpose: Capacity building in MOH to identify, prevent, and control emerging and reemerging infectious diseases.

National results at end of project include:

(1) Malaria prevalence reduction of no less than 50%.

(2) Stabilization and/or reduction of sexually transmitted diseases (STD), especially HIV.

(3) Tuberculosis (TB) prevalence reduction, ranging from 150.5 to 107 per 1,000 inhabitants.

(4) Continuous decrease in annual prevalence of cholera cases; mortality rates to have remained under 1%.

(5) Coverage of 50% of hepatitis B vaccine for children under 5 years of age living in areas with moderate to high endemic rates.

(6) 80% coverage of yellow fever vaccine in endemic areas with migrant population and in migrating areas.

(7) 100% coverage of rabies vaccine in areas where people are at risk of contracting wild rabies.

Purpose Indicators:

VIGIA's purpose was to strengthen national and local capacity to identify, control, and prevent emerging and re-emerging infectious diseases effectively in Peru. Six purpose indicators (PIs) were used to guide VIGIA:

PI 1: MOH has up-to-date surveillance systems and control measures for infectious diseases of national and regional importance.

PI 2: MOH monitors the behavior of infectious agents, their resistance patterns, and risk factors for emerging and re-emerging infectious diseases (EREID)

PI 3: MOH has substantially reduced inadequate prescription of pharmaceuticals in EREID.

PI 4: MOH applies education, communication, and community participation strategies in the prevention and control of EREIDs.

PI 5: The national laboratory network has the capacities to provide valid and timely diagnosis in 100% of outbreaks.

PI 6: MOH has two centers for research in EIREDs matching international standards.

3. Project Phases

The VIGIA project took place over a 10-year period during which there were four changes in the national government with major swings in orientation of the MOH. In the course of the evaluation, it was observed that these changes and swings affected the structure of the project, its management and administration. Three phases were identified by interviewees, which determined the context for VIGIA implementation.

Phase 1 (1997–2000): Vertical Context

During Alberto Fujimori's second term in office, from July 1997 through July 2000, the government was involved in consolidating a State reform known for its openness to the free market system, reinsertion into international relationship processes, and efficiency-based social policies. All of the above took place in the context of the 1990s Latin American concept of "health sector reform."

During that time, the MOH was undergoing an intense process to draft a health sector reform proposal, which—according to Project 2000—clashed with the "old MOH" ((the existing structure peopled by long-term bureaucrats). Thus, when VIGIA came on to the scene, the Project Director reported directly to the Minister and Deputy Minister of Health, facilitating funds to be directed to the new project.

During this time, VIGIA was announced as "a new activity to start in Fiscal Year 1996 that will mobilize resources from the Peruvian government and other donors to reduce transmission of Sexually Transmitted Infections and HIV in Peru" under Strategic Objective 3 (SO3) of the USAID Country Strategy.

Experiences in the Ministry of Health during this period were intense and are clearly reflected in the structure and operations of VIGIA. A characteristic of this period was—despite its technical efficacy—the limited coordination or consensus with other stakeholders, such as local NGOs, civil society, and private sector providers, as part of a vertical/hierarchical model (Cueto, 2001). Thus, in Phase 1 the VIGIA Project was implemented with strong vertical management which

favored technical efficacy and administrative efficiency over participatory management and consensus-based decision-making as part of the organizational culture in the MOH at the time.

The Bilateral Grant Agreement specified the project would have an MOH Director who would be the counterpart to the U.S. Centers for Disease Control and Prevention (CDC) epidemiologist and USAID. Three Macro-Regional Advisors had to report to the Project Director. A Special Project Unit within MOH was selected for administrative purposes to provide logistical and administrative support. The VIGIA Director worked with each Director General of the MOH, depending on the theme or activity at hand.

Phase 2 (2001–2002): Slowing Down and Uncertainty

Alberto Fujimori's administration ended in late 2000 and was followed briefly by a transition government, which characterized VIGIA's second phase. Peru returned to democracy and as a result the Ministry of Health and the country as a whole demanded social agreement and consensus as building blocks for policy making. This brief period, July 2001–June 2003 had two Health Ministers known for their conservative stance on sexual and reproductive health. Their change of orientation and subsequent turnover of MOH personnel led to a slowing and reorientation of activities throughout the MOH. In VIGIA's case, HIV and tuberculosis activities slowed down.

This phase can be described as a transitional phase during which the project's initial structure became obsolete due to the fundamental organizational and political changes in the MOH, the government, and the country as a whole. The NHI Project Manager during this transition initiated dialogue between the Office of International Cooperation, Project Management, and USAID, which laid the groundwork for a third phase. The first Project Director was replaced in April 2002.

In its May 2002 Closing Report for Strategic Objective 3 (SO3) USAID stated that for the previous period, "VIGIA implemented a change in the anti-malaria drug policy, surveillance system and intrahospital infection control, and in the assessment of alternative tools to control malaria (intermittent dry irrigation and rapid tests)." They also highlighted development and implementation of the Health Intelligence Units[10] in 10 locations.

Phase 3 (2003-2008): Participatory Context and Decentralization

The third phase in VIGIA is marked by more open and horizontal relations within the MOH that continued generating consensus. Country regionalization and decentralization as State policy became very important topics during the presidencies of Alejandro Toledo (2001–2006) and Alan García (2006–present). The main processes driving the return to democracy were the "National Agreement,"[11] a national consultation on the fight against poverty, and decentralization. As stated previously in the Background section above, the decentralization process that began in 2003 highlighted the concerns of national, regional, and local stakeholders, all of whom had to redefine their roles within this new framework.

[10] The Health Intelligence Units were established in 1997 to integrate the various MOH information systems. The General Directorate of Epidemiology has a health intelligence executing directorate that coordinates with the various regions. Although implementation varies by region in accordance with decentralization the general functions include: situational analyses; outbreak control; consolidating and reporting surveillance information; and producing updated health statistics.

[11] The National Agreement was the process of an open multiparty and multisector forum that established democracy, equity, open competitiveness, and a transparent and decentralized state as central themes of the GOP reform process. This agreement provided the broader framework for decentralization of the health sector.

A new way of governing the project was formalized in September 2003 with the formation of a Board or Steering Committee consisting of six members: five Directors General (People's Health, Epidemiology, Drugs, Environmental Health, and the National Health Institute), and the Project Director; it was presided over by the Director General on People's Health. The National Health Institute (NHI) retained its administrative support role.

4. Financial Performance

The NHI is a financially autonomous body within the Peruvian government, a Public Decentralized Entity, or PDE. As such, it receives funds directly from the MEF, and administers and reports expenditures independent from the MOH. By November 20, 2008, VIGIA had implemented 97% of subobligated funds:

TABLE H.2 VIGIA PROJECT IMPLEMENTATION, 1998–2008 (IN US DOLLARS)

	Subobligated Amount	Amount Settled	Not Utilized	% Implemented
1998 Work Plan	$354,306.53	$304,424.67	$49,881.86	85.92%
1999 Work Plan	$1.234,049.00	$1,283,570.74	–$49,521.74	104.01%
2000 Work Plan	$1,531,488.00	$1,531,488.11	–$0.11	100.00%
2001 Work Plan	$1,125.033.76	$1,125,032.98	$0.78	100.00%
2002 Work Plan	$1,613.675.00	$1,613,675.19	–$0.19	100.00%
2003 Work Plan	$1,297.749.23	$1,299,520.47	–$1,771.24	100.14%
2004 Work Plan	$1,232.564.40	$1,232,564.40	$0.00	100.00%
2005 Work Plan	$1,233.160.00	$1,197,159.56	$36,000.44	97.08%
2006 Work Plan	$1,012.330.50	$936,262.01	$76,068.49	92.49%
2007 Work Plan	$1,243.396.79	$1,185,287.91	$58,108.88	95.33%
2008 Work Plan	$742.270.40	$529,018.71	$213,251.69	71.27%
Total 1998-2008	**$12,620,023.61**	**$12,238,004.75**	**$382,018.86**	**96.97%**

Source: USAID

It is worth mentioning, however, that execution is based on the readjusted, subobligated amount and not on the amount originally approved (US$18.8 million). According to the Final Project Report, VIGIA implemented 63% of the resources, with percentages varying between 59 and 74% from one year to the next. The reason for this difference, as explained by the VIGIA steering staff, is the under-implementation year after year attributable to the slow remittance process at the NHI. Another interviewee expressed it the following way: *"Problems were a constant with NHI. Constant disbursement problems weakened performance."*

5. Funds Flow

According to the Peruvian budgetary structure, Public Decentralized Entities (PDE) enjoy the highest administrative level and autonomy in terms of budget management. Therefore, assigning operations to a PDE was an important first step. From an administrative perspective, VIGIA performed three types of activities: technical assistance recruitment, procurement of goods (equipment and materials), and procurement of services (consultants, various services). The whole procurement process from selection of vendors to reception of goods/services and payment

was carried out under Peruvian regulations and standards. Whereas the NHI status as a PDE allowed it to be slightly more efficient in financial execution than the MOH, it was still not seen by interviewees and the assessment team as nearly as efficient in remittances and re-imbursements as external project management units.

Resources committed by USAID in the Agreement were subobligated in annual amounts and included in the corresponding Operational Plan. In essence, USAID operated by advancing funds on a monthly basis and settlements to NHI. NHI would then channel the funds to DIRESAs as Remittances. DIRESAs agreed to this Operational Plan because it allowed more flexibility than ordinary transfer of funds through the Public Budget, as it was not subject to, for example, verifications of the Integrated Financial Administrative System. Nonetheless, coordination problems between the technical person responsible for activities and the Administrative Unit generated delays in the accountability of remittances. This, in turn, forced VIGIA/NHI to "expedite" said accountability and settle the funds provided in advance by USAID.

6. Summary

Implementation of VIGIA was done in the context of three distinct periods of socio-political changes or "phases" which affected the project organization. The first phase was in the context of a vertical environment that focused on Director-based management. The second was a time of uncertainty, reflected by the slowing down of project implementation. Third was a participatory phase represented by the Managing Board. Phases 1 and 3 were periods of successful management and operations; Phase 2 was a moment of crisis with slow implementation and the imminent risk of project cancellation.

B. Methodology

Twenty in-depth interviews with key informants were conducted. Special care was taken to seek documentary (direct observation of printed documents) and physical evidence (personal visits to the Regional Reference Laboratories equipped by VIGIA to verify in situ the presence of equipment provided by the project). In Iquitos we visited the Level III Laboratory built by the project. Interviewees included the Executive Director of MOH International Cooperation, former VIGIA Project Director, DIRESA officers (Directors General and executive staff) of venues visited, personnel responsible for Regional Reference Laboratories, and DIRESA administrative area staff.

Two additional meetings took place with USAID personnel for an in-depth analysis of technical (Dr. Jaime Chang) and financial (Mrs. Nelly Ríos) aspects of the project. Lastly, after the regional visits, the team held internal meetings to consolidate and systematize findings. Findings were then presented and further discussed with MOH staff, many of who accompanied the team on its visits.

C. Findings

The subsections that follow summarize the outstanding achievements of the VIGIA Project as described by interviewees with regard to health policy, organization and management, technical innovations, training, and methodology. Other sources of information came from document reviews and observation of physical evidence (facilities and equipment) during site visits.

1. VIGIA: Contributions to Health Sector in Peru

Interviewees believe the following were the most important contributions by VIGIA to the health sector in Peru:

- Evidence-based decision-making mindset; as indicated by
  - Health System Assessment methodology (ASIS)
  - Change of treatment protocol for malaria
  - Validation of the highly active anti-retroviral therapy (TARGA/HAART)

Although the first contribution listed, the ASIS is a 1996 document created prior to VIGIA, the project standardized the methodology and provided nation-wide training of the same. ASIS provided a uniform methodology that allowed MOH and the regions to draft plans based on the epidemiological profile, on health indicator analyses, and on the social response to health problems. Once disseminated, it became an essential component of operational and strategic plans generated in MOH, the regions, and local levels (networks and micronetworks). For example, the Arequipa Health Directorate webpage allows for browsing of ASIS 2001–2008.

Certain specific decisions were made based on evidence generated by VIGIA. One of the two mentioned in the interviews was the change of the treatment protocol for malaria. VIGIA provided support for the study of antimalarial resistance, which led to nationwide adoption of a new antimalarial treatment regimen (Neyra et al., 2003). Something similar happened with HAART, where VIGIA financed therapy follow-up and technical support in the drafting of standardized technical documents for the Health Strategy for Prevention and Control of STDs, HIV/AIDS, and the HAART manual.

- Organization and management:
  - Health intelligence proposal
  - Directorate responsible for management

An element interfering with good health management was the isolation of those who generated information from the end uses, i.e., Epidemiology, Statistics, and Planning. Until 1997 Epidemiology basically performed epidemiological surveillance, as stated in the VIGIA Baseline Report. On the other hand, by 1996 DIRESA San Martín had experience integrating Statistics and Laboratory information. It is upon this base that between 1999 and 2000 the project helped the MOH Epidemiology Office (OGE) create Health Intelligence Units in ten DIRESAs.

Another important element was the implementation of a Directorate to allow MOH Directors General working closely with the project to make decisions such as selecting activities to be included in the work plan and approving and implementing the annual Project Operational Plan. One of the more important changes in the 2003 amendement was to make the Directors General co-responsible for implementing activities included in the work plan. This further corroborated the feasibility of a new management model with the international cooperation of MOH.

- Technical contributions:
  - Intermittent dry irrigation as a malaria-fighting strategy
  - Change in the malaria treatment scheme
  - Use of malaria quick tests
  - Work done on intrahospital infections (IHI)

- Work on rational use of medicines

Intermittent dry irrigation was one of VIGIA's most significant technical contributions because it linked the productive sector in northern Peru to malaria vector control. Combined with the above-mentioned change in treatment, the introduction of rapid tests in remote areas by health promoters (Peruvian Amazon), it can be seen that VIGIA heavily influenced malaria treatment and control in Peru. Furthermore, through the USAID-supported Amazon Malaria Initiative, processes begun in Peru influenced the approach to malaria throughout the region.

Another pioneering area was IHI and the subsequent rational use of medicines approach. In the words of an interviewee: *"Before VIGIA everything focused on mother-child care; nothing was done with regard to intrahospital infections."*

VIGIA contributed to the generation of technical documents and personnel training on key preventive measures—hand washing, aseptic techniques, and isolation—and in the creation of model units to be used for hands-on training and demonstration.

- Training and methodology:
  - The Field Epidemiology Specialization Program (FESP)
  - INTERFASE application (Piura)[12]
  - Curricula modification (San Martin)

One of the greatest achievements in this regard is the Field Epidemiology Specialization Program (FESP). The program started in 1989 with sponsorship from USAID and with training support by Peruana Cayetano Heredia University (UPCH) following the US Centers for Disease Control and Prevention (CDC) Field Epidemiology Training Program model. After the first two rounds of training (1990–92 and 1993–95) the program based on this model had trained 39 field epidemiologists, which was an insufficient number to cover the country's needs. In 1997 a new training model was formulated based on different levels of training in accordance with the role that the trainee was expected to play in the health system, including (1) micro-networks; (2) health districts; (3) the DIRESA and national level; and (4) professional specialists. A major contribution of the new VIGIA-supported model was the close collaboration with the General Office for Epidemiology (OGE) to strengthen the National Epidemiology Network (RENACE)[13] which required larger numbers of persons at the primary level with less complex skill sets. The training was designed as a four-stage system of progressive certification where students with the best performance would pass to the next level:

- Stage 1 began with 850 professionals from the health services micronetworks.
- Stage 2 admitted 350 professionals to work in the health district offices.
- Stage 3 trained 96 professionals to work at the regional and national levels.
- Stage 4 trained 55 professionals who graduated as Field Epidemiology Specialists.

[12] The INTERFASE software application was developed in the Piura Region to extract information from the MOH's Health Information System (HIS), according to Ministry requests for indicators not found in the HIS reports. Before INTERFASE, DIRESAs resolved this manually or by creating parallel forms. Staff in the Piura Region designed the INTERFASE application to group different routines extract information from the HIS database, generating reports as requested by different MOH health strategies.

[13] RENACE is conducted by the OGE and consists of approximately 6,500 reporting sites primarily from the MOH but also including the Social Security Institute. Among other things, it collects and reports on notifiable diseases. It also holds annual meetings for sharing of experiences and improving the system.

Thus, at the end of the VIGIA-supported process, Peru had a total of 94 epidemiology experts, 240% more than at the beginning. Moreover, close to 800 professionals concluded one of the initial training phases and became effective participants in RENACE. Another key element of the model was its multi-professional process: 16 out of the 55 epidemiology specialists were nurses. This achievement validated the concept of a specialization open to professionals from different fields.

FESP trainees received practical training to develop competencies for practical performance. Since all the trained staff are part of RENACE, the training strengthened the organization. In fact, FESP provided health team members with technical assurance and pride, as expressed by one interviewee: *"We work well. We have an FESP in our team!"*

FESP, unlike other training—and even teaching—processes, is part of a system that welcomes trainees and assigns them specific tasks within a clear institutional structure: the General OE and RENACE. OGE participation facilitates their incorporation into a professional specialty system. This four-stage model is no longer functioning, although there are currently master's-level programs at the National University of San Marcos and the Peruano Cayetano Heredia University, each with a capacity of 20 students per year.

Other relevant contributions still in effect include the INTERFASE application and curricular modification (it involves the incorporation of health topics, e.g., dengue, as practical content areas into the regular school academic curriculum, such as math or reading).

The INTERFASE application was developed in the Piura Region in response to stressful service situations. Everyone entered his or her information in the Health Information System (HIS) sheets, but Ministry programs requested reports that required indicators not found in the HIS reports. This was resolved manually or by creating parallel forms. Because of this problem, staff in the Piura Region designed INTERFASE, an application that groups routines and that works on the HIS databases, generating reports as requested by different MOH health units. VIGIA identified it as innovative, helped improve it, and disseminated it by sponsoring exchange workshops, which extended INTERFASE to other regions.

Likewise, the San Martín Region developed a curricular modification methodology to integrate health content, such as dengue, into the schools' academic curriculum. VIGIA identified the value of the curriculum modification approach and sponsored information- sharing workshops, which took the methodology to other regions and adapted it to other topics.

A further contribution of VIGIA was the elevation, in the context of the epidemiologic transition, of the status of emerging and reemerging diseases within the Peruvian health system. *"Before VIGIA, all projects focused on mother-child health. My personal opinion is that no support had ever made 'transmissible diseases' its focus, as VIGIA did."*

2. VIGIA: Quality and Usefulness of Materials and Training

It was unanimous that materials produced by VIGIA are high quality, with great content, friendly, easy to understand, based on local experience, and validated in the field. Materials mentioned most frequently by spontaneous recall were:

- Health Promoter Manual (malaria)
- Curricular modification materials for schools (dengue, HIV)
- Malaria Economic Assessment, Tuberculosis Economic Assessment
- Intrahospital Infection Prevention Manual.

VIGIA trainings were also described as very good. Some testimonies said:

"It was the best training I have ever participated in." (TBC laboratory operations staff)

"Excellent! This is what was needed right now."

"*VIGIA allowed DIRESA to make decisions."*

Recommendations for improvement included:

- Hold practical workshops for skill development.
- Hold workshops for experience sharing.

As interviewees said:"Participants from each region share problems or reasons why they are lagging behind and explain how they have managed to go forth."

3. VIGIA: Technical Assistance

VIGIA provided technical assistance to the MOH, both through outside contractors and from its in-house technical team. The latter frequently supported staff from the general and regional directorates and especially colleagues working on the National Sanitary Strategies. In the later years of the VIGIA project this in-house TA component gained importance relative to hired contractors.

Support also included technical assistance coordinated with General or Regional Directorates, as required (as long as it was included in the Project Operational Plan) and approved by the Directorate. In compliance with national legislation, recruitment had to be included in the NHI Annual Recruitment and Procurement Plan. Once approved and scheduled, bids for service procurement were sent in accordance with the reference amount, as required by the Ordered Unique Text of the State Contracting and Procurement Act, Presidential Decree No. 083-2004-PCM.

This requirement meant that potential technical assistance professionals had to be registered beforehand in the National Vendor Registry and had to be free of penalties or limitations to participate in bids with the Peruvian government. Payment method—due to the amount—was direct award (three potential vendors) or direct award for smaller amounts (one candidate is sufficient as long as he/she meets technical demands and reference amount).

DIRESA and MOH Directorates were of the opinion that the technical assistance provided by VIGIA was of high quality, efficient, and appropriate. Timeliness was most appreciated in some areas, such as nosocomial infections, where VIGIA pioneered the work in the country, and the support to the ASIS methodology, which came at moments of perceived urgent need. However, several consultants stated that since GAO-NHI management required strict compliance with GOP regulations, there were frequent delays (awarding of technical assistance, honorarium approval, or payment) and malaise. The consultants felt that they had to adhere to strict product delivery schedules although their payment schedules were not as strict.

4. VIGIA: Contribution to Sustainability

Of all the efforts undertaken, the following are still in use today (as expressly stated by interviewees):

- Use of immunofluorescence microscopes in regional laboratories
- Use of tetraocular microscopes in regional laboratories for training purposes

- Malaria: policy for "intermittent dry irrigation" (a Regional Presidential Resolution in Lambayeque, northern Peru, declares this is of regional interest)
- Curriculum modification against dengue (presently being used to fight AH1N1 influenza)
- IHI tools (e.g., IHI Epidemiological Surveillance System)
- Rational Use of Medicines Manual

The team verified in hospital visits that prevention and control activities against IHI continue. The biologist responsible for the activity in the Iquitos Regional Hospital routinely uses the reports each time he is at the hospital. The Quality Control Department head in the Loreto Regional Hospital confirmed that one of her priorities is to coordinate IHI prevention activities in the hospital.

5. VIGIA: Professional Development of Staff and Influences on the Project

In general terms, interviewees believe the project played an important role in their personal development, as it opened employment or research doors for them: *"It was the right time to help me see potential new options."*

In San Martín, an interviewee said: "The 'San Martín Myth' was thus born: young people with a dream who had the power and technical capability to make it happen. And people believed."[14] San Martin continued to play an important two-way role in that its experience influenced the project and as a laboratory for VIGIA innovations. It continues to be a leader to this day.

6. VIGIA: Decentralization

VIGIA activities, by their nature, supported decentralized implementation. The INTERFASE software, the FESP training, and many other interventions described above empowered regional and local health workers to undertake their work autonomously, without receiving direct orders from the central level.

In terms of the formal government decentralization process, interviewees felt that it had little direct impact on their work. Many regions and interviewees were unaware of changes in their activities before and after decentralization, except in resource reduction, which has impacted activities such as supervision. In some cases, the impact has been drastic, as in the case of San Martín, where the Regional Directorate for Medicines, Supplies and Drugs (DIREMID) is being eliminated and its roles are being reassigned to other entities.

Current resource restriction—or the perception thereof, as compared to those available for these activities when VIGIA was in operation—is currently affecting job quality in some areas. Two out of three regional laboratories complained they could not purchase supplies or reagents because the Regional Government had cut their budgets short saying "they are not profitable" and "do not generate revenues." Thus, when performing sputum smears, they had to wash the slides instead of using new ones, as the standard requires.

Another problem with decentralization is the lack of clarification for certain key aspects in defining a new relationship between national and regional responsibility entities. For example, the Biosafety Level III laboratory built by VIGIA in Iquitos is still not operating, although

[14] In the 1990s, San Martín was considered a highly innovative region. A team of young professionals came together; they all had high technical capabilities and were enthusiastic about making a difference. This attracted various projects to support the San Martín region. It was considered among the Pilot Regions for the Health Reform of the 1990s. When VIGIA was created, its Director was the former Director General of the San Martin DIRESA, as was the Deputy Director (who became Director in 2002), and their experience in San Martin influenced the project's direction.

construction ended two years ago. The Loreto DIRESA stated they had no information whatsoever on that laboratory—which they considered part of the "IH and not related to the DIRESA"—while the regional reference laboratory (Biosafety Level II) is in precarious conditions.

Most of those who received training for the new roles resulting from decentralization stated they had received said training from several different stakeholders (USAID Project HS 20/20, MOH, the Cabinet [PCM], regional government, and the Ministries of Economy and Finance). However, staff at operative level said some of these trainings tend to be biased to favor officers and never reached line personnel.

To ease the transition to decentralization, the informants recommended that specialized personnel be trained on project formulation and management. Another suggestion stated that entities such as MOH and others need to provide more autonomy for the regions.

7. VIGIA: Future Direction

The following were identified as areas to consider for future planning:

- Support for work on infectious diseases:
  - Reinforce work being done with IHI.
  - Reinforce work being done with TB, especially when interacting with HIV.
  - Support work on leptospirosis.
- Communication strategies
- Stronger links with training organizations, using the FESP experience as a model for developing technical careers or specializations and not depending only on stand-alone training events
- Fostering plans for equipment maintenance
- Perhaps not fractionating counterpart funds (the molecular biology equipment VIGIA provided could not be used in San Martín, since part of it had to be purchased with counterpart funds and this never took place)
- Greater logistic support for malaria (rapid test kits)

D. CONCLUSIONS

Key factors in VIGIA's success include:

1. It was an organization in which the project is subordinate to guidance and direction by the MOH. The Directorate is proof of this. Although all the phases previously described did in fact take place, the common denominator was MOH's organizational and political context.
2. MOH-USAID teamwork: the MOH, USAID/Peru and VIGIA representatives highlighted the importance of teamwork; this began by choosing knowledgeable technical experts. All of them had previous experience in the MOH or in DIRESA and became part of a well consolidated team. The MOH knew it had the support of USAID; even though USAID had to approve its proposals, it was merely procedural, for communication flowed easily between them. USAID is to be congratulated for maintaining this fluidity of communication.
3. Creation of a professional team which took ownership of the project: For FESP, although training for field epidemiology specialists began before VIGIA, the project contributed with the third C\class and with the initiatives that provided support to this group. These efforts

contributed significantly to evidence-based public health information-generation routines and links between and the information generation and management (ASIS methodology, sanitary intelligence).

4. Creation of evolving concepts: Health Intelligence is a good example of this. The original version suggested joining Statistics and Information Systems with Epidemiology and Planning in order to make planning and management decisions based on statistical and epidemiological evidence. Even though this proposal has evolved (in San Martín, Statistics and Epidemiology work together; in Cusco, the Health Intelligence Directorate has linked Statistics, Epidemiology and National Defense, but not Planning), the core concept has been maintained: management must be evidence-based. However, in terms of evolving concepts, it is acceptable if different regions adapt and design their own structure.

5. Multidisciplinary focus and links to the private sector: Intermittent dry irrigation (as a proposal to combat malaria) and curricular modification (applied by VIGIA in the specific case of dengue) proved that multidisciplinary focuses on health problems and their relation to the private sector were key elements for sustainability and ownership of healthy policies by other stakeholders.

6. Success-based identification and expansion: Curricular modification was not a VIGIA innovation. This proposal was incubated in the San Martín Region long before VIGIA. However, VIGIA had the clarity to pinpoint its potential and showcase it in other regions. Something similar happened with applications developed by other regions, e.g., INTERFASE (developed in Piura, it optimizes HIS reports allowing health strategies to utilize the reports created). VIGIA organized internships that disseminated its use to other regions. It is presently being used in San Martín.

7. Management by an implementing entity other than GAO-MOH, by means of remittances. Interviewees agreed that GAO-NHI implementation was an advantage that allowed for swifter implementation compared to GAO-MOH.

Some challenges and considerations for the future:

1. Decentralization: VIGIA Directors were part of MOH and the regions were under the impression that often "Everything came from Lima." This perception merits review under the current concept of regionalization.

2. Greater coordination between training entities: Despite its success, neither FESP nor the FESP model (certification by levels, multiprofessional specialization) have been adopted by any university.

3. Greater dissemination of progress made: Articles printed in the *Peruvian Journal of Experimental Medicine and Public Health* have been a success, but many consulting experiences and technical documents have yet to be disseminated.

4. More emphasis on administrative personnel: DIRESA administrative staff participating in VIGIA said they had not received any training for those tasks.

5. Distinction between Management and Directorate: Although GAO-NHI management was better than GAO-MOH, it did encounter some small problems (delay in remittances) and some large problems (role mix-up between NHI-Director and NHI-Manager). Several persons stated that even though MOH leads by means of a strong and empowered Directorate, management should be outsourced.

6. Risk of keeping a low profile: VIGIA management through a Directorate with strong MOH presence meant in several cases that regional health personnel were not aware of the origin of funds; credit sometimes was simply attributed to the MOH.

Centralization still strong: Despite having received radio equipment and computers that can transmit data, DIREMIDs only communicate with DIGEMID, and reference laboratories only communicate with NHI. There is no horizontal communication between regions or with similar entities.

E. Assessment Team Recommendations

Key Success Factor Strengthening

1. Project management via Directorates: When reviewing the whole scenario, this is one of the most important factors the team identified for effective management. The team recommends that USAID consider adopting it as a project management strategy.

2. Extended training processes for teams: FESP experience suggests that training processes where trainees take ownership of the specialty area for their professional development is a good strategy. This benefit is maximized when training is provided over an extended period of time, facilitating bonding between the participants. Scholarships, on the other hand, do provide training, but their output is isolated. The team recommends that USAID consider further promoting this long-term training and support model.

3. Sustain certain key activity lines of action (e.g., malaria, FESP) over time to ensure that they continue to develop and evolve in order to achieve meaningful results and contribute to overall improvement of the health system in the long run. The team recommends that USAID consider incorporating transition plans for these key activities and processes so as to not lose momentum in furthering their evolution.

4. Adopt other stakeholders' sensible practices: The intermittent dry irrigation experience to fight malaria, curricular modification, and INTERFASE merit further dissemination. In addition to wanting other stakeholders to adopt USAID project methodologies, the team recommends that USAID continue to seek and adopt successful other-party innovations as per these examples. Processes in evolution, such as the last two mentioned in the previous sentence, demonstrate ownership by the MOH and the regions, and the team recommends that USAID place emphasis on further identifying and encouraging these processes to enhance project sustainability.

5. The assessment team recommends that USAID consider project management by an implementing entity other than GAO-MOH, via remittances. Future project management should be done through implementing agencies other than GAO-MOH, MOH, or PDE. Outsourced management should not pose a threat to an empowered MOH.

On future challenges and tasks:

1. Decentralization: VIGIA Directorate members were part of MOH. In the new regionalized scenario, the team recommends that project directorates incorporate DIRESA Directors from participating regions with subdirectorates within the regions to further promote decentralization.

2. Greater participation of training entities: The team recommends that USAID promote the possibility of FESP becoming a regular program provided by several public or private universities in Lima and the regions, ensuring OGE leadership and direction of the programs. This model can also be used to professionalize other areas.

3. Greater dissemination of progress made: All VIGIA—and future project—material needs to be disseminated. Professional groups and other stakeholders (universities, NGOs, and research institutes) should be encouraged to use these materials. An example is sponsoring software to randomly measure the impact of publications (impact of Peruvian scientific materials within the country). Those institutions that have publications in the projects receive an acknowledgement from a well-recognized entity, such as MOH or the Peruvian Association of Medical Schools (ASPEFAM).

4. Differentiate Management from Directorate: If project management is done through a public implementing entity, the team recommends a PDE that is not part of the Directorate. This will help avoid role confusions (i.e., role confusion in VIGIA between NHI-Director and NHI-Manager).

5. Foster interregional cooperation: VIGIA's experience on the relationship between peer Directorates in the region shows inertia in centralization. A strategy that VIGIA has proven to be powerful is interregional cooperation. This cooperation was provided by the project, as in the case of INTERFASE, where Piura personnel traveled to other regions to give training or received interns. Other regions adopted INTERFASE, generated their own applications, and disseminated them, as was the case in San Martín.

COVERAGE WITH QUALITY (CwQ)

A. Background

The Coverage with Quality (CwQ) project was carried out in Peru under a limited scope grant agreement between the Government of Peru and USAID. CwQ was designed to strengthen the MOH to be able to respond to the family planning needs of the Peruvian population in a very complex health care setting with high rates of maternal mortality due to multiple social, economic, cultural, and health factors in a country with a generally weak health care system.

CwQ implementation was closely coordinated between USAID and the MOH, in that the changes, adjustments, and clarifications that occurred were the result of analysis and concurrence on the decisions. It supported Peru's compliance with its earlier international commitments, such as the 1987 Safe Motherhood Initiative from UNICEF, WHO, and UNPFA and the 1994 International Conference on Population and Development in Cairo, proposing reproductive health as the central axis of the project. Likewise, changes in the Ministry of Health since 2001, in which the National Programs converted into Health Strategies, implied broadening the objectives and activities in maternal-perinatal health through a comprehensive care approach, and finally a continuous quality improvement (CQI) approach, with emphasis on the quality of care in maternal and perinatal services.

The scope of CwQ was nationwide in its initial years of implementation (1996–2002), it then concentrated its intervention in the seven (later expanded to nine) selected regions: Ucayali, San Martín, Huánuco, Huancavelica, Ayacucho, Cuzco, Junín, Pasco, Piura and Sullana, involving a variety of healthcare facilities, including posts, centers, and hospitals.

The grant agreement was signed in September 1996, with activities beginning in May 1997 and ending in December 2007. The agreement was amended eight times, permitting the extension of the life of the project and of the financial implementation beyond the initially contemplated five year period.

The technical approach can be grouped into four phases.

First Phase: 1997–99

The aim was to improve the quality of family planning services, expanding the supply of public sector health services and promoting the use of different methods of family planning. Technical assistance sought to inform and motivate Ministry of Health personnel to achieve improved performance in their health care services. It sought to develop technical documents and logistics to enable the Ministry to assume responsibility for the procurement of contraceptives and at the same time to train human resources in all health regions of the country. There was a clear emphasis on the objective of making all family planning methods available.

It succeeded in training human resources in all the health regions. It contributed to the elaboration and distribution of a *Family Planning Manual* along with brochures, manuals, and guidelines for family planning that are easily understood by health providers and by public health service users. The process of transferring to the GOP the provision of contraceptive methods began in 1998 and culminated in 2003.

Second Phase: 1999–2000

The strategic objectives of CwQ incorporated the concepts discussed in the Cairo conference, with the family planning services being immersed in a broader concept of sexual and reproductive health, including adolescent health, cervical cancer, and HIV/AIDS, among others.

As a result, the Standards for Family Planning and their implementation were revised, with particular emphasis on service quality and maximizing information for users to ensure their freedom to choose among contraceptive methods. Special emphasis was placed on community participation as a mechanism to strengthen reproductive health services and ensure their use by the citizens with complete knowledge and freedom to exercise their rights in family planning. Sensitization workshops and training were held for providers of all family planning methods, as well as counseling on reproductive health and family planning.

Third phase: 2001–2002

During these years, there was particular concern for safe and healthy maternity. The objectives were aimed at reducing maternal mortality through improved health services at different levels for both individual and group care, considering health promotion to be a basic element of reducing maternal mortality.

Thus, regional plans to reduce maternal and perinatal mortality were developed, along with technical and administrative standards for quality management, with an emphasis on a safe maternity. Also developed and disseminated were technical standards on safe maternity, including essential obstetric care (EOC) for high-risk pregnancies and complications, including family planning, prenatal care, and safe delivery. Changes were made to the contraceptive donations (OCs and IUDs) by USAID.

Fourth Phase: 2003–07

The objectives of CwQ were aimed at improving maternal and perinatal health services through the design and implementation of comprehensive care models, with an emphasis on the quality of care and support for accreditation and the promotion of health, with wider and more equitable and decentralized coverage. Training for health professionals was aimed at a comprehensive improvement of medical services in gynecology, obstetrics, and neonatology. The project also succeeded in promoting pre-delivery “waiting houses” for pregnant women from rural areas as a means of promoting institutional deliveries and thus reducing maternal mortality.

Similarly, the Ministry of Health implemented the process of accreditation of healthcare facilities and medical support services. Technical assistance also supported the training of professionals in the prioritized regions, while designing, elaborating, publishing, and disseminating technical materials and documents nationwide.

From the administrative standpoint, CwQ went through three stages that were independent of the technical phases described above:

First stage: 1996–2001

The funds of CwQ were administered by the Special Projects Unit of Project 2000 (UEP), which had its own administrative team separate from the MOH. USAID transferred funds, with the UEP expediting transfers and liquidating accounts, which made for efficient project implementation.

Second Stage: 2002–05

CwQ funds were administered by the Program for Administration of Management Support (PAAG) of the MOH, with a procedure similar to that of the UEP, permitting the project to continue execution in accordance with existing operational plans.

Third Stage: 2006–2007

Once the PAAG was deactivated, project funds were administered by the General Administration Office (GAO) of the MOH, which conducted administrative management according to established procedures. Fortunately, the person responsible for CwQ in the PAAG went to the GAO, thus maintaining some institutional continuity and fluidity.

TABLE H.3. FUNDS APPROVED AND IMPLEMENTED DURING THE CWQ PROJECT (IN US DOLLARS)

Project Component	USAID Approved	Implemented	Balance	Peruvian government
1. Short-term technical assistance	159,920	161,335	6,988	130,000
2. Medium-term advisory services	741,520	734,532	–1,415	112,000
3. Educational materials	552,238	521,395	13,929	200,000
4. Training in services	2,400,008	2,386,079	30,841	1,200,000
5. Equipment and supplies	1,941,865	1,786,848	155,017	0
6. Supervision of monitoring and evaluation	526,957	413,982	112,975	1,700,000
7. Audits	27,494	18,363	9,131	150,000
8.Contingencies	0	0		0
Not requested			141,137	
TOTAL	6,350,000	6,022,534	327,466	3,492,000

In summary, CwQ accompanied the MOH through a long process that began with institutional strengthening to improve family planning services, then moved on to incorporate concepts of

reproductive health. comprehensive health care. and continuous quality improvement of care within a process of accreditation of healthcare facilities.

CwQ achievements include the contribution to the Ministry of Health to establish logistics mechanisms for the procurement of contraceptives; technical assistance via information, education, and human resource training nationwide, including the priority areas of family planning and reproductive health; support and promotion of pre-delivery waiting houses; the perinatal information system; and the promotion of comprehensive health care and the continuous quality improvement of health services.

In terms of administration, CwQ also participated in the development of a public system of resource management, the principal support being the donation of computers. Similarly, since the creation of the Health Quality Directorate in May 2004, the project supported the dissemination of technical health standards related to quality services and the accreditation of healthcare facilities and medical support services. It also coordinated with technical teams and teams of experts.

During the life of CwQ 95% of the funds originally authorized and subobligated by USAID were executed. However, this high rate of financial execution was due to the fact that the project was extended to ten years (five years more than the originally contemplated period of five years).

B. Methodology

The general methodology followed in assessing the CwQ project was similar to that used for the other two projects. Specifically, the regions of San Martín, Ucayali, and Ayacucho were visited, where personnel from the DIRESAs, healthcare facilities, and pre-delivery waiting houses were interviewed. Twenty-six interviews were carried out, of which eight were people from the community. With respect to pre-delivery waiting houses, managers, technicians, health promoters, and users were interviewed, together with their partners, when they were present.

During the interviews with key informants, 10 cover pages of materials printed and disseminated by the project were shown. They were asked whether the materials were recognized, if they had copies that they could show and if they knew whether the publication was still used. In the Ministry of Health, meetings were held with two people who were responsible for project implementation in the regions of Junín and Piura, and this information was then contrasted with that obtained during visits to the regions. Interviews were also held with other persons who knew of, or had links with, the CwQ project, including UNICEF and the former Director of Personal Health in the MOH during the critical period of 2000 to 2003.

Extensive discussions were held within the assessment team and during two meetings with members of the MOH extended team that also went on visits to regions in order to validate the findings. Dr. Lucy López, who was USAID/Peru coordinator during the entire life of the project, provided much valuable information. A variety of technical and administrative aspects were also reviewed with Dr. Luis Seminario and Carmela Sarmiento.

C. FINDINGS

Visits to Regions

Most of those interviewed knew of the existence of the project, and all the authorities knew of it. However, young professionals currently working in outlying facilities did not know of it, or in some cases had little notion of what it was:.*"When I was in the university, they spoke much of coverage with quality, but I need more since I finished; I have been working here for a year and nobody says anything."*

Many trained personnel, particularly at the primary level, were no longer working in healthcare facilities where they were trained. However, there were also some exceptions of people who had been working more than 10 years

Educational materials, mainly on health promotion and sexual and reproductive health, were available in very small quantities in the DIRESAs. No materials were found the outlying healthcare facilities. They tried to explain this situation by saying, *"As one never knows where he will go, it's better to leave with the booklets because who knows, they may be useful later on."*

This comment illustrates the employment instability and uncertainty of healthcare personnel and explains the absence of materials and guidelines in healthcare facilities.

Equipment and supplies donated by the project were found in the outlying healthcare facilities, mostly in good condition and in full use, for example, episiotomy equipment, minor surgery tool kits, blood pressure gauges, and thermometers. For some workers, this is a very concrete and valuable help: *"These little things help us give proper care. People feel good, and we do too."*

The usefulness of the ambulance donated by the project to the Curimaná health post in the Region of Ucayali was noted, with its monthly reports showing an average of more than 20 patients transferred to the regional hospital each month.

Finally, several informants in hospital quality improvement units mentioned that a patient-satisfaction/organizational-climate software package that they had used in 2004 (SEEUS) was appreciated, but that they could not continue to use it because it was tied to a proprietary system (SPSS) and annual licenses were too expensive. Ten SPSS licenses were purchased by the CwQ project but were not renewed when the project ended.

Training

All those interviewed referred to the large number of courses, workshops, technical sessions, and meetings held at the local, regional, macroregional and national levels for personnel at all levels. For example, during the first phase of the project, about 2,000 primary care professionals were trained in sexual and reproductive health counseling, with an emphasis on family planning methods, and over 1,000 were trained in the comprehensive health care model, with an emphasis on maternal and newborn care. During the last two years of the project, over 1,000 healthcare professionals were trained in maternal and perinatal quality standards and indicators and in the implementation of technical standards of accreditation of healthcare facilities and continuous improvement of organizational quality and climate.

Those interviewed also agreed on the high quality of the training, reporting that the instructors were very knowledgeable of the topics presented. The interviews revealed that the training process involved the technical managers of all the country's DIRESAs in family planning, sexual and reproductive health, comprehensive healthcare, healthcare facility accreditation, and the process of continuous quality improvement. The training for personnel of outlying facilities was very important, as they usually were not considered for such courses. It was thus a motivating element, and many interviewees expressed their appreciation to USAID for this support: *"This project has helped me professionally and especially personally. I was one person before and another after the project."* However, there was no systematic documentation of improvements in knowledge and performance through the training.

Educational and Support Materials

CwQ contributed to the printing and dissemination of many documents, brochures, posters, charts, clinical histories, guidelines, handbooks, and technical standards (Appendix H). These materials had two purposes: (1) training of personnel; and (2) program implementation. In addition, some regions have elaborated their own training materials from within their own health directorates and in other cases in coordination with universities. However, at present there is an

almost total absence of educational materials (flip charts, leaflets, pamphlets) in healthcare facilities and for community education programs.

Those interviewed recognized the covers of the materials according to their specialty and profession. For example, facility doctors and nurses recognized the "Practical Clinical Guides for the Care of Diarrhea and Respiratory Diseases," while those responsible for quality recognized "Institutional Accreditation," "Quality Standards and Indicators," "Quality Management System in Health," the *Handbook for the Continuous Quality Improvement,* and the "Methodology and Plan for the Study of Organizational Climate." The materials that had a Ministerial Resolution for their publication are still in use and are available on the Ministry of Health website. This is not the case with the occasional publications such as "So Close ... So Far," which looked at successful experiences in institutional delivery and was not recognized by anyone.

Equipment

Appendix E shows how the project contributed to equipping f outlying healthcare facilities, such as episiotomy equipment, minor surgery instrument kits, blood pressure gauges and thermometers, among others, mainly for perinatal maternal health.

Significantly, the 127 communication radios are still functioning in places with difficult communications, between the larger and smaller facilities, whether via land or river. For example, the visit of the team to Curimaná in San Martín department was notified by radio, since there is neither a landline nor a cellular phone in the village. In the regions of San Martín, Ucayali, and Ayacucho, which were visited, the radios were in use.

The computers purchased by the project to strengthen the quality information system of the National Health Information System are operational in San Martín, Ucayali, and Ayacucho, and are being used in the management of perinatal indicators and also in administrative matters.

Technical Assistance and Advisory Services

With support from the project, many advisory services and consultancies in strengthening health activities were carried out, especially in the regions and communities. Most of them were training, including the following:

- community participation
- community participation in reproductive health
- counseling in family planning
- guidance and counseling
- adult training
- self-analysis of skills
- training of facilitators
- training of health promoters in sexual and reproductive health
- social marketing of sexual and reproductive health
- counseling on bio-safety
- management of sexually transmitted diseases
- sexual and reproductive rights

- comprehensive health care
- care for women and children, maternal and perinatal health indicators and the perinatal information system
- health promotion
- management of quality tools
- continuous quality improvement projects
- continuous quality improvement
- organizational climate and information management methodology in the management of quality.

To initiate the process for providing consultancies, the MOH requested authorization from USAID to hire consultants for training or to develop a topic within the Annual Operating Plan. Usually the process was fast because the amounts involved were small. The hiring was carried out by the responsible parties in the MOH, who also monitored performance, thus reporting on the quality of the consultancies. In interviews the informants reaffirmed that the consultants were well qualified and that the training was well carried out. However, as mentioned above, there was no systematic documentation of the results of the training

The project contributed to the MOH through consultants in sexual and reproductive health, comprehensive care, and continuous quality improvement of maternal and perinatal care, among others. The consultants also participated in working sessions and technical discussions in each of the topics. A crucial stage was the technical support during changes of governments and ministers that occurred after 2000, a period that also saw deep changes in the project. Examples from this period were the deactivation of the call center that was established to answer user queries on topics of sexual and reproductive health and the deactivation of the Documentation Center.

Aspects of the project that were remembered by several persons interviewed were the impetus given to quality improvement, the evaluation of organizational climate and patient satisfaction, and the accreditation of facilities. The MOH still uses the indicators for the accreditation of healthcare facilities, a process begun in the final years of the project but that slowed down at the end of the project.

Monitoring, Evaluation, and Supervision

With respect to monitoring and evaluation, those interviewed reported two means of monitoring the progress of the activities under the Annual Operating Plan developed by the General Health Directorate of the MOH:

- from national annual technical meetings, which yielded information on progress; and
- from the General Health Directorate or from Health Promotion, in coordination with the DIRESAs, for learning of progress in the Annual Operating Plan of each region.

In both cases the technical assistance, materials, training, and budget implementation items were reviewed. However, there were no pre- and post-test measures of results.

Respondents indicated that coordination meetings were held at the local and regional levels to verify skills and abilities in care for obstetrical and neonatal emergencies and to develop local projects that would improve the comprehensive care of women and newborn babies. In the final phase of the project, local proposals were sought to improve the quality of care, and it was reported that at the end of the project, there was more demand for such proposals.

In addition to the annual national meetings, the MOH supervisors conducted quarterly visits to the DIRESAs to verify progress in activities or to disseminate information. With the transition from vertical to integrated programs in 2002, supervisory visits were conducted by comprehensive and multidisciplinary teams. During supervision a control was carried out of compliance with goals and objectives set during the previous period, and activities were rescheduled for the following period.

Administration

As was noted above, the project had three financial administrators: the Special Unit of Project 2000, the PAAG, and the GAO. Informants indicated that the lack of continuity in the administration of funds and the limited knowledge of the projects by the new administrators (esp. GAO) hindered the flow of funds to regions and implementing units and the rendering of accounts to USAID.

The delay in the liquidation of accounts by the implementing agents caused delay in the delivery of new remittances. The major consequence of the untimely implementation of the funds was the extension of the project five years beyond the originally contemplated period, which resulted in the implementation of 95% of the obligated funds by the end of the extended period.

Regional administrators report that they felt marginalized from the implementation, and that they managed the activities without knowing what they were about: *"We started off with our engines cold, then they stressed us out by blaming us for the delays."* This resulted in dissatisfaction and hence a low level of motivation of administrative personnel: *"We had to stay up all night and were never acknowledged for this."*

The project contracted the services of PRISMA (an NGO with extensive logistics experience in other USAID projects) as an operator of logistics services for the delivery of contraceptives and educational and promotional materials. The deliveries were timely and efficient, according to the informants.

D. CONCLUSIONS

During its first phase, CwQ improved the quality of family planning services, achieving that (1) the population had greater access to all contraceptive methods and information sufficient to permit women to make a free choice regarding the use of family planning, and (2) health personnel could provide counseling on sexual and reproductive health.

CwQ delivered technical assistance and educational, training and administrative materials to outlying healthcare facilities in support of the decentralization process.

CwQ promoted and supported implementation of the pre-delivery waiting houses to reduce barriers to and facilitate care in institutional delivery for people living in rural areas far from healthcare facilities. During implementation, CwQ supported 10 waiting houses with training and some equipment, with the participation of civil society, NGOs, and local government authorities. The waiting houses concept supported by the project is now part of the National Strategic Plan for the Reduction of Maternal and Perinatal Mortality, with variations on the model being applied in different localities. According to MOH records, more than 300 of them are currently active.

The high turnover of staff, mainly in the outlying healthcare facilities, revealed the systemic lack of in-service training, which does not permit the maintenance of the necessary skills for quality care in these services.

CwQ improved the response capacity of the outlying healthcare facilities through the donation of radio communications equipment, basic medical equipment and supplies, and ambulances.

CwQ's impact on reducing the maternal mortality rate cannot be determined due to the absence of pre- and post-intervention evaluations and because there were many other factors and actors involved.

Much of the equipment and supplies were sent via a logistics operator that ensured the efficient delivery of products.

Results, Legacy and Lessons Learned

CwQ gave a boost to quality improvement in family planning and reproductive health in healthcare facilities through numerous courses and materials that reached over 4,000 people. It supported the creation of quality units in many facilities and promoted the accreditation of healthcare facilities. This support fed into the activities that USAID carried out through other major projects referred to in the Background section above, such as Health Policy Initiatives and Quality.

CwQ provided technical support for the implementation of first-rate facilities, which was of value in that it promoted: the work of the MOH, the regions, and professionals, and improved their personal esteem. This was achieved through the training of staff in their own healthcare facilities or in their regions.

The equipment and supplies donated by CwQ are still operational and improved the clinical care response capacity. The dissemination of educational materials for clinical and administrative use also contributed to improved services.

E. Assessment Team Recommendations

In order to implement the National Strategic Plan for the Reduction of Maternal and Perinatal Mortality in the framework of the SIS, the team recommends the further integration of maternal and child health services, from the pre-delivery waiting houses to the highly specialized centers, thus strengthening the role of the SIS as insurer.

The team recommends involving administrators in the design and implementation of new projects along with the technical experts and political authorities (regional and local governments).

Due to the high turnover of personnel, the team recommends in-service training as a permanent activity, along with knowledge-updating and healthcare training for personnel at all levels, with an emphasis on the outlying facilities. In this way, a Human Resources Policy that involves a competency-based National Health Training would be established so that professionals working in outlying healthcare facilities may work toward “a professional career” through education.

It is recommended that the experiences with continuous quality improvement and improvements in the workplace of the CwQ project be documented and disseminated as a practical example of how to foster problem-solving capacities and access in outlying areas. This requires conducting political advocacy with authorities from different sectors and different levels of decision making on health

The team recommends that USAID place further emphasis on monitoring, evaluation, and follow-up on projects, programs, and activities for greater efficiency in their implementation, in the use of human and financial resources, and in furthering sustainability over time. Ideally this would be collaboration with the MOH and the DIRESAs. The monitoring and evaluation should begin during the planning stage.

The team recommends that USAID systematize the lessons learned from the various experiences and models of the pre-delivery waiting houses, in conjunction with other stakeholders such as the MOH and UNICEF.

The team recommends the use of an efficient financial and logistical administration mechanism because many technical aspects are not achieved due to bureaucratic procedures or a lack of management familiarity with the project. The projects should include both administrative and technical health personnel at the various levels of complexity of health services in order to achieve a model of technical-administrative-financial integration, with the participation of administrative personnel starting with the project design.

The team recommends that USAID projects consider using only runtime packages or open-source software that do not require continuous licensing expenses.

IMPROVED HEALTH FOR POPULATIONS AT HIGH RISK (PAR)

A. Background

The health problems that afflict Peruvians require changes in health behaviors and lifestyles that would minimize the use of curative services in clinics and hospitals. The strategic settings chosen by the MOH Directorate General of Health Promotion (DGPROM) for activities with potential for improving health education and behavior are families, schools, communities, and health services. With this in mind a Strategic Objective Agreement (SOAG) was signed on September 30, 2003, between the Republic of Peru and the Government of the United States of America under the name "Improved Health for Populations at High-Risk." The scope of action includes the regions of Ucayali, San Martin, Junín, Cusco, Pasco, Ayacucho, and Huánuco.

Logical Framework

Strategic objective: Improve the health of high-risk populations.

Intermediate results:

- No 1. Quality Health Care Services Accessible and Utilized. Agency Responsible: Directorate General of Personal Health (DGSP).
- No. 2. The Population Uses Good Health Practices. Agency Responsible: Directorate General of Promotion of Health (DGPROM).
- No. 3. Health Sector Policies and Programs that Respond to Health Needs. Agency Responsible: the DGSP.

It must be noted that the initial agreement hoped to implement five components, with the goal of fortifying regional and local training in health promotion within the public health system. These components are:

1. Methodological development and instrumentation (procedures);
2. Advocacy and political consequences of health promotion projects;
3. Training of health personnel;
4. Development of pilots to evaluate methods and strategies; and
5. Monitoring and evaluation through a set of indicators for health promotion activities.

Phases

Both the MOH and USAID were given roles and responsibilities when the grant agreement (No. 527-0412) authorizing the PAR project was signed. The MOH's main responsibility was to appoint an Activities Director, whose main function was the preparation of work plans, the execution of those plans, and the preparation of annual budgets for each component of the agreement. The General Administration Office (GAO) managed the transfer of funds to each of

the regions involved in the execution of activities. The USAID total estimated contribution was set at $5,000,000. The agreement also specified that "the activity will be managed jointly by the MOH Activity Director and the USAID Activity Coordinator" and that short term technical assistance (TA) would be procured by the Mission with grant funds as needed.

After the agreement was signed in 2003, the directors of the DGSP and the DGPROM changed several times. Dr. Carlos Mansilla was in charge of the negotiation stage of the project; later Dr. Ricardo Bustamante was in charge of the development of activities; and finally the conclusion of the activities was under Dr. Elsa Mantilla.

USAID was responsible for assigning a part-time activity coordinator. Dr. Luis Seminario assumed this function. USAID was also responsible for providing continuous technical consultation through other agreements. To this end Dr. Nancy Fuk was hired through the USAID/ POLICY project to provide technical support to the Ministry of Health in the development and execution of the work plans as well as assisting in the budget area. Dr. Fuk was also responsible for reporting monthly to USAID regarding the progress of project activities. She occupied an office in the DGPROM.

TABLE H.4. CHRONOLOGY OF THE PAR PROJECT

Amendment/ activity	Date	US$ Increment / Accumulated	Intermediate Results/Amount	Observations
Grant agreement No. 527-0412	Sept. 30, 2003	US $574,925	2 (US$374,925) 3 (US $200,000)	Total estimated USAID contribution: US $5,000,000. End Date: Sept. 30, 2007
Administrative aspects are finalized	Sept. 16, 2004			·Assignment of persons responsible from MOH and USAID is formalized. ·Administrative processes are finalized with APCI, Congress, the Ministry of Foreign Relations, and DGSP. ·The activities plan and budget are reprogrammed.
Amend. N°1	Sept. 29, 2004	U$429,387 Accumulated: U$1,004,312	1 (U$185,000) 2 (U$224,287) 3 (U$20,000)	
Operations begin	May 2005			The Annual Operating Plan is approved in April 2005 and in May operations begin.
Amend. N°2	Sept. 27, 2005	US$404,207 Accumulated: US $1,408,519	1 (US$150,604) 2 (US$202,103) 3 (US$51,500)	
1st Financial Revision	Oct. 18–Nov. 2, 2005			Financial evaluation in Cusco, Huánuco, Cerro de Pasco, Junín, and San Martín due to delays in settling of accounts.

TABLE H.4. CHRONOLOGY OF THE PAR PROJECT				
Amendment/ activity	Date	US$ Increment / Accumulated	Intermediate Results/Amount	Observations
Amend. N°3	July 25, 2006	US $1,408,000 Accumulated: US $2,816,519	1 (US$200,000) 2 (US$253,000) 3 (US$100,000) Coordination (US$855,000)	
Amend. N°4	Sept. 29, 2006	US$200,000 Accumulated: US$3,016,519	Coordination (US$200,000)	
2ª Financial Revision	Oct.–Nov. 2006			Financial evaluation in Cusco, San Martín, Piura, and Loreto, due to delays in settling of accounts.

Management Approaches

In the three years the project operated, different management approaches were taken to accomplish the activities. From the information provided by the consultant who was hired by the USAID/POLICY project, it can be concluded that during the first year of the project activities were mainly coordinated by the Program for Administration of Management Support (PAAG), an office of the GAO in charge of the reception and administration of funds disbursed by USAID to MOH, with the DGSP in charge of the technical aspects of the project. The tasks carried out in 2005 focused on legal aspects, communication (communication aids), and reinforcement of technical and normative knowledge (workshops) on tuberculosis, malaria, HIV/AIDS, immunizations, control of vector-borne diseases, mental health and stability, micronutrients, sexual and reproductive health, and support for the decentralization of the health sector.

During the project's second year, 2006, the previously mentioned aspects continued, in addition to the implementation of activities related to DGPROM. Three programs were implemented: the Program for Healthy Communities and Municipalities; the Program for Healthy Schools; and the Program for Healthy Families and Homes. Additionally, communication aids were produced on senior health subjects and were greatly appreciated by the person in charge of this area.

Monitoring and Evaluation

The Activity Approval Document (AAP) developed for this project in April 2002 included a list of indicators for each one of the three intermediate results that would be measured by health statistics and by information collected by the National Demographic and Health Survey (DHS). Nevertheless, there exists no list of indicators in the amendments of the project or in the implementation documents. The results of the project are measured only by the description of the activities implemented for the different subjects.

Funding

During the project's three years of operation the amounts subobligated through Implementation Letters sent to the Ministry of Health were:

TABLE H.5. SUBOBLIGATED AMOUNTS FOR THE EXECUTION OF ACTIVITIES*	
2005	US$574,031
2006	US$420,765
2007	US$284,700
Total	US$1,279,496

*$1.71 M was spent on administration and technical assistance.

TABLE H.6. SUBOBLIGATED AMOUNTS FOR MOH ACTIVITIES WITH USAID FUNDS

	Line Items	CHILD SURVIVAL					TOTAL CHILD SURVIVAL	P O P	AIDS	TOTAL
		Maternal Mortality	Micro-nutrients	TBC	Malaria	Other Inf. Diseases				
	El 1 - Quality Health Services	170,103	0	88,046	119,986	123,416	501,551	0	10,502	512,053
	El 2 - Healthy Behavior	298,125	76,466	43,823	25,626	96,547	540,587	344,161	39,498	924,246
	El 3 - Health Sector Policies	140,000	0	14,850	0	67,488	222,338	51,500	0	273,838
(A)	TOTAL SUB-OBLIGATED BY PILs (MoH)	608,228	76,466	146,719	145,612	287,451	1,264,476	395,661	50,000	1,710,137
(B)	TOTAL SUB-OBLIGT FROM ADMIN COSTS	731,940	0	27,000	0	45,000	803,940	315,000	0	1,118,940
(C)	TOTAL AMOUNT SUB-OBLIGATED (A + B)	1,340,168	76,466	173,719	145,612	332,451	2,068,416	710,661	50,000	2,829,077
(D)	Balance	129,690	3,534	23,450	19,388	11,380	187,442	0	0	187,442
(E)	TOTAL BILATERAL AGREEMENT (C + D)	1,469,858	80,000	197,169	165,000	343,831	2,255,858	710,661	50,000	3,016,519

B. Methodology

The collection of information for the assessment of PAR followed steps similar to those of the other projects, VIGIA and CwQ. In this case 21 in-depth interviews were conducted, four of which were in communities with "healthy schools" (where interventions were undertaken to improve sanitary conditions in bathrooms and kitchens, and students were instructed in healthy behaviors, including eating habits and personal hygiene) in order to understand the experience attained in this area. The directors of each school and at least two teachers were interviewed concerning their experiences relating to changes seen in the students and in their parents. In informal interviews at all the schools, the students answered questions about practices concerning health, particularly hand-washing, and cold prevention and cure. In Cusco the interviews coincided with a nutrition fair that had positive participation on the part of many parents. One mother took part in an interview about changes in family behavior.

Additionally, two meetings were held with USAID personnel. The interview guide was not applied in these meetings, but technical aspects were analyzed in detail with Dr. Luis Seminario and Nelly Rios, and financial aspects were reviewed with Víctor Llajaruna. At the end of the visits to the regions, the team held more meetings in order to consolidate and organize the findings that had been presented and discussed with the MOH team members. The project consultant, Dr. Nancy Fuk, was not available for an interview. The interview with Mr. Llajaruna from USAID was important because of two visits he had made to evaluate problems that had occurred during the project's operation. Financial information sent by personnel in the different regions was compared to the information received by the coordinators of MOH at the central level.

C. Findings

Technical

The MOH health services personnel who participated in PAR activities did not know about the specific objectives or intermediate results of the project. Interviewees mainly recalled the financial support that was supplemented by other sources and that allowed for the implementation of activities and aids that helped strengthen technical areas. These items included workshops and communication aids (flip charts, brochures, posters, norms, transportation, travel allowances and refreshments for the workshops). Since technical and financial support was complementary, there is no record with respect to processes or policies that can be credited specifically or exclusively to PAR.

When asked about the printed materials that the project procured (documents relating to TB, malaria, quality standards, and the Concerted National Health Plan), the interviewees readily remembered the material and associated it with the activities that were sponsored with funds from MOH at the central level, in other words by PAR. Only 15% of the interviewees could show, at the time of the interview, PAR documents in their offices or in neighboring offices. The majority affirmed that they were familiar with the documents because they had used them at some point for training or as resources; some said they had seen them frequently in the offices of health service colleagues.

In a few cases, the technicians in the various regions received copies directly from MOH at the central level, on other occasions they got funds for printing large quantities, and they also mingled funds from different sources for more copies. Most of the material was considered to be of good quality. There were two known cases in Cusco where the illustrations on the covers of printed material had ethnic differences with the group it was directed toward and had to be redesigned.

Training sessions in the Ministry of Health are frequent and diverse. The PAR project is not recalled for promoting a specific training theme, although many times it did. Most often it is remembered as a complementary fund used for training courses or as a resource for allowing people to participate in training courses elsewhere. A clear example, and one which occurred more than once, was the support given to the training workshops on the Concerted National Health Plan. The discussion required several meetings at intra-regional as well as national levels, the need for funds was obvious, and PAR contributed with an important amount by paying for printed material and for participants. According to a participant from the MOH, *"PAR was important because it allowed us to complete the activities in the work plan."*

Another example that shows support given by PAR was during the malaria training workshops for teachers as well as the community, in the tropical region of Cusco. The teaching material had been procured by the VIGIA project. However, transportation for the trainer and for participants living in outlying communities was paid for by PAR.

In addition to printed material and training courses, two other processes were initiated thanks to the project and are still in effect. One of these has to do with senior citizen health-related activities under the supervision of Dr. Del Pozo from the Ministry of Health. Dr. Del Pozo was able to identify funds that were being underutilized and channeled them, in coordination with the DGSP, to help finance activities and communication tools used in the regions that were visited. At the present time there is a lack of educational and promotional material for the senior citizen support centers and community programs.

Another process still active is Healthy Schools, in which PAR participated with other programs or organizations such as USAID/HCM, the Regional Governments, USAID/CATALYST, Kallpa, and World Vision, either by supporting the logistics of the events or by sharing a theme with other groups but in different fields. Examples are the activities in Junín where the Regional Government, USAID/HCM, and PAR (through the Ministry of Health) promoted healthful practices in Healthy Communities, Healthy Families, and Healthy Schools.

Healthy Schools was perhaps the most important and novel experience that the project supported. In the schools that were visited there was a high degree of commitment on the part of the teachers and significant understanding of healthful practices on the part of the students. These practices included hand washing, covering one's mouth when sneezing, good nutrition with the "healthy lunchbox," personal hygiene, etc. The classrooms provided clean drinking water, clean storage for towels, and a good quantity of visual aids that had either been made at the school or donated by various organizations. The students answered questions quickly and knowledgeably about healthy practices. These are all positive aspects related to project achievements in the Healthy Schools.

There is no measurable evidence of direct impacts resulting from PAR. The PAR project consultant presented the work plans and monthly information. Nevertheless, the activities reported at times were financed exclusively by the project and at other times financing was partial, whether for transportation and/or covering the cost of new teaching tools or various other materials, making attribution virtually impossible.

Management and administration of the project, including technical responsibility and the development of work plans (implementation of activities) was in the hands of the DGSP (responsible for intermediate results 1 and 3) and the DGPROM (responsible for intermediate result 2). Both departments relied on the consultant's technical support. The consultant also presented technical progress reports to USAID, made sure the project complied with the objectives stipulated in the agreement, and kept tabs on the funds.

Aspects related to health reform and decentralization did not affect health workers' performance. Although the interviewees recognized a difference in budgetary and financial processes established for the decentralization process, these were not significant enough to modify their daily activities. Some of the interviewees attended training workshops to understand new concepts and procedures on decentralization. They also stated that these workshops did not affect their activities.

All the interviewees said that having participated in the PAR project activities was a positive experience, both personally and professionally. Some stated how important it is to participate in projects financed with funds that do not come from the Ministry, since according to their experience this type of project provides participants with more exposure to novel ideas, especially concerning technical aspects: *"I was highly motivated to work in the region."*

Funds Flow

The financial management component of PAR required special attention given the problems that appeared throughout the execution of the project. Local personnel who were interviewed on visits

to the various regions did not recognize USAID/PAR as a specific source for the activities' financing; instead, they assumed the funds originated in the Ministry of Health at the central level. In fact, the GAO of MOH handled the finances, so the flow did come from the Ministry.

The main difficulties in handling the funds were related to the training workshops. Expenses for the purchase of material are incurred before the courses take place, which means the funds should be available ahead of time. Nevertheless, the interviewees stated that they frequently had serious difficulties during the events, both in receiving funds and later in liquidating accounts. This last point was so prevalent that on several occasions, personnel from the central level had to travel to the regions with the sole objective of compiling the necessary documents to balance the accounts. Fresh funds would be available only when the accounts were settled, since that was the condition accepted in the Donation Agreement with USAID.

Opinions held by the technical personnel in the regions with respect to the efficiency of the administrative office were always negative. Likewise, the opinion that the administrators held of the technical personnel was also negative and referred to excessive demands and unrealistic time limits. The opinion of officials at the regional level with regards to the administrative personnel at the central level was also negative and referred to the delay in the fulfillment of requirements.

USAID personnel in charge of the project were constantly aware of this problem and organized two visits to the regions in November 2006 and November 2007 by advisers from the office of USAID's Regional Inspector General. These visits confirmed the problem: cumbersome administrative procedures hindered the transfer of funds from MOH to the regions: *"We must work as a team in order to create flowcharts that identify the bottlenecks."*

These funding-flow problems led MOH and USAID personnel in charge of the project to meet on more than one occasion with administrative and management personnel in order to find a way to minimize unneeded procedures. Nevertheless, positive results were not obtained. The amount executed by the MOH only reached US$1,279,496, 25% of the amount USAID approved for this project, which was US$5,000,000. The funds executed by MOH in the three years between 2005 and 2007 shrank yearly because of the difficulties in liquidating accounts and the consequent inability to approve more expenses. USAID was forced to channel funds meant for PAR to other projects and institutions like CEDAR, USAID/HPI, and the World Bank.

D. Conclusions

Technical

1. During the three years the project lasted many activities were implemented to strengthen technical aspects and health promotion. This resulted in an improvement in healthcare giver capacities on a regional and local level.

2. PAR is not recognized as having developed methodology, strategies, or procedures in addition to those already developed by other projects, such as Project 2000, VIGIA, and CwQ.

3. Given its profile—support for other activities—the project also had a promotional effect. It helped implement activities that did not have sufficient funds, especially those related to epidemiology, service quality, and healthy schools. This was an important stimulus for the recently created DGPROM.

4. As stated in the paragraph on monitoring and evaluation, previous documents indicated the need to implement a system of indicators that measures achievements. Nevertheless, this was not done. Therefore, it has not been possible to measure any direct impact on health promotion. Likewise, since the project does not have a baseline, it is impossible to assess impact. However, this does not invalidate its contribution.

Management

1. PAR did not have a visible or recognizable Director as such (a supervisor or a directorate). The DGSP and DGPROM carried out separate activities, and communication between the departments was not efficient. The fact that both departments were responsible for intermediate results diluted the responsibility of either department in fulfilling objectives.

2. Within this kind of framework the role of the consultant did not produce the leadership effect (vertical) necessary for solving technical problems or avoiding administrative and financial barriers, as was often needed.

3. In spite of the fact that the institutional collaborators recognized the problems with the administration of funds, especially related to the liquidation of accounts, no one was able to come up with a solution. Consequently, the execution of funds diminished to the point that only 25% of the approved amount was used for the project.

Legacy and Lessons Learned

1. The experience of the Healthy Schools Program is encouraging. School directors, teachers, and students have assimilated healthy practices. Furthermore, the personal approach used by the health workers is very important ,since they are in direct contact with the community, especially with young children. In addition, collaboration with other organizations gives health a new meaning and strengthens its global concept of a multisectoral approach.

2. The results from a project within the health sector are rarely exclusively attributable to the project. Nevertheless this does not invalidate management's need for a baseline as well as post-intervention measurements that would later allow easy recognition of the project's achievements. PAR has made it clear that it is necessary to have the information from the outset of the project.

3. Likewise, the previous statement is bound to the fact that using evaluation and follow-up indicators would help support any changes in the project's direction during its execution. PAR also lacked that option.

4. In spite of the difficulties in measuring improvements achieved by the project, it should be noted that the need for technical training in the MOH is permanent and all support in that area is positive.

Scope of MOH and USAID Objectives

1. In general terms the objectives drawn up in the initial agreement were not achieved; specifically, that was creation of a tool that would strengthen DGSP and DGPROM in order for them to carry out health promotion campaigns.

2. Simply stated, the strategic target of the project was to improve the health of high-risk populations. An operational definition for "high-risk" was not given; thus the scope of the population was never properly established.

3. Intermediate objectives 1 and 3: Quality Health Services Accessible and Utilized, Health Sector Policies and Programs that Respond to Health Needs, do not have quantitative goals. Furthermore, the definition is vague; therefore, any activity can be easily included and it becomes difficult to establish whether it achieved its goal.

4. Intermediate objective 2: The Population Uses Good Health Practices: In spite of having a more specific title and PAR having actually carried out activities related to the subject, like Healthy Schools and Healthy Communities, this objective does not have quantitative goals

either; nor were there systematic before-and-after measurements made of PAR activities. Therefore, it is difficult to consider that this objective was achieved.

5. Although this was not a specifically stated PAR objective, sustainability of the project was not achieved.

E. Assessment Team Recommendations [HC]

1. The team recommends that activity support projects be clear about what the thematic scope of the project will be, as well as the characteristics of the population, so that no unnecessary overlaps occur. This is especially true for projects with the MOH, where there is a great diversity of donor-supported projects.

2. Other basic requirements the team identified are the need for a baseline and intermediate and post-intervention measurements. These are the only means to recognize impact and achievement of the original objectives.

3. The assessment team recommends creation of a set of indicators that measure the ongoing impact of the project so that all aspects are dealt with correctly and the project is headed in the planned direction.

4. The team recommends that USAID establish clearer lines of authority and responsibilities so that technical and administrative decisions are swift, and timely corrections can be made.

5. The team recommends that USAID stipulate that technical documents produced by the project be available in both digital and hard copy versions at the central and regional levels.

6. The team recommends that the appropriate authorities of the MOH seek solutions for the administrative and financial problems that were observed throughout the project, particularly related to the flow of funds and the liquidation of accounts: .*"Once they reach MOH, the resources to continue with become unavailable."*

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