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STUDY OF USAID SUPPORT TO PERU´S RESPONSE TO THE COVID-19 PANDEMIC, 2020-2022

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CONTENTS

ACRONYMS AND ABBREVIATIONS

AOR	Agreement Officer's Representative
APCI	Peruvian Agency for International Cooperation
APS	Annual Program Statement
ARPA	American Rescue Plan Act
CEDRO	Center for Information and Education for the Prevention of Drug Abuse
DIRESA	Regional Health Directorate
ENSAP	Peruvian School for Public Health
GDP	Gross Domestic Product
GERESA	Regional Health Management Office
ICU	Intensive Care Unit
IDB	Interamerican Development Bank
IHR	International Health Regulations
LHSS	Local Health System Sustainability Project
MEF	Ministry of Economics and Finance
MINSA	Ministry of Health
NIH	Peruvian National Institute of Health
OGCTI	MINSA Office for International Cooperation
PAHO	Pan American Health Organization
PIO	International Public Organization
PPE	Personal protective equipment
SES	*Socios en Salud*
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

PURPOSE AND SCOPE

The purpose of this study is to identify lessons learned from USAID/Peru's support to Peru's response to the COVID-19 pandemic, with the intention of improving the agency's and other donors' reactions to a potential new global health threat or health emergency.

The study aims to: i) analyze the flexibility of USAID/Peru to adapt its programs and operations, ii) analyze the different processes of the COVID-19 response that were funded by USAID/Peru, iii) analyze the contributions of USAID/Peru's activities to strengthening the capacities for preparedness and response to future health emergencies in Peru, and iv) identify lessons learned and best practices.

These objectives are embodied in 4 questions:

1. How did USAID adapt its programs and operations to respond to the different stages of the COVID-19 pandemic and its context?

2. How did USAID and implementing partners respond to the pandemic and its context?

3. How did COVID-19 focused interventions contribute to strengthening the national capacity to respond to epidemics and humanitarian crises?

4. What are the lessons learned that may be useful in future interventions?

The scope of the study is confined to the set of activities of five implementing partners: *Socios en Salud*, PRISMA, Pan American Health Organization (PAHO), Local Health Systems Sustainability (LHSS), and the Center for Information and Education for the Prevention of Drug Abuse (CEDRO), from their inception in April 2020 until the closing of the last activity in February 2023.

METHODOLOGY

The methodology used for this study was mainly qualitative, given the main objectives of describing the COVID-19 intervention and obtaining lessons learned from various individual and collective perspectives.

The study team organized data collection and analysis in three stages. The first stage was a desktop review of management documents from USAID/Peru and its implementing partners. The second stage included semi-structured interviews and focus groups with key actors selected for their proximity to, and knowledge of, the design and implementation of the partners' activities. In total, the study team interviewed 51 people: 8 from USAID, 11 from implementing partners, and 32 from the Ministry of Health (MINSA) and regional governments. The third stage was a workshop to validate the results and lessons learned from the study, with the three types of actors.

To carry out the analysis of the intervention, the team processed the primary and secondary information, identifying the intervening factors, the methods applied, the resources used, and the results obtained. Given the different modalities of the intervention associated with each activity, the actors' reflections contributed to the knowledge of the context, the situation before and after the intervention and the role they played. This information was organized into matrices based on three perspectives

associated with the roles played in the intervention – USAID/Peru, the implementing partners and MINSA/GERESA/DIRESA – and four thematic axes that corresponded to the questions of the study.

The answer to the study questions is based on the analysis of the information. The level of detail of the analysis is limited by the quality of the responses provided by the interviewees.

THE INTERVENTION

DESIGN

At the onset of the COVID-19 pandemic, USAID/Peru had a small professional team that had previously led activities related to the Zika emergency and the migration of Venezuelan citizens to Peru. This small team quickly recognized the need to mobilize and collaborate with the country in its response to the COVID-19 pandemic. They organized a local intervention expeditiously, specifically designed to address the needs of the Peruvian health system. Choosing to work in collaboration with local partners allowed the team to organize an intervention that was highly adaptable and contextualized. This approach also allowed the team to adapt based on new insights and best practices as they emerged, both locally and globally. Moreover, by working with local partners, the team not only leveraged their technical expertise but also capitalized on the commitment they had to address the health issues of their own communities.

The USAID/Peru team, together with local partners Socios en Salud, CEDRO, and PRISMA (from now on referred to as intervention team) used their expert knowledge about the complex Peruvian health system and established effective relationships with national and regional authorities. These relationships allowed the intervention team to provide rapid support to the country. During a second stage of the intervention, focused on promoting vaccination as the primary strategy to combat the pandemic, two global partners, LHSS and PAHO, joined the intervention team.

Having a single Agreement Officer's Representative (AOR) improved the coordination among intervention team partners. In this way, USAID/Peru, through the AOR, was able to clearly outline the intervention areas of each partner, both geographically and thematically, avoiding duplicities and overlaps. The initial effort to establish an organizational structure proved valuable in ensuring direct and effective coordination between all actors involved. This coordination structure also allowed for a more efficient distribution of resources and efforts benefiting the response to the pandemic in Peru.

STRATEGIES USED DURING IMPLEMENTATION

The intervention implemented through multiple partners had different strategies. The emergency context that the pandemic generated strongly influenced the implementation process, which demanded agile and rapid execution of activities. The usual procedures of intervention design, needs assessment, and planning were significantly shortened. Below are some of the strategies that allowed the intervention team to adapt to exceptional circumstances. The strategies also illustrate the responsiveness and flexibility of USAID/Peru and its partners in the face of unforeseen challenges:

- A single USAID officer supervised the various activities. The officer was also USAID's point of contact for the partners.
- The intervention team established a coordination platform among partners, allowing them to forge strategic alliances, form functional teams, and leverage shared resources.

- The implementing partners predominantly worked with regional and local authorities, although some technical assistance activities focused on MINSA.
- The intervention team introduced activities to national and regional authorities at the onset of their implementation, allowing for alignment of the intervention with the priorities of the government counterparts and promoting ownership of the intervention by authorities and their teams.
- The intervention benefited from the recruitment of coordinators, advisors, or local teams and gave them the autonomy and authority to adapt the activities and respond quickly to environmental changes.
- Some activities included peer learning visits. These visits proved valuable in strengthening participants' capacities, as well as encouraging the formation of committed teams and cooperation networks among peers.
- One of the intervention's priorities was to include vulnerable populations. The intervention team was able to include these groups by expanding health services for remote communities, working closely with their leaders, and including cultural elements in the design of specific activities.
- In remote areas where native Amazonian populations live, managing cultural codes of communication and relationships became essential as the team implemented their activities. A gradual and steady approach to collaboration and direct work with community leaders make it possible to work with vulnerable communities.
- USAID approved a general, rather than a detailed, budget for each implementing partner, giving them ample flexibility in managing field operations.
- The learning and innovation capacities of implementing partners resulted in a dynamic intervention that integrated new knowledge and adaptation to abrupt environmental changes.
- Some activities lasted until the first months of 2023. This extended period of implementation provided the opportunity for the intervention team to share achievements and advocate for good practices with the new regional authorities that took office on January this year.

The study team also found several factors that hindered the activities' implementation:

- Some partners expressed that USAID's periodic reporting requirements were a distraction from their work in managing the implementation of activities.
- Continuous changes among MINSA authorities and officials hindered collaboration at the national level. Each new official came with different priorities and levels of interest in the activities.
- The new national administration of 2021 rejected working with the implementing partners.
- At the regional level, there was a shortage of providers and professionals with the appropriate experience and profiles.
- Health networks lacked competent staff for the implementation of vaccination campaigns, hindering progress in vaccination coverage.
- The activities' implementation was challenged by the poor management capacity of some public officials,

OUTCOMES OF THE INTERVENTION

USAID/Peru's activities complemented and enhanced the work of the Peruvian health system, at both national and regional levels. The intervention team strategically oriented the activities to support key aspects of the pandemic response and significantly contributed to mitigating the pandemic's effects. The intervention also helped build skills and capabilities among health providers. The intervention's activities improved the health system's response capacity by providing assistance in the management of health services in 23 regions of the country and by producing relevant information for decision-making.

The intervention team implemented each activity gradually with different objectives, times, and scopes. The intervention fostered processes and procedures for a rapid emergency response, which would have taken longer through regular administrative paths.

SCOPE OF THE INTERVENTION

The intervention began a few weeks after Peru declared the outbreak of COVID-19 as a pandemic and focused on the following critical areas of response: health services, epidemiological surveillance, diagnosis, patient management, and health personnel protection. Due to the difficult implementation circumstances, the intervention's activities did not have specific coverage goals, but rather worked to achieve milestones and deliver products. Later, USAID/Peru set goals under a cooperative agreement with PRISMA. Coordination among partners was a feature of the intervention that allowed for the prioritization of needs, optimization of resources, and provision of care to COVID-19 patients and those with chronic conditions.

By engaging local leaders, the intervention team successfully involved communities in the fight against the pandemic. The intervention's community agents made home visits for health education, epidemiological surveillance, and clinical follow-up, contributing to the prevention of hypoxia, and protecting people and their families.

STRENGTHENING INSTITUTIONAL CAPACITIES

USAID/Peru's intervention covered key areas including diagnosis, treatment, vaccination, epidemiological surveillance, and inter-institutional coordination. Respondents coincided in their belief that the intervention significantly contributed to the mitigation of impacts of the health crisis in the country. USAID donated a mobile laboratory for molecular tests to MINSA, and more than 116,000 rapid tests and 31,000 molecular tests conducted in Lima. Also, USAID strengthened diagnostic capacity in Peru's regions by acquiring equipment and training laboratories' staff for genomic surveillance.

To improve treatment, USAID addressed the oxygen shortage and improved the capacity of the health system to provide oxygen treatment in multiple locations. Additionally, provided over 473,000 non-COVID and COVID teleconsultations, delivered medications at home for patients with chronic diseases, and provided psycho-emotional support to the population, including mental health services.

To improve epidemiological surveillance, the intervention team established rapid response teams and conducted home visits for contact tracing. The intervention team also assessed the capacity of health establishments at regional and local levels to prevent and control the infection. In hard-to-reach areas, the intervention team provided comprehensive care services via river routes and included medical care, obstetrics, mental health, vaccination, and laboratory tests. The intervention team also supported vaccination through communication campaigns to promote vaccine acceptance and immunization in jungle communities. Finally, USAID donated cold chain equipment to the regions.

STRENGTHENING INSTITUTIONAL CAPACITIES TO RESPOND TO SIMILAR FUTURE SITUATIONS

The intervention strengthened the response capacity of public health institutions. It improved active surveillance, detection, and reporting of COVID-19 cases, and followed the standards of the International Health Regulations (IHR). The intervention included providing high-level training to specialists at the National Institute of Health (NIH), as well as improving the availability and accuracy of molecular tests, diagnostic capacity, and genomic sequencing.

The intervention improved the capacity of health establishments by providing beds, oxygen concentrators, and solar panels and ensured patient care in rural areas. The intervention also promoted vaccination through scenario analysis and recommendations to include the COVID-19 vaccine into the regular vaccination schedule. The intervention team helped develop a master plan to improve the "*Teleatiendo*" platform, which was successfully implemented and allowed for online access to medical care during the pandemic.

USAID conducted training and awareness efforts, especially in vulnerable communities in the Amazon and southern Peru. These efforts included cultural elements within their communication strategies.

LESSONS LEARNED

DESIGN AND COORDINATION OF ACTIVITIES

- Having a health activity manager in USAID/Peru was significant for a quick response and adaptation of the objectives and scope of the intervention.
- USAID/Peru has some discretion margin to adjust its processes in emergency contexts.
- USAID used special hiring mechanisms with reduced administrative and bureaucratic processes that minimally diverted resources from the intervention.
- Selecting the most appropriate implementing partners is crucial. In Peru there was a pool of organizations with experience working with USAID and the necessary certifications, which facilitated the selection process.
- A good partner is one that has demonstrated good technical and administrative capacity.
- Working with implementing partners that have a team and a network of local professionals facilitates quick organization, deployment, and startup of an intervention.
- It is important to build and maintain an open, transparent, flexible, and constructive relationship between USAID and implementing partners.
- Supervision and technical support of implementation can be done remotely.
- Recognition of USAID and the support of the people of the United States is limited "in the field," mainly due to lack of knowledge of the agency's contributions, although the partners highly complied with the branding and marking requirements.

MANAGEMENT OF ACTIVITIES

- Regional Governments allowed for quick and direct startup of the intervention.

- Including national and regional officials in the design and implementation of activities improves the activities' speed and response capacity so the team can focus on the most critical needs.
- Close coordination between implementing partners and health authorities facilitated the achievement of objectives in timely manner.
- An effective strategy to implement activities is to have a local team or advisor, especially for short-term, complex activities of less than 1 year.
- Despite a limited supply of suitable personnel, recruitment and hiring are important factors in the success of implementing partners.
- Training of health personnel on specialized topics through non-traditional mechanisms was critical for the success of the intervention.
- The learning capacity of partners during the implementation of an activity is especially valuable as it can leads intervention improvements and innovation.
- It is necessary to train professionals on public administration.
- Intersectoral and intergovernmental coordination is key to facilitate a quick response, especially when launching activities such as vaccination efforts.
- Exchange visits and peer learning between regions proved to be an effective strategy that promotes the sustainability of the intervention.
- The lack of a comprehensive and timely information system hindered activity management and decision-making.
- Even in a state of emergency, where flexibility was provided for administrative processes, transparency is critical for all procedures.

OPERATION AND SUSTAINABILITY OF ACTIVITIES

- Even in health emergency situations, it is possible to establish decentralized planning processes that include the effective participation of community leaders.
- Involving people responsible for managing resources as well as those responsible for health facilities contributed to organizing an effective response.
- Maintaining a minimum capacity to attend to other (non-COVID) patients is essential to avoid excess mortality and greater health risks.
- The pandemic generated stress and anxiety among the general population and health personnel.
- Identification and evaluation of essential resources is necessary for planning.
- Cultural elements and the use of local languages are key in the design of activities, especially if focused on remote and vulnerable communities.
- Working with local personnel, community leaders, and women's groups facilitated the implementation of activities and generated trust for the health teams.
- Critical staff at DIRESAs and GERESAs were not always able to attend training activities because of high demand of their services in the regions.
- The exchange of international experiences helped strengthen the COVID-19 surveillance system.
- Virtual or remote work was strengthened during the pandemic and has proven to be a very useful tool. However, some virtual activities were not effective, including some training sessions.

- During the emergency, the priority of the activities is the response to the crisis; however, it is possible to implement interventions that endure over time.
- The generation and development of skills and abilities in health personnel is one of the most effective ways to give continuity to the actions implemented.
- Implementing partners developed some activities that favored sustainability.
- Closing the gaps in human resources, supplies, medications, equipment, and infrastructure is key to prepare the health system to face future emergencies.
- Health staff is now better trained in the use of personal protective equipment and the use of protective measures.
- The population should be informed and have reliable channels through which they can receive information in a timely and ongoing manner.

CONCLUSIONS

Despite not having a health office or health programs, USAID/Peru provided significant support to Peru during the COVID-19 crisis through five implementing partners: *Socios en Salud*, CEDRO, PRISMA, LHSS, and PAHO. These activities were launched using processes and procedures that streamlined administrative procedures and used flexible hiring mechanisms. A single AOR managed all five activities, which allowed for a good geographical and thematic distribution among the implementing partners. The activities implemented and leveraged processes for immediate response to the emergency that would have taken longer through regular public administrative systems.

USAID's activities incrementally focused on strategic aspects of the pandemic response in line with the government's established plan. During an initial stage, characterized by high morbidity, high mortality, high lethality, and limited government response capacity, the intervention established processes and procedures to strengthen epidemiological surveillance and diagnostic capacity. Likewise, USAID provided personal protective equipment (PPE) to the staff of health facilities, as well as medical oxygen and equipment to improve their operability and performance. In Loreto and Ucayali jungle communities, USAID delivered comprehensive care services by river, including mental health care.

During a second stage, when vaccination became the priority strategy to fight the virus, USAID provided support in some Peruvian regions in terms of vaccination campaign management, design strategies, and the development of communication campaigns. These included significant cultural elements of the target communities and required intersectoral and intergovernmental coordination. Finally, USAID provided assistance for some Peruvian regions to develop their own response plans for future health emergencies.

The intervention's activities resulted in added value for the system's capabilities, increasing the competencies and capacities of health facilities and staff in both urban and rural areas. Significant results included an increase in vaccination coverage in regions where vaccine rejection was high. The activities also strengthened the capacities of the health system, such as improved services including a wider laboratory network and oxygen supply.

Counterparts highly value USAID's support in response to the pandemic. Respondents mentioned the intervention's management approach, its flexibility to adapt to context variations, the versatility of its communication component, and its cultural adequacy as reasons for its success.

ASSESSMENT OF USAID SUPPORT TO PERU'S RESPONSE TO COVID-19 PANDEMIC, 2020-22

PURPOSE AND QUESTIONS OF THE STUDY

PURPOSE

The purpose of this study is to identify lessons learned from USAID/Peru's support in responding to the COVID-19 pandemic in Peru. The lessons learned will help improve the agency's and other donors' future responses to new global health threats or health emergencies.

STUDY QUESTIONS

There are four main objectives of the study:

1. Analyze the flexibility of USAID/Peru to adapt its programs and operations in response to the emergency caused by the COVID-19 pandemic.
2. Analyze the different processes in the response to COVID-19 financed by USAID, and the stakeholders involved in those processes including USAID/Peru, fund recipients who executed activities, beneficiaries of the activities in the public sector, and the affected communities.
3. Analyze the contributions of USAID/Peru's activities to strengthening Peru's capacities for preparedness and response to future health emergencies.
4. For the different activities, identify lessons learned and best practices, considering the conditions that facilitated or hindered the intervention.

These objectives are reflected in 4 questions shown below:

1. How did USAID adapt its programs and operations to respond to the different stages of the COVID-19 pandemic and its context?
2. How did USAID and implementing partners respond to the pandemic and its context?
3. How did COVID-19 focused interventions contribute to strengthening the national capacity to respond to epidemics and humanitarian crises?
4. What are the lessons learned that may be useful in future interventions?

SCOPE

The scope of the study is limited to the set of activities that were part of this intervention through five implementing partners: Socios en Salud, PRISMA, PAHO, LHSS, and CEDRO from its beginning in April 2020 until the closing of the last activity in February 2023.

Given geographic and population differences among the intervention's target areas and groups, the study team analyzed the context during the start of the intervention, what each activity did, who the actors were, how the implementation occurred, and the resources that were used. The study team took into account the type of intervention, as well as the strategies and components of this intervention.

The study team collected data in the following intervention areas of the implemented activities:

Table 1: Intervention Regions of the Activities

	NORTH	CENTER	SOUTH
Coast	Lambayeque	Ancash	Arequipa
	Piura	Callao	Moquegua
	La Libertad	Ica	Tacna
	Tumbes	Lima	
Mountains	Cajamarca	Junín	Cusco
		Huánuco	Huancavelica,
		Pasco	Ayacucho,
			Puno
Jungle	Loreto		Ucayali
	San Martín		Madre de Dios

METHODOLOGY

DATA COLLECTION TECHNIQUES AND INSTRUMENTS

The methodology used for this study was mainly qualitative, given the main objectives of describing the COVID-19 intervention and obtaining lessons learned from various individual and collective perspectives. Additionally, the study applied some elements of appreciative inquiry, emphasizing investigating the aspects that facilitated the intervention and those aspects that especially allowed the intervention to be timely.

The first stage of data collection was a desktop review of management documents from the five implementing partners who jointly formed USAID/Peru's intervention in response to the pandemic. Through this review, the study team identified activities and results from each implementing partner, as well as administrative lessons learned for each partner.

The second stage included interviews and focus groups discussions with key actors selected for their proximity to, and knowledge of, the design and implementation of the partners' activities: key officials from USAID/Peru, staff from the five implementing partners, health authorities, and health service providers who were beneficiaries or participants in the intervention (the Ministry of Health and Regional Health Directorates) and other individuals who participated in the intervention (e.g., other international cooperation organizations and civil society organizations). The study's fieldwork, detailed in a subsequent section, gave inputs and data for the study team to reconstruct the intervention experience and reach the conclusions presented later.

The third stage included designing and conducting a participatory workshop to present the main conclusions of the study to key stakeholders who had participated in the second stage of data collection. The workshop provided a space where stakeholders identified recommendations as well as best practices.

SAMPLE

The study team identified participants for the interviews and focus groups discussions through convenience sampling. USAID/Peru provided a contact list to the study team that included the mission's technical team and staff from the implementing partners. The implementing partners then provided a list of their internal teams and of counterparts at national and regional levels, mainly from the Ministry of Health and Regional Health Directorates/Management Offices. All individuals on the lists actively participated in the coordination and execution of the intervention activities. From these lists, the study team selected and invited participants for interviews or focus groups discussions.

The study team used three criteria to select participants: 1) the role they played during the period of study, 2) their geographic location, and 3) the number of activities implemented in each region.

The first selection criterion, the role the selected individuals had during USAID/Peru's intervention, included respondents' responsibilities during the dates of the implementation of the intervention, regardless of whether they had a different role during the data collection period. The second selection criterion, which helped the study team select regions to visit, was the geographic distribution of the implemented activities. A third criterion was the number of activities per region.

Considering these criteria, the study team conducted interviews in Lima, including officials responsible for the national intervention, as well as in Loreto, Arequipa, Cajamarca, and Ayacucho to collect local experiences.

FIELD WORK

The second stage of data collection began in Lima with interviews of USAID/Peru staff and of the teams of implementing partners in charge of carry on the activities. Through these interviews the study team identified other potential participants, from Lima and the regions, who represented other perspectives based on the role they played during the USAID/Peru intervention.

Table 2 provides a summary list of participants for the in-depth interviews and focus groups discussions that were part of the second stage of data collection.

Table 2: Sample of the Second Stage of Data Collection

	LIMA	LORETO	AREQUIPA	CAJAMARCA	AYACUCHO	TOTAL
USAID	8					8
Implementing partners	8	1		1	1	11
Ministry of Health	3					3
Regional Governments and DIRESA		4	3	10	8	25
Hospitals			2	2		4
Total	**19**	**5**	**5**	**13**	**9**	**51**

Own production

In total, the study team interviewed 51 people: 8 from USAID/Peru, 11 from implementing partners, 3 from MINSA, 25 from regional governments and directorates, and 4 from hospitals. Through the interviews and focus group discussions, the study team documented the critical elements of the intervention as well as the factors that facilitated or hindered the achievement of the intervention's objectives. The data collected helped the study team better understand the processes that influenced USAID's intervention in support of the response to the COVID-19 pandemic in Peru.

The study team conducted the third stage of data collection through a participatory workshop in which they validated the lessons learned gathered in the two previous stages. Fourteen participants attended the workshop: 3 from USAID/Peru, 7 from the implementing partners, 1 from MINSA, 2 from regional governments, and 1 from a private association.

DATA PROCESSING AND ANALYSIS

Respondents were able to express their opinions and share their knowledge of the intervention and its context. The study team then conducted the analysis focusing on the perspectives of the three kinds of stakeholders interviewed: USAID/Peru, implementing partners, and public officials from MINSA, GERESA/DIRESA, health providers, and others.

Each of the activities of USAID's COVID-19 response focused on different approaches to support the health system: skills development, health service organization, logistical support, communication campaigns, etc. Different stakeholders developed each approach, and each stakeholder had different perceptions of USAID's support. The study team aimed to capture these varied perspectives.

Collecting multiple perspectives posed three methodological challenges: 1) how to identify relevant actors, 2) how to analyze the different viewpoints of each participant, and 3) how to synthesize the knowledge comprehensively.

The study team processed and analyzed primary and secondary information to better understand the intervention, its characteristics, the methods applied and the resources to implement it, and its results. The study team developed a series of matrices and used those to conduct the analysis. These matrices allowed the study team to organize the information collected from the participants based on the roles of each stakeholder. The study team organized the data analysis matrices into four thematic axes that corresponded to the four study questions.

The study team collected data from both primary and secondary sources. The quality of the information collected through interviews varied by interviewee, which limited the ability of the study team to answer some of the study questions and to provide a detailed analysis.

CONTEXT

The World Health Organization (WHO) informed the international community on December 31, 2019, that it received notification of a cluster of cases of an acute respiratory syndrome of unknown etiology identified in the city of Wuhan, China. The infection likely started in a market in China and spread, by air, from Asia to Europe and America and then propagated globally. Since then, COVID-19 was added to the disastrous list of epidemics and pandemics that have taken place throughout history (the plague, smallpox, malaria, tuberculosis, cholera, influenza, HIV, etc.).

The virus is known as SARS-CoV2, belonging to the coronavirus family, and the disease it causes is known as COVID-19. The main route of transmission is airborne, through the aerosol produced when an infected person coughs or sneezes. Transmission is also possible, although less effectively, by touching one's eyes, nose, or mouth after touching contaminated surfaces. Since the onset of the first reported cases until the end of March 2023, over 684 million cases and 6.8 million deaths have been reported worldwide. COVID-19 has had a profound impact on global health, well-being, economy, education, and mobility.

Health systems globally, including those of South American countries, and particularly Peru's, were not prepared to face a catastrophic biological event caused by the spread of a new pathogen. Additionally, most societies did not have enough levels of education, social protection, and civic responsibility to implement effective control measures. Peru was at a disadvantage compared to its South American neighbors when comparing public health expenditure as a percentage of GDP, the availability of staff, hospital beds, and intensive care units. Table 3 shows these and other indicators of Peruvian health system.

Table 3: Data on Peru´s Health System Prior to the COVID-19 Pandemic, 2018

Indicator	
Health expenditure per capita in dollars adjusted for purchasing power parity (1)	USD 671
Public health expenditure as a percentage of GDP (2)	3.2%
Hospital beds (per 1,000 inhabitants) (3)	1.6
ICU Beds (4)	852
ICU beds (per 100,000 inhabitants) (5)	2.58
Medical professionals (per 10,000 inhabitants) (6)	12.7
Nursing professionals (per 10,000 inhabitants) (7)	13.5
Intensivists (per 10,000 inhabitants) (8)	2.1
Mechanical ventilators (per 100,000 inhabitants) (9)	5.0
Laboratories for COVID-19 (10)	9

Source: (1)(2)(3)(6)(7) PAHO/WHO. Data compiled by the Department of Health Systems and Services from the Global Health Expenditure Database. Washington, D.C. Last updated: May 15, 2018. (**http://www.who.int/health-accounts/ghed/en/**)
(4)(5)(9)(10) Ministry of Health. Daily report. www.minsa.gob.pe (8) Peruvian Society of Intensive Care Medicine

During the pandemic, the World Health Organization requested the activation of crisis management policies so that countries could prepare and proposed eight pillars for each national response (WHO 2020): 1) country-level coordination, planning, and monitoring; 2) risk communication and community engagement; 3) surveillance, rapid response teams, and case investigation; 4) points of entry; 5) national laboratories; 6) infection prevention and control; 7) case management; and 8) operational support and logistics (MINSA, 2021).

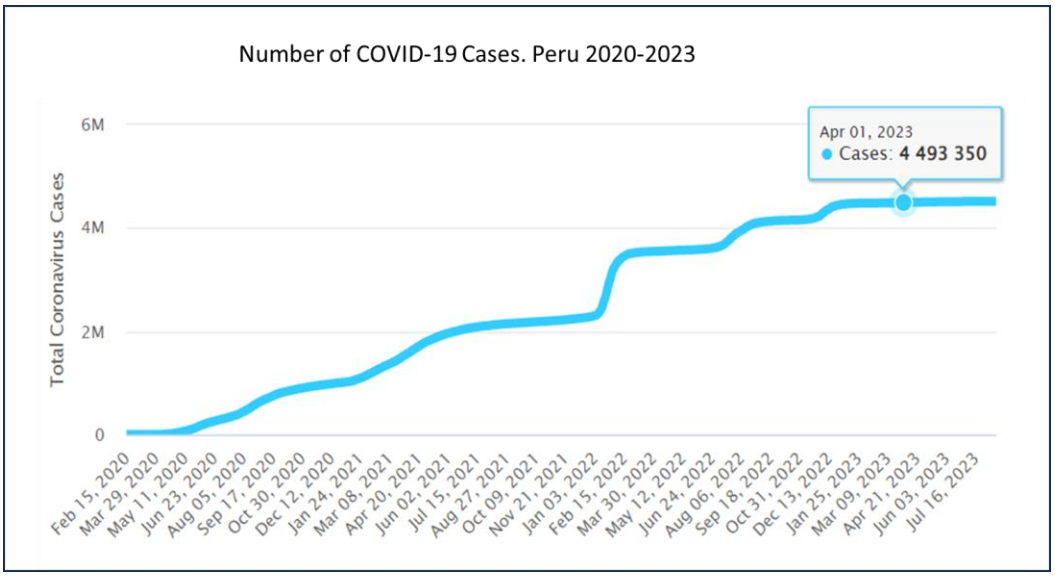
Faced with the progression of the pandemic and its consequences, countries had to develop strategies aimed at containing the curve of cases and deaths, mitigating economic effects, and mobilizing resources and capabilities, all over a relatively long period of time. Faced with adverse outcomes in terms of morbidity and mortality, countries had to strengthen their response capacity, improve surveillance within the framework of the International Health Regulation, develop processes to monitor interventions and organized social responses, as well as promote the exchange of experiences and technological developments.

The nature of the disease and the state of response capacity resulted in very high morbidity and mortality rates in most Latin American countries, as compared to countries in other regions. These results were largely related to the following factors: 1) saturation of hospitals and assistance services, 2) lack of Intensive Care Unit (ICU) beds and critical supplies such as oxygen, 3) insufficient human resources and limited initial skills for proper management of complications, 4) limited capacity for timely diagnosis (lack of availability of molecular or antigenic tests, transportation, and processing limitations), 5) difficulties acquiring necessary resources for biosecurity such as personal protective equipment (PPE), 6) weak organization of health response and surveillance, 7) poor governmental decision-making, and 8) lack of accurate information, spread of false information (misinformation), and irresponsible behaviors (COVID parties, mask and vaccination rejection, etc.).

In Peru, the COVID-19 pandemic highlighted the critically inadequate situation of the health system that was fragmented and characterized by financing and human resource allocation problems, ineffectiveness of its preventive actions, and the limits of a comprehensive response capacity. These deficiencies resulted in nearly 4.5 million cases and 220 thousand deaths from the beginning of the pandemic until March 2023 in Peru (Exhibit 1). The country, with 33 million inhabitants, had the highest reported mortality per inhabitant worldwide (665.81 deaths/100,000 inhabitants).

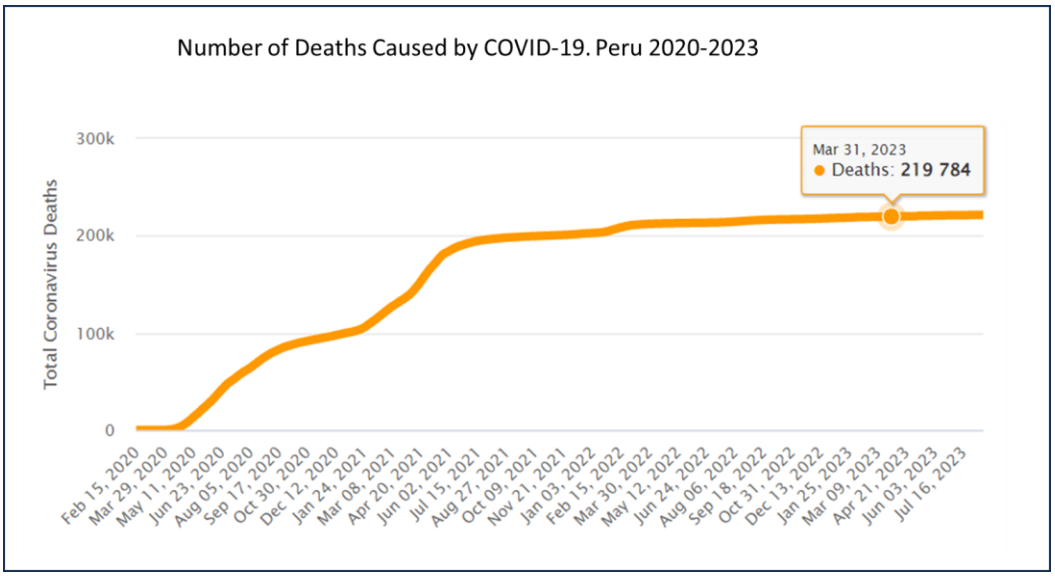
As of April 2023, the prevalence of the disease was approximately 134 cases per million inhabitants, with a mortality of 6,572 per million inhabitants and a fatality rate of 4.8% (Exhibit 2).

Exhibit 1: Number of COVID-19 Cases in Peru, 2020-2023



Source: *OMS. Reporte situacional. Enfermedad por Coronavirus 2019 (COVID-19)*

Exhibit 2 Number of Deaths caused by COVID-19 in Peru, 2020-2023



Fuente: OMS. Reporte situacional. Enfermedad por Coronavirus 2019 (COVID-19)

The country and its health system had to face other concurrent crises that resulted from the economic and social effects of the pandemic and that further stressed the health system: food vulnerability, unemployment and informal employment, violence, mental health problems, seasonal diseases, and migration. In addition, patients with other pathologies (chronic diseases, rare and orphan diseases, oncological diseases, surgical interventions, etc.) were not attended to, contributing to excess mortality (as compared to previous years).

Another aspect that hindered efforts to contain the pandemic was the lack of continuity of MINSA's leadership. On March 20, 2020, just a few days after the first case was diagnosed and the declaration of state of emergency, the health minister was changed. Between March 2020 and December 2022, there were ten health ministers in Peru.

Peru was the first country in the region to decree a mandatory general quarantine on March 15, 2020. At the beginning of the National State of Emergency and quarantine, people could only circulate on public roads to access or acquire essential services and goods. The quarantine was later modified with the progress of vaccination efforts and the ebbs and flows of pandemic waves. Also, in the early months, Peru decreed a full border closure where all international passenger transport was suspended. The Ministry of Education postponed the start of the school year and started online education.

To improve the capacity to care for infected by COVID-19, the Peruvian government opened health facilities at the Pan American Village. Also, the government designated a new hospital, the Hospital de Lima Este Vitarte, to comprehensively attend coronavirus cases. The ICU bed capacity increased from 120 to 852 in the first wave of contagions, reaching almost 1,500 for the second wave (MINSA, 2021).

The government implemented economic measures to address the impact of the epidemic, including subsidizing workers with salaries of less than 1,500 soles. Also, the government allowed citizens to withdraw up to 2,400 soles from their pension funds, assigned 300 million soles (approximately USD 85 million) to support medium and small enterprises, and 12,900 million soles (approximately USD 3.7 million) to repatriate Peruvians stranded abroad.

On March 22, 2020, the Ministry of Economy and Finance (MEF) set an economic bonus of S/380 (approx. USD 105) for each vulnerable family and named the bonuses "I stay at home." The government distributed bonuses to 2.7 million households in urban poverty or extreme poverty in March and May of 2020. The government also set an "Independent Bonus" for over 773,000 households of independent workers. This subsidy was also divided into two deliveries of 380 soles (both in April 2020). The "Rural Bonus" benefited 980,138 households in rural poverty or extreme poverty and was set at 760 soles and distributed in May 2020. The government then set a "Universal Family Bonus" which was a single installment of 760 soles. The payment of the first installment began in May 2020 to benefit more than 1.7 million families and in August 2020, 2.5 million additional families received the Universal Family Bonus. The goal of this subsidy was to reach 6.8 million households (75% of all Peruvian households) that could not cover their basic expenses due to quarantine.

In November 2020, MINSA approved the Preparedness and Response Plan for a possible second pandemic wave of COVID-19 in Peru through Ministerial Resolution No. 928-2020-MINSA. The plan's objective was to reduce infections through the prevention measures, reduce severe cases through treatment at the first level of care, and reduce critical cases at the second and third levels of care. MINSA developed strategies to implement the plan with the objective of strengthening public health surveillance and the country's health intelligence (MINSA, 2021).

One of the most significant public health efforts in Peru was the implementation of the National COVID-19 Vaccination Plan. In a short period of time, the national government, the regional governments, the private sector, and a high percentage of the general population made a significant effort to vaccinate the population against COVID-19. Vaccination in Peru began during week 6 of 2021. As stated in the national vaccination plan, health personnel and front-line workers (e.g., armed forces personnel, firefighters, red cross staff, security personnel, community police and brigades, cleaning staff, and health students) received the vaccine first. Peru then moved on to vaccinating the general

population (MINSA, 2021). Peru set a goal of vaccinating 35,185,356 people. By April 2023, the coverage was of 94% for the first dose, 90.35% for the second dose, 74.4% for the third dose, and 27.11% for the fourth dose.

USAID/PERU'S INTERVENTION

The United States Agency for International Development has had a presence in Peru since 1961. USAID/Peru receives political guidance from the U.S. Department of State and its main purpose has been the promotion of development and cooperation between both countries. USAID has focused its efforts on "poverty reduction, food security, improvement of basic infrastructure and the national road network, the restoration of key democratic institutions after the fight against terrorism, and innovations to improve health and education services to meet the needs of citizens in remote areas of the country" (USAID, 2023).

USAID/Peru has had a significant role in strengthening the Peruvian health system, especially in the nineties and the 2000s. Some examples of the programs and activities that helped with the strengthening were Project 2000, the Food and Nutrition Program for High-Risk Families (PANFAR), Health Policy Initiative, and Promoting Partnerships and Strategies.

The agency's support priorities changed due to Peru's own advancements and changes in support needs. USAID/Peru shifted from implementing activities related to satisfying basic needs to supporting Peru in implementing its own development priorities.

Between 2015 and 2017, USAID gradually withdrew from health and education support and placed greater emphasis on programs and activities dedicated to the promotion of governance, the environment, and alternative development. The withdrawal reflects a policy oriented towards supporting the country's self-sufficiency.

Still, USAID funded a few selected health activities after this withdrawal. Namely, USAID/Peru supported the Peruvian government to fight the Zika pandemic and to address health challenges associated with the immigration of Venezuelan citizens.

INTERVENTION DESIGN

At the beginning of the COVID-19 pandemic, the Regional Office of Migration[1] of the mission in Peru had a small team focused on Zika and Venezuelan migrant needs. Even there was not accurate information on the characteristics of the virus or concrete evidence on which strategies to implement to control the pandemic, the Regional Office made a point on the importance to take action and face the looming crisis.

The declaration of the pandemic in March 2020 marked a critical turning point for the office. The team quickly recognized the need to mobilize resources and collaborate with the Peruvian government in its response to the global health emergency. The team's previous experience managing epidemiological outbreaks allowed them to provide effective solutions in a time of unprecedented uncertainty. The urgency of the situation demanded a response focused on mitigating the effects of the pandemic on Peru's health system and facilitating access to a range of critical services, especially among vulnerable population subgroups.

[1] In February 2021, the office's name changed to Regional Office of Migration and Health due to the magnitude of USAID's intervention in response of the COVID-19 pandemic.

The office responded to the unique situation of the pandemic by organizing a prompt local intervention designed to address the needs of the Peruvian health system. It was USAID/Peru's first health intervention in many years, and the office decided to collaborate with local partners that had a significant understanding of the Peruvian health system and the country's social and cultural dynamics.

Choosing to collaborate with local partners, some of whom USAID had worked with in the past, meant that the office could organizing a highly adaptable and contextualized intervention. Such a flexible intervention allowed USAID and its partners to react quickly and adaptively to the uncertainties of the pandemic in Peru. This approach also allowed the team to include new insights and best practices as they emerged, both locally and globally.

This local and flexible strategy both leveraged the technical expertise of local partners and capitalized on their commitment to address the health problems of their own communities. Despite the abrupt transition to remote work, all teams were committed to the launch of the intervention as quickly and effectively as possible. The USAID/Peru team had the task of starting the implementation of activities as soon as possible. They even sought approval for certain processes during non-working hours with missions like that of New Zealand. The implementing partners were capable of drafting proposals or concept notes in just days. And public officials were able to organize a large number of activities in a short period of time to take advantage of USAID's support. Everyone showed a high level of commitment to promoting a technically solid and dynamic response in the shortest possible time that effectively contributed to mitigating the adverse effects of the pandemic in Peru.

The leadership of the local USAID/Peru team was critical for the successful implementation of the intervention. Their commitment, flexibility, ability to adapt to changes in context, and knowledge of the Peruvian health system facilitated the incremental design of this intervention. Their experience in managing health activities and coordinating technical assistance activities through strategic collaboration with local and global partners proved crucial for a highly efficient and adaptable intervention in response to the COVID-19 pandemic.

On one hand, the local USAID team, together with local partners who executed the activities in the first stage of the intervention, contributed their expert knowledge on the complex Peruvian health system. On the other, they established effective relationships with national and regional authorities to provide rapid support to Peru. This level of collaboration among stakeholders allowed the intervention team to continuously adjust their strategies and make informed decisions in a context of uncertainty. The intervention then moved to a second and key stage where global partners joined the local partners to focus on promoting vaccination.

In 2021, as more partners joined the intervention, USAID recognized the need to strengthen coordination among activities. Having a single Agreement Officer's Representative (AOR), facilitated the coordination and helped avoid overlaps and duplicities among partners. USAID/Peru clearly outlined each partner's intervention areas, both geographically and thematically, to provide technical assistance to national and regional government counterparts. While coordination among partners was not effective in some situations, the initial effort to establish a solid organizational structure proved valuable to ensure direct and effective coordination among all stakeholders.

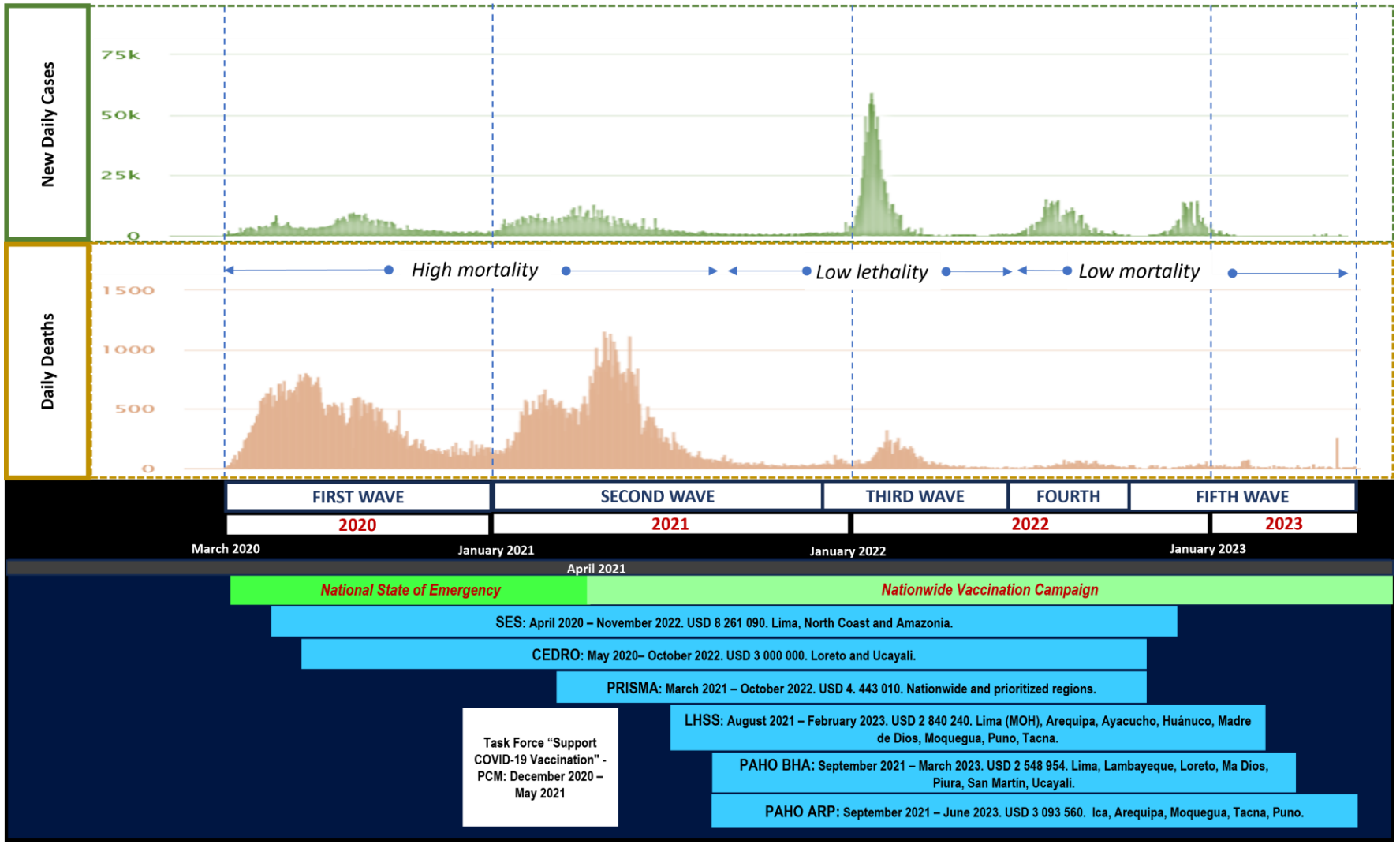
Collaboration among partners also allowed for a more efficient distribution of resources and efforts to benefit the response to the COVID-19 pandemic in Peru. The established order helped prevent overlaps and maximize the impact of technical assistance activities. Unfortunately, the coordination platform

among partners was not always translated to the regional level among local teams from different implementing partners.

In addition to directly supporting the health crisis, USAID/Peru worked closely with the Presidency of the Council of Ministers on putting together the logistics necessary to acquire supplies for COVID-19 care, ensuring a transparent and efficient process. USAID also funded the work of a task force that assessed and proposed adjustments to improve the Peruvian government's response to the pandemic. Moreover, the USAID team played a critical role in overseeing and monitoring the implementation of the vaccination program, significantly contributing to the comprehensive management of the health emergency in the country.

Exhibit 3 presents the timeline of the intervention, through the five implementing partners, and compared to the evolution of the pandemic in Peru.

Exhibit 3: Timeline of USAID Support to the Country Response to COVID-19 Pandemic, 2020-2023



FIRST STAGE

In 2020, the intervention started with two activities implemented by Socios en Salud and CEDRO (See Annex 2 with the factsheets of these activities). The activities focused their efforts on strengthening epidemiological surveillance, oxygen provision, infection prevention and management, COVID-19 case management, and the care of patients with other diseases (including the care of mental health cases and violence in remote communities). These activities extended health services to vulnerable and remote communities, many of which were only accessible by river.

Although USAID has processes designed for emergency situations, the USAID/Peru team demonstrated their commitment by finding mechanisms that further accelerated the procurement and implementation of activities with local partners. Taking advantage of the flexibility inherent in the emergency context, the USAID/Peru team proactively expedited the implementation of the intervention. This strategic and adaptable approach is a testament to USAID/Peru's commitment to effective crisis management, ensuring that assistance efficiently reached affected communities.

Members of USAID/Peru, in close collaboration with local partners who were already involved in responding to the pandemic crisis, jointly designed the intervention. The collaboration allowed for rapid mobilization of resources and knowledge, shortening timelines, and ensuring that help arrived quickly to those who needed it the most.

During the initial phase of the intervention, through the use of calls for Annual Program Statement (APS) and of Fixed Amount Agreements, USAID/Peru and its partners reduced the administrative burden of regular procurement processes and were able to focus on co-creation and execution of activities.

Although USAID/Peru implemented measures to lighten the administrative and supervisory burden of activities, this in no way meant abandoning fundamental USAID principles, such as promoting gender equality and the inclusion of vulnerable populations. For example, CEDRO's activity had the explicit mandate of expanding health services among remote vulnerable communities of the Amazon.

This first stage of the intervention was marked by the flexibility and agility adopted by the USAID/Peru team and the work of its partners in strengthening epidemiological surveillance, the provision of critical services and supplies, such as oxygen, and ensuring access to health services in remote areas where vulnerable populations reside.

- SOCIOS EN SALUD

Just weeks after the state of emergency was declared in Peru, the coordinated response described above started with the agile implementation of the first activity in collaboration with Socios en Salud. While the activity had a greater impact in Lima due to population density and because Socios en Salud had a previously established network there, it also extended to other regions, including Ancash, Arequipa, Callao, Cajamarca, Cusco, Huánuco, Ica, Junín, La Libertad, Lambayeque, Loreto, Madre de Dios, Moquegua, Pasco, Piura, Puno, San Martín, Tumbes, and Ucayali.

The Socios en Salud activity focused on strengthening the capacity of target health establishments for: 1) surveillance, diagnosis, and the provision of oxygen treatment, 2) teleconsultation care for COVID and non-COVID patients including mental health care, and 3) social support to vulnerable families to cope with the emergency during the first wave of the pandemic. By providing logistical support to public hospitals, Socios en Salud significantly improved their capacity to face the crisis.

This rapid and coordinated response supported the provision of care for some of the communities most affected by COVID-19 in Peru. Through close collaboration, USAID and Socios en Salud, quickly adapted to changing needs across the country, strengthening the response capacity and resilience of health systems in an unprecedented crisis.

- CEDRO

CEDRO's activity was launched in May 2020 and focused on the protection of native populations of Loreto and Ucayali. This initiative focused on Amazon riverside communities that are only accessible by water. The activity succeeded in bringing essential health services to the native communities of the Amazon during the pandemic. One of the challenges for CEDRO were punishing river conditions in Ucayali, which difficulted access to some communities.

CEDRO partnered with the Esperanza Amazónica Project, which operates two river ships as mobile health centers. These ships transported a wide range of health services, from dental care to emergency care, to the most remote communities. CEDRO's support included the addition of mental health care services, of promotion and administration of COVID-19 vaccines and other diseases, and of prenatal control activities.

The activity provided essential services to remote Amazonian communities, complementing the work of the Regional Health Directorates (DIRESA) which focused on caring for COVID-19 patients in cities. CEDRO also established close collaboration with community leaders, promoting an intercultural approach to service delivery.

SECOND STAGE

In 2021, when Peru began the implementation of the National Vaccination Plan, USAID designed activities to support this new response strategy. The first of these activities was with a local partner, PRISMA, an organization with recognized experience in strengthening the health system in Peru and committed to supporting various Regional Health Directorates in the timely and equitable implementation of the National Vaccination Plan.

With funds approved through the American Rescue Plan Act (ARPA), USAID also worked with two other partners within mechanisms centrally managed from Washington D.C.: Abt Associates Inc. and the Pan American Health Organization (PAHO) (See Annex 2 for the factsheets of these activities). These two partners have extensive experience working in strengthening the Peruvian health system.

These centrally managed agreements lightened the administrative burden of USAID/Peru. After the initial design and planning stage, local teams worked directly with the USAID/Peru team almost exclusively on the technical aspects of the activity.

- PRISMA

PRISMA implemented a third locally managed activity between March 2021 and October 2022. Its main objective was to collaborate in the execution of the National COVID-19 Vaccination Plan in the regions of Ancash, Ayacucho, Cajamarca, Cusco, Huancavelica, Junín, Lambayeque, Piura, and Ucayali, covering remote geographical areas and rural and native communities.

The activity supported Peru's efforts to reduce vaccination gaps in rural and native communities, significantly contributing to vaccination coverage goals. PRISMA implemented the activity taking into

consideration cultural and geographical differences of the target communities. The activity also helped establish regulations and coordination processes that allowed for greater efficiency in the vaccination effort.

PRISMA focused on providing comprehensive support, particularly on key logistical processes, to DIRESA's health personnel and other authorities in charge of implementing the vaccination plan.

- LHSS

Implemented between August 2021 and February 2023, LHSS was the first activity under a centrally managed contract with Abt Associates and funded with ARPA funds. The activity's target regions were Arequipa, Ayacucho, Huánuco, Madre de Dios, Moquegua, Puno, and Tacna. LHSS conducted a communication campaign in each region, within the framework of the implementation of the vaccination plan, which included the consideration of cultural characteristics of the target audiences.

LHSS provided direct technical assistance the regional governments of Ayacucho and Huánuco in managing the response to COVID-19 through advisors assigned to each region. These regional advisors played a crucial role in supporting the management of vaccination campaigns and encouraging collaboration with other sectors and levels of government. Additionally, LHSS organized peer learning visits so that the management teams of these DIRESA could directly observe successful experiences in the Ancash region.

The activity had a significant impact on strengthening the capacities of regional health sector officials, as well as promoting intersectoral and intergovernmental coordination. LHSS results include a reduction in the vaccination gap in Ayacucho, which was notable because the region had a lower number of deaths from the pandemic as compared to other regions.

Most of LHSS's efforts took place in Ayacucho and Huánuco. The synergy among the various efforts in these two regions resulted in higher vaccination coverage than the national average.

A feature of this activity is that it also provided technical assistance to the Ministry of Health (MINSA) to strengthen epidemiological surveillance and the national network of laboratories, as well as by helping the ministry improve processes such as sample collection and transfer, and the provision of telemedicine services.

- PAHO

The Pan American Health Organization (PAHO) implemented an activity funded through ARPA. The mechanism USAID chose in this case was an umbrella agreement with this International Public Organization. PAHO's work focused on the southern regions of Arequipa, Ica, Moquegua, Puno, and Tacna. Its primary objective was to reduce mortality, morbidity, and complications associated with COVID-19 among patients and their families.

PAHO's activity focused on infection prevention and control, epidemiological surveillance, social communication of vaccination campaigns, and diagnostic capacity with molecular tests in the regions most affected by the pandemic. One of the most notable achievements was the acceleration of universal and equitable access to vaccine distribution in target areas, significantly contributing to mitigating and reducing mortality from COVID-19.

To achieve these results, PAHO carried out information distribution efforts, helped with process standardization, and supported improvements in the responsiveness of health facilities. PAHO's efforts derived into greater protection for both health personnel and the general population in southern regions of the country.

STRATEGIES USED DURING IMPLEMENTATION

The implementation of the intervention through multiple partners involved a variety of executive strategies. These strategies were strongly influenced by the emergency context of the pandemic, which demanded agile and rapid execution of activities. Within this emergency context, the usual procedures of activity design, situation assessment, and activity planning were significantly shortened. The immediate implementation of activities to support the Peruvian government's response became a top priority for USAID/Peru given the urgency of the situation.

Below are some of these strategies that allowed USAID/Peru to quickly adapt to those exceptional circumstances and illustrate the Mission's and its partners' responsiveness and flexibility in the face of unforeseen challenges.

SINGLE USAID OFFICER SUPERVISING THE FIVE PARTNERS (AS AGREEMENT OFFICER'S REPRESENTATIVE OR ACTIVITY MANAGER)

At the onset of the pandemic, only one member of the USAID Regional Office of Migration -later named Regional Office of Migration and Health- had experience in managing health interventions. This official was assigned as AOR/Activity Manager to supervise the five implementing partners. Having a single person with solid technical, managerial, and field experience benefited the whole intervention.

The AOR/Activity Manager nurtured a strong, flexible, and transparent relationship with each of the implementing partners, based on trust and open communication. This positive connection was critical to achieve adaptive operations throughout the activity life cycle. The AOR/Activity Manager provided constant oversight and technical support during the implementation of the activities and had the flexibility to adapt new knowledge and processes to daily implementation.

The AOR/Activity Manager stood as the focal coordination point for implementing partners, significantly simplifying the coordination processes with other various units of USAID/Peru. Likewise, having a single AOR/Activity Manager promoted greater articulation and synergy in the activities and more effective coordination between partners.

COORDINATION BETWEEN IMPLEMENTING PARTNERS

In the third quarter of 2021, after all partners were on board, USAID/Peru convened a decisive working meeting with representatives of all implementing partners. In this meeting USAID laid the foundation for articulation and coordination among partners. The aim was to establish a synergistic, dynamic, and well-defined relationship between the various activities and to lay the foundations for smooth and constant coordination between the partners.

During this meeting, participants clearly delineated each activity's work components and geographic areas of intervention to avoid any overlap between activities. This delineation allowed for a complementary and efficient distribution of resources and efforts, and greatly facilitated the implementation of activities.

The coordination efforts agreed on this meeting resulted in strategic alliances with functional teams and shared resources. An example of this synergy is the support of the epidemiological surveillance system. Socios en Salud had worked on this topic during the first year of intervention. Following their work with the Lima Norte health services network, Socios en Salud actively contributed to launching specialized response teams for surveillance and contact tracing. At the same time, LHSS' approach to strengthening epidemiological surveillance focused on assessing and proposing improvements in system processes and collaborating with various MINSA directorates. The two activities closely collaborated and built on the foundation established by Socios en Salud, which started working more closely to MINSA and in new regions where it had not previously worked.

Nonetheless, the intervention teams also faced coordination challenges. An example of a challenge was the collaboration between PAHO and LHSS for the vaccination communication campaign. Despite an initial agreement to jointly design and implement these campaigns in the southern regions of the country, work did not progress as planned. Then they decided that the best solution would be for PAHO to implement the campaign in the Quechua zone of Puno, while LHSS would handle the Aymara zone. This example highlights the importance of effective communication and coordination, even during challenging circumstances.

Even though the intervention team established coordination mechanisms among partners at the national level, these did not always naturally translate to the regional level when local implementing partner teams coincided in one region. This could have been due, in part, to the urgency of executing activities within a limited timeframe or to the assumption that the delineation of thematic scopes avoided duplication of efforts. The intervention team quickly realized that local coordination is as important as that at the national level to ensure efficiency and coherence in implementation.

Implementing partners also played a fundamental role in promoting interinstitutional and intergovernmental articulation of the DIRESA in support of vaccination campaigns. A notable example is that of the Cajamarca region, where PRISMA collaborated with DIRESA to coordinate with the private sector, through the Chamber of Commerce, to organize campaigns to promote vaccination in schools and private establishments. This initiative resulted in a significant increase in participation and awareness of vaccination in the community. In Ayacucho, LHSS played a crucial role in supporting DIRESA with articulation with the Regional Education Directorate to effectively involve teachers as allies in the vaccination campaign and to organize activities promoting vaccination among students.

WORKING DIRECTLY WITH REGIONAL GOVERNMENTS

While the partners involved in this intervention predominantly worked with regional and local authorities in each of their thematic areas, there were instances of collaboration with MINSA. For example, LHSS provided technical assistance to the National Health Institute, the Directorate General of Telehealth, Referrals, and Emergencies, the Directorate General of Strategic Interventions in Public Health, and the National Center for Epidemiology, Prevention, and Disease Control. Likewise, Socios en Salud and PRISMA collaborated with the National School of Public Health.

The Peruvian health system is decentralized. It is impossible to support the response to a health crisis without working with the DIRESAs. Two characteristics marked the collaboration between the partners and the various DIRESAs: the need for technical support in the DIRESAs' work and their enthusiasm and desire to work hand-in-hand with the partners.

The partnerships with the DIRESAs were significant because they allowed partners to provide the necessary support for regional governments to develop their own health strategies. Instead of implementing MINSA's directives, the collaboration between DIRESAs and the partners enabled activities to adapt and respond directly to the specific needs of each region. Moreover, the activities implemented their work considering the cultural context, geography, and existing health services capacity in each region.

Nonetheless, the work of the intervention with MINSA was crucial as well to ensure the long-term sustainability of the activities. Various of the activities strengthened MINSA's role as national oversight institution by directly or indirectly contributing to the development and implementation of regulations that have had a tangible impact on the national health system.

While collaboration at the regional level was necessary to ensure the adaptability and effectiveness of the interventions, working with the national level ensured continuity and a lasting influence of the activities on the country's health system. Both complementary approaches ensured the achievement of the intervention results.

JOINT DESIGN OF ACTIVITIES WITH COUNTERPARTS

The intervention team ensured the effective implementation of the activities by presenting their workplans to national and regional authorities during the initial stages of implementation. This approach allowed the intervention team to align the intervention with the priorities of government counterparts and complement their work.

In addition to ensuring consistency with needs that the public sector had already identified, the intervention team ensured that the government counterparts developed ownership of the intervention's efforts. In contrast with other international cooperation partners that impose rigid work plans, USAID/Peru's strategy generated greater commitment and cooperation among the authorities.

Designing the activities with counterparts was key to the success of the intervention because everyone involved was committed to the execution of the activities.

EXTENSION OF TEAMS AT THE LOCAL LEVEL

The intervention included the incorporation of coordinators, advisors, or local teams as part of each partners' implementation team. This strategy, used successfully in previous interventions, improves the effectiveness of the technical assistance provided to the DIRESAs. Implementing partners had experience in rapidly expanding their local teams during the execution of cooperation activities. This local-level expansion allowed partners to adapt and quickly respond to environmental changes. It is essential that local staff have decision making autonomy as related to the execution of activities and the management of assigned resources.

In some cases, the partners asked the DIRESAs for agreement with embedding local advisors into their management teams. The DIRESAs provided office space and other support to the advisors.

These local advisors possessed the necessary technical and management skills to provide effective support to the DIRESAs. The DIRESAs saw these advisors as colleagues with experience in similar situations and who have found solutions for the implementation of activities. The advisors strengthened the technical and management capacities of regional officials by directly coaching them.

A significant challenge for this strategy, though, is the limited supply of professionals with the required skills, particularly during a health emergency. The implementing partners do maintain a network of professional contacts at the regional level, which improves the probability of finding qualified staff. PRISMA, for instance, faced difficulties in finding staff with the specific profiles needed and chose to hire individuals with similar profiles. PRISMA's central team then had to closely monitor their regional level staff.

Including local staff in the partners' teams proved to be an effective strategy to expedite the execution of activities. Closely collaborating with the DIRESAs allowed implementing partners to have direct access to crucial information and to make decisions quickly and effectively. Despite the challenges related to the availability of qualified professionals, embedding staff within government counterpart agencies remains a valuable tool in emergency response situations.

PEER LEARNING VISITS

Peer learning visits were valuable in strengthening the participants' capacities by allowing them to observe successful experiences in the field. Additionally, the visits fostered the creation of committed teams and cooperation networks among peers. The opportunity to closely witness the work of teams that who have successfully addressed challenges similar to those faced by visitors, provided a deeply enriching experience.

For the visits to be effective, partners ensured that participants include officials with the authority to make decisions related to the implementation of the activities being visited.

An example of the visits was when Ayacucho and Huánuco teams traveled to Ancash to observe the management of vaccination campaigns. Before this visit, Ayacucho and Huánuco had low vaccination coverages, well below the national average. After observing what was being done in Ancash, the Ayacucho and Huánuco teams were able to effectively organize and learned to manage their campaigns. A lesson learned from the visit was the need to involve other institutions, such as municipal governments and the Regional Education Directorates, for the effort to be effective.

After the visit, vaccination coverage rates significantly increased in Huánuco and Ayacucho, even surpassing the national average. Ayacucho, in particular, stood out for its success in managing vaccination campaigns and ended up receiving visits from teams from other regions and countries, such as Puno and Bolivia.

WORKING WITH EXCLUDED AND VULNERABLE POPULATIONS

USAID's priority of including vulnerable populations in all activities was a significant aspect of the intervention. This priority was most evident in CEDRO's activity, which had the objective of bringing health services to remote areas and native communities of Loreto and Ucayali. Those areas and communities, which would have otherwise been neglected because DIRESAs were focusing on densely populated cities, became a priority for the intervention team.

The decision to include vulnerable populations required adaptations to the intervention's activities. Particularly, when developing vaccination communication campaigns, the intervention team decided to use cultural elements unique to the target communities. This included the use of native languages to ensure understanding and acceptance of vaccination.

Another illustrative example comes from PRISMA's work in Cajamarca, where staff deployed various strategies to increase vaccination rates among native communities, such as *Naranjos* near the Ecuadorian border. To overcome resistance to vaccination in these communities, staff first provided information to community leaders. In *Naranjos*, the turning point occurred when a community leader (Apu) agreed to get vaccinated, leading to a notable increase in the vaccination coverage in the rest of the community.

These examples highlight the commitment of the USAID/Peru intervention team in ensuring that the most vulnerable and marginalized populations had access to health services and were included in pandemic response strategies. Cultural adaptation and sensitivity to the specific needs of these communities were critical aspects of this effort.

OTHER FACTORS THAT CONTRIBUTED TO THE SUCCESS OF THE INTERVENTION

In addition to the previously presented strategies, the study team found other factors that contributed to the success of the intervention:

- USAID approved general, rather than detailed, budgets for implementing partners, giving them ample flexibility in managing field operations. This flexibility proved critical for staff in the field, allowing, for instance, for the purchase of food for nurses during vaccination campaigns in remote areas.
- Implementing partners have rigorous institutional procedures that align with the administrative processes required by USAID/Peru. Despite having administrative exceptions for the execution of these activities, the partners' internal management processes significantly expedited USAID's supervision process.
- USAID/Peru highly values the learning and innovation capacity of implementing partners, who were able to integrate new knowledge into their activities and adapt to abrupt changes in the environment. This learning and innovation capacity is especially important during emergency health situations, where there is no evidence on the effectiveness of response strategies.
- In remote areas where native Amazonian populations live, the use of cultural codes of communication and relationships with community leaders became an essential component of the intervention. A gradual and steady approach to collaboration and direct work with community leaders provided the opportunity to work with vulnerable communities that would have not otherwise been open to the intervention.
- Some activities extended their operations until the first months of 2023. The additional time was spent sharing achievements and lessons learned with new government teams in the regions, after this year's administration change. Moreover, this extension provided the opportunity to promote the continuity of activities and best practices of the intervention. The extension of the Abt Associates Inc. activity allowed the team to present preparedness and response plans for future respiratory virus emergencies to the new DIRESA teams from Ayacucho and Huánuco.

FACTORS THAT HINDERED THE INTERVENTION

The study team identified the following obstacles to the implementation of activities:

- Some partners expressed that USAID's periodic reporting requirements were a distraction from their work in managing the implementation of activities. Reporting requirements were especially burdensome during the months prior to activity closeout, when partners were dedicated to completing planned activities.

- Continuous changes in MINSA leadership and officials difficulted collaboration with the national level. These changes not only meant the interruption of ongoing activities but also meant that the priorities and receptivity of the new authorities could be different from those of the people before them. LHSS was the partner that provided the most technical assistance to various MINSA directorates. The success of this effort was a result of the resilience of LHSS' team, who persevered despite the numerous changes in ministers, deputy ministers, directors, and high-level MINSA advisors. To a lesser extent, these changes also hindered cooperation activities at regional level.
- Collaboration with MINSA was difficult because of the many demands MINSA staff had and to changes in their priorities during the pandemic. The new national administration in 2021 rejected working with partners. This rejection resulted in the cancellation of some previously coordinated activities, such as designing a communications strategy in support of the National Vaccination Plan that LHSS was helping develop. Also, despite the demonstrated effectiveness of the Yellow Button, a pharmacovigilance tool that PRISMA developed to record vaccination (or general medication) side effects, MINSA did not officially adopt it. This lack of institutionalization resulted in the discontinuation of the tool in regions where it had previously been successfully implemented.
- At the regional level, the intervention faced a shortage of providers and professionals with the appropriate experience. Socios en Salud, for example, faced significant difficulties in finding a provider with the necessary experience in oxygen supply in Loreto. On the other hand, PRISMA faced challenges when looking for nursing staff capable of coordinating activities in Ica and Ayacucho. PRISMA ended up identifying obstetricians with the necessary skills, but they were not well received by the teams in charge of vaccination campaigns.
- The scarcity of competent staff within health networks for the implementation of vaccination campaigns was a factor that hindered progress in vaccination coverage.
- Public officials with low management capacity also resulted in challenges during the activities' implementation. For example, during the launch of a vaccination campaign in Ancash, the population had already arrived to the vaccination site, but the vaccine did not arrive due to logistical problems related to the transport service. To address this problem, PRISMA coordinated directly with CENARES to obtain transport authorization of the vaccines from a national warehouse.
- Although the Peruvian government reassigned part of its health budget for pandemic response, it did not assign sufficient additional public resources to effectively support that response. Along with management difficulties, limits to financial resources posed challenges for the efficient execution of vaccination campaigns.

OUTCOMES OF THE INTERVENTION

USAID/Peru's intervention in response to the pandemic significantly contributed to the effort of the Peruvian government to address the health emergency. USAID's support was especially effective for some of MINSA's technical areas, regional governments, health service providers, and to reach the most vulnerable populations (low-income individuals, native communities, and people with chronic diseases). The intervention's activities mitigated the effects of the pandemic and succeeded in strengthening system capacities by increasing the skills and abilities of healthcare providers and community agents.

Each of the activities was implemented incrementally with different objectives, timings, and intensities; contributing significantly to epidemiological surveillance, diagnostic capacity, the ability to provide oxygen therapy, and improving oxygen availability at regional and local levels. Additionally, in contribution to the national response, the intervention team provided support to improve epidemiological information for decision-making at the national level and the implementation of the International Health Regulations (IHR). Likewise, the activities contributed to the reformulation of procedures for diagnosis in regional laboratories.

SCOPE OF THE INTERVENTION

- ADAPTATION

Implementing partners carried out the activities successfully by adapting constantly to the pandemic context, the characteristics of the target locations, and the conditions of the governmental and non-governmental actors involved. Adaptation did not mean that the implementing partners lost sight of each activity's main purpose. Flexibility in planning and administrative aspects of the activities allowed the intervention team to effectively execute the activities. This flexibility was most important during the challenging first few months of the pandemic where the country faced strict restrictions.

- SPEED OF RESPONSE

USAID/Peru and its partners managed to quickly launch technical cooperation activities during the first weeks after the health emergency was declared in Peru (March 2020). These activities started with the one with Socios en Salud (April 2020) and then the one with CEDRO (May 2020). These two initial activities focused on strategic aspects of pandemic response, quickly supplementing some deficiencies in health services such as surveillance and epidemiological response, diagnosis, patient management, and health personnel protection.

- COVERAGE

The intervention helped mitigate the health, social, and economic impact of the pandemic on vulnerable populations in 23 regions. The activities did not measure coverage indicators, however. Each activity only measured milestones and output indicators, such as quantitative information on activities conducted and number of beneficiaries reached.

- QUALITY

Despite the challenges of the emergency context, the partners conducted the activities under quality standards that related to compliance with technical provisions (protocols, clinical practice guides, manuals); respect for patients and communities (communication strategies, cultural adaptation,

socioeconomic support, facilitating access), and suitable conditions for provision, including personnel and patient protection (personal protective equipment, solar panel provision, oxygen equipment).

- INTERINSTITUTIONAL COORDINATION

The intervention team promoted coordination with governmental authorities at national, regional, and local levels throughout the implementation of the activities. This coordination helped guide the activities towards priority needs and allowed partners to successfully provide health care and community support, and support health establishments.

The coordination allowed intervention staff to understand how they could complement the actions of governmental and non-governmental providers to serve people directly and indirectly affected by COVID-19. Additionally, intervention staff were able provide care to patients affected by chronic conditions who were impacted by the closure or overcrowding of health establishments.

- PARTICIPATION

Implementing partners engaged social actors, community leaders, and the people themselves in their efforts to provide services to communities. This focus on working with communities encouraged commitment and participation and helped protect families against the pandemic. The IPs' community agents made home visits to provide health education, epidemiological surveillance, identify risk groups, and follow-up to prevent hypoxia.

STRENGTHENING INSTITUTIONAL CAPACITIES

- DIAGNOSIS

USAID/Peru donated a mobile laboratory with the capacity to perform molecular tests for SARS-CoV-2 to the Ministry of Health. Later, the Ministry implemented two other mobile laboratories based on the design of the one that USAID donated. Also, intervention partners conducted over 116 thousand rapid tests and 31 thousand molecular tests in the city of Lima. At a regional level, USAID strengthened diagnostic capacity through the acquisition of equipment, supplies, and staff training to enhance the genomic surveillance of SARS-CoV-2 laboratories.

While health services almost exclusively focused on COVID-19 patients, the intervention allowed continuity of care for the most vulnerable patients and continued diagnosis of other diseases. Partners performed approximately 6.5 thousand Gene Xpert MTB Ultra Rif tests for TB diagnosis, over a thousand HIV screenings, 11 thousand blood pressure screenings, and over 3.1 thousand screenings for Diabetes Mellitus exclusion.

- TREATMENT

At the beginning of the pandemic, the lack of oxygen and competencies to perform oxygen therapy hindered efforts to address the crisis. USAID's response to this challenge was to focus initial actions on developing capacities to provide oxygen treatment (87 establishments and 27 hospitals and a temporary oxygenation center, adding 552 oxygen output points and delivering 141 oxygen concentrators with a capacity of 10 L/min in Cusco, Ucayali, La Libertad, Lambayeque, Lima, Arequipa, San Martín, and Ica).

USAID strengthened care provision, giving guidance to patients through more than 473 thousand non-COVID and COVID teleconsultations. USAID also gave support for continuity of care by delivering medicines at home for patients with chronic diseases, via a motorized service or through Community Health Agents visits.

COVID also impacted the mental health of the population, so USAID provided individual psych-emotional support services and mental health promotion and capacity strengthening workshops. USAID also funded a chat-bot for mental health telecare, which provided psychological first aid and, for those who needed it, referred them to psychiatric consultation. One of the versions of the chat-bot was in Quechua.

In the Amazon, USAID provided comprehensive care services by water, including medical care, obstetrics, mental health, vaccination, and laboratory analysis.

- VACCINATION

As soon as the government approved the national vaccination plan, USAID efforts focused on promoting widespread and equitable access to COVID-19 vaccines. These efforts included communication activities to encourage vaccination acceptance and behavior change among people who had decided not to get vaccinated. At the regional level, USAID and the regional governments conducted vaccination clinics in Amazonian communities through the medical facilities of hospital ships that included COVID other vaccines as well (Human Papillomavirus, Tetanus, Hepatitis B, Influenza, etc.). USAID also donated cold chain equipment to various regions.

- EPIDEMIOLOGICAL SURVEILLANCE

At the beginning of the intervention, partners established rapid response teams for epidemiological surveillance and contact tracing (20 DIRIS Lima Norte and 10 DIRIS Lima Este). The teams conducted over 24 thousand home visits.

For health centers, partners conducted a baseline assessment on prevention and control of infections caused by the COVID-19 coronavirus. The assessment included the identification of gaps for staff training, and the prevention of infections associated with health care at regional and local levels.

- INTER-INSTITUTIONAL WORK

USAID and its partners successfully implemented the interventions largely thanks to collaborative work with governmental authorities at national, regional, and local levels. They also established relationships with non-governmental entities and the private sector to operationalize the provision of care services to Amazonian populations and vaccination campaigns. These activities were very successful as a result of their pertinent timing and how they complemented what local providers were doing.

- HANDLING CORPSES

USAID also helped increase the capacity to handle corpses in four hospitals (Lambayeque, Lima, Loreto, and Piura), which was necessary due to the increase in deaths during the first months of the pandemic.

STRENGTHENING INSTITUTIONAL CAPACITIES TO RESPOND TO SIMILAR FUTURE SITUATIONS

- IMPLEMENTERS

Implementing partners identified good practices and lessons learned that, if applied, will allow them to cope with similar future situations. These good practices and lessons learned have been extensively described in this document.

- PUBLIC INSTITUTIONS

The intervention strengthened the response capacity of public institutions at all three levels of health management and care. Partners helped improve active surveillance, timely detection, and reporting of suspected COVID-19 cases through the standardization of processes and skills for data detection, collection, and analysis within the framework of International Health Regulations (IHR).

USAID funded the training of ten high-level specialists from the National Institute of Health at Seoul Clinical Laboratories (SCL) in South Korea. During the training, the specialists reviewed procedures and key management aspects for the improvement and expansion of COVID-19 diagnosis, PCR quality control, and molecular and genomic surveillance. The training resulted in the strengthening of NIH's capacity to improve the availability and accuracy of tests nationwide, improve the diagnostic capacity of regional laboratories by modifying requirements and procedures, improve the collection and transport of samples for PCR tests in primary care facilities; improve processes for PCR tests at the National Institute of Health (NIH) and hospitals; improve genomic sequencing procedures at NIH laboratories; design a PCR quality control instrument; and expand and improve genomic sequencing. Also, partners trained 40 NIH workers and 15 establishments in 8 regions on PCR sample collection and transport, as well as managing a national network of laboratories for respiratory virus surveillance.

USAID strengthened the capacity of health facilities in Lima (DIRIS Lima Norte) by providing them with beds and oxygen concentrators to implement a Temporary Oxygen Therapy Center (OTC), as well as those located in rural areas by installing solar panels. The partners trained health sector workers on general maintenance of medicinal oxygen systems.

The intervention also supported the vaccination campaign by providing MINSA with a scenario analysis to incorporate the COVID-19 vaccine into its regular vaccination schedule. This support also included contributions on budget estimation and subsequent negotiations with the Ministry of Economy and Finance.

USAID also helped the MINSA develop a master plan to expand the scope of "*Teleatiendo*", a technological platform to record the requests for care and the care provided during the COVID-19 pandemic. *Teleatiendo* improved access to healthcare for people with non-COVID related diseases. Six months after the end of this effort, many of the master plan's sections have been implemented, and others are in the process of being implemented.

Finally, the partners implemented activities that improved readiness for future health emergencies. For example, in the Ayacucho and Huánuco regions, the partners helped regional governments develop plans to prepare for a future pandemic or health emergency. These plans reflect the progress made during the implementation of the intervention and also identify the critical activities that must be

performed to strengthen these regions' response capacity. The plans also provide a roadmap of actions that can be implemented to face a future health emergency.

- COMMUNITIES

USAID strengthened communities through training and awareness work for community agents and other community leaders. Partners gave priority to vulnerable communities, especially in the Amazon and southern Peru, where activities included cultural elements that helped with the response to the pandemic. Likewise, the intervention's communication strategies can be replicated to implement continuous health education programs.

The pandemic left a wealth of experiences and lessons learned that will contribute to the success of future cooperation interventions and that strengthened USAID's management team, especially with regards to health activities and emergency and disaster responses.

In general, USAID/Peru's activities complemented and enhanced the work of the Peruvian health system, both at national and regional levels. The intervention's activities were strategically oriented to support key aspects of the pandemic response and significantly contributed to mitigating the effects of the pandemic. The intervention generated added value in the health system's response capacity, providing assistance to health services management in 23 regions of the country, generating relevant information for decision-making, and seeking sustainability. USAID's intervention resulted in the implementation and leveraging of processes and procedures for immediate response to the emergency that would have taken longer through the regular administrative path in the public sector, avoiding possible negative consequences due to the delay of interventions.

LESSONS LEARNED

The lessons learned presented in this section are the product of information provided by key actors who participated in a series of interviews and the validation workshop held between July and September of 2023. Beyond the documentation of lessons learned, the data collection and validation process provided the opportunity for stakeholders to reflect and learn from the experience. The study team obtained the lessons below through reflection and critical analysis, focusing on what facilitated or hindered the execution of the activities, as well as the factors that positively or negatively affected the intervention (PMI, 2017).

These lessons are derived from the process of reconstructing the support activities that USAID and its partners implemented in response to the pandemic. The lessons encompass key elements that played a crucial role in achieving tangible results. Presented below are lessons learned from this experience, recognizing that "documenting lessons learned plays a vital role in illuminating new knowledge, facilitating its dissemination, promoting practical application, and encouraging reuse." (IDB, 2015).

DESIGN AND COORDINATION OF ACTIVITIES

- Having a dedicated Health Activity Manager within USAID/Peru has proven indispensable for swift, localized response and effective alignment with the intervention's objectives and scope. This role also fosters the establishment of coordinated and collaborative spaces among USAID's administrative bodies, implementing partners, and health authorities, promoting synergy and effective management.
- USAID/Peru benefits from a certain degree of flexibility in adapting its processes during emergency situations. While administrative procedures are typically well-defined for these kinds of situations, the remarkable reduction in execution timelines during emergencies can be attributed to the flexibility, dedication, and commitment of the staff. This highlights the potential for enhanced efficiency in the implementation of future interventions.
- Some of the hiring mechanisms that USAID employed effectively mitigated distractions stemming from administrative or bureaucratic processes, all the while maintaining the desired outcomes of the intervention. The utilization of contracting mechanisms, such as fixed amount agreements, successfully reduced the administrative workload and enabled both USAID/Peru and its implementing partners to focus more on the intervention itself and the required adaptations, particularly in a context where knowledge about the virus, transmission mechanisms, and the most effective strategies to combat it remained limited.
- The selection of implementing partners stands as a pivotal decision. When global and local partners already possess specific certifications, the hiring process becomes more streamlined. An effective mechanism for expediting the implementation processes, when working with global partners that have a local presence, is to ensure their registration within the official channels of the U.S. government.
- A good partner is one that showcases a strong track record of both technical expertise and administrative competence. In Peru, a group of such partners has proven their ability to respond rapidly during the pandemic. However, this response time can be further expedited when these partners are well-informed and up to date on the administrative processes of USAID.
- Collaborating with partners who maintain a team and network of highly skilled local professionals at the national and/or regional levels greatly expedites the organization, deployment, and

implementation of an intervention. The successful involvement of partners in supporting the pandemic response can be attributed, in part, to their robust network of locally trained professionals who maintain excellent relations with health authorities.

- Establishing and nurturing an open, transparent, flexible, and constructive relationship between USAID and its implementing partners is of paramount importance. Such a positive relationship not only facilitates the implementation process but also allows for necessary adjustments to operations throughout the activity's duration.
- Remote supervision and technical support for implementation are viable options. To ensure effective remote oversight, it's crucial to maintain a regular and periodic schedule for coordination and compliance monitoring calls to track products, deliverables, and milestones as laid out in workplans.
- Recognition of USAID and the support of the American people can be limited, particularly in the field, primarily due to a lack of awareness regarding their contributions. A highly effective strategy for garnering recognition in various intervention areas is to actively involve USAID officials and the U.S. embassy in the implementation and supervision of activities, because this involvement includes protocolary and media engagement. Interestingly, in certain regions, the recognition of implementing partners tends to be more pronounced than that of the support of the American people.

MANAGEMENT AND ADMINISTRATION OF ACTIVITIES

- Regional Governments provide a swift and direct pathway for international cooperation agencies to launch interventions. This is particularly so in situations where scant information complicates decision-making at the national level or when national authorities are preoccupied with other demands that impede coordination with implementing partners.
- The inclusion of national and regional authorities in the design and implementation of activities enhances both the speed and responsiveness of those activities, with a focus on the most critical needs. Activities have demonstrated greater efficiency, effectiveness, and sustainability when officials from MINSA or GERESA/DIRESA actively participate in their design, implementation, and evaluation.
- Close coordination between partners and health authorities played a pivotal role in achieving objectives in a timely manner. Numerous instances underscore this, such as the prompt supply of oxygen, vaccination efforts, and the transportation of personnel and materials to remote areas (including to regions exclusively accessed via river) by boats and other transportation options provided by either the regional government or implementing partners. One such example is the Esperanza Amazónica Medical Program.
- An effective approach for implementing activities, particularly for short-term and complex projects lasting less than a year, is to engage a local team or advisor. This approach empowers partners to swiftly adapt to changing contexts and assist regional authorities in overcoming minor obstacles that may impede progress. Beyond coordination responsibilities, a local advisor should possess both technical and management skills to provide support to the DIRESA. The work of a local advisor can serve as a valuable strategy to enhance technical and managerial capabilities among public officials.
- The recruitment and hiring of qualified personnel constitute a pivotal factor for the success of the intervention. The availability of professionals possessing the requisite qualifications to join implementing partner teams is limited, but USAID and its partners made concerted efforts to secure the necessary workforce for field work. Also, at the regional level, there was a high demand and

fierce competition for professionals with technical and managerial competencies among activities focused on strengthening the health system.

- Providing specialized training to healthcare professionals through non-traditional methods emerged as one of the intervention's central activities in addressing the challenges posed by the pandemic. For instance, implementing partners actively sought out universities with expertise in relevant areas and identified thematic managers with strong pedagogical skills. To ensure the timely delivery of these training programs, USAID provided support to the School of Public Health (ENSAP) by assigning a dedicated manager during the planning and implementation of courses and programs.
- The learning capacity of partners during the implementation of an activity is especially valuable as it leads to improving the intervention and innovation. This is crucial when facing a health emergency, especially when there is not much clarity about the effectiveness of response strategies.
- There is a pressing need to train professionals in public and administrative management within the public sector. This need became evident while collaborating with the health system, as certain delays and implementation challenges were attributed to managerial limitations among government staff.
- Intersectoral and intergovernmental coordination plays a pivotal role in expediting a rapid response, particularly when it comes to launching critical activities such as vaccination. Responding to a health emergency transcends the purview of health authorities, underscoring the importance of establishing intersectoral coordination that clearly delineates roles for each stakeholder. Such coordination requires political support from governors and regional and local administrators.
- Exchange visits and peer learning between regions are successful strategies to promote the sustainability of the intervention. Subnational authorities and technical teams are willing and interested in improving their capacities by learning from successful experiences in, and establishing coordinated work with, other regions.
- The absence of a comprehensive, reliable, and timely information system posed challenges to effective management and decision-making. The existence of various applications, divergent reports, and inconsistent information across national, regional, and local levels complicated analytical and decision-making processes. The staff within the health system did not have adequate computer skills, nor access to adequate information systems. These limitations underscored an urgency to integrate and bolster information systems, particularly in collaboration with EsSalud, and to enhance training at the health system level.
- Even in a state of emergency, where flexibility was afforded for administrative processes, it is necessary to transparently record all procedures. Transparency supports control efforts and eliminates the need for further questioning of activity processes.
- The private sector can join government efforts and be a valuable ally that facilitates the expansion of strategies such as vaccination and oxygen supply. Coordination between public and private institutions with the common goal of protecting people's health is possible.

ACTIVITY OPERATION AND SUSTAINABILITY

- Even in critical situations, it is feasible to implement planning processes with a decentralized approach and with the effective participation of community leaders (such as Apus, teachers, community health agents, and members of social organizations). This inclusive approach facilitates the implementation of interventions and promotes better results.

- Involving individuals responsible for the management of resources and of health centers significantly enhances the organization of an effective response. This involvement streamlines communication, enabling the timely identification of priority issues and critical healthcare establishments for urgent intervention.
- Maintaining a minimum capacity to attend to other (non-COVID) patients is essential to avoid excess mortality and greater health risks. The health system must ensure the continuity of care and treatment of the population requiring health services for chronic diseases or conditions requiring urgent or emergency care.
- The pandemic gave rise to stress and anxiety among both the general population and healthcare workers. Staff shortages resulted from infections and the necessity to exclude individuals with comorbidities and other high-risk characteristics for COVID-19, intensifying the burden on healthcare providers due to the heightened demand for care.
- Effective planning requires identification and evaluation of essential assets. The absence of official information regarding the initial status of assets, including oxygen equipment, oxygen supply, personal protective equipment (PPE), essential medications for intensive care, and the absence of clear protocols, presented challenges in developing a supply plan to meet both regular and increased demands. This delay impeded the initiation of the response efforts.
- The use of cultural elements and local languages is critical for the design of communication strategies, psychoeducational activities, and counseling and psych-emotional support. This is particularly the case in remote areas and for vulnerable communities, that may have additional difficulties when accessing information. The success of strategies was directly linked to the extent to which healthcare personnel enhanced their communication skills, effectively addressing people's concerns about the pandemic. This proficiency reduced vaccine hesitancy.
- Collaborating with local personnel, community agents, and leaders, particularly women within the community, played a pivotal role in successfully executing planned activities and establishing trust with healthcare teams. In certain instances, the public vaccination of a community leader proved to be more effective than conventional communication campaigns in gaining access to vaccination-resistant subgroups within the population.
- The DIRESA/GERESA were not always able to attend training activities because their personnel couldn't be spared from their duties. In such circumstances, it was impractical to temporarily relocate a specialist from a hospital or health center for off-site training that spanned several days.
- The exchange of international experiences proved to be instrumental in bolstering the surveillance system and enhancing various operational processes. Such exchanges offer a valuable opportunity to gain new insights and adapt local practices. Furthermore, visits to other countries led to the modification of procedures used by the NIH, resulting in quicker diagnoses and adjustments to the requirements for regional laboratories.
- The pandemic bolstered the practice of virtual/remote work, highlighting its value as a useful tool when employed with well-defined objectives and established protocols. Virtual work proved particularly beneficial during the pandemic in areas where physical presence was limited within health services, areas lacking specialized professionals, or remote regions. Nonetheless, it’s important to acknowledge that not all virtual activities, such as some training sessions, were equally effective.

- During the emergency, the priority of the intervention's activities was the response itself, however, it is possible to implement actions that endure over time. At least during the initial stage of the emergency, it was crucial to prioritize the response efforts and keep doing so until the deployment of strategies that established a minimum level of stability. Subsequently, it became feasible to enhance sustainability and achieve long-term results through activities aimed at strengthening the health system, improving problem-solving capabilities, advancing decentralized management, fostering intersectoral collaboration, orchestrating the engagement of various social stakeholders, developing emergency preparedness plans, and promoting collaboration between the public and private actors.
- The cultivation and enhancement of skills and capabilities in personnel stand as one of the most effective means to sustain the actions that have been implemented. These acquired skills persistently serve in benefit of patients and remain applicable in potential future situations of contingency.
- Implementing partners implemented some activities that resulted in sustainability and long-term results. For example, in the Ayacucho and Huánuco regions, partners helped draft plans to prepare for a future pandemic or health emergency. These plans not only capture the progress achieved during the intervention, but also identify what is needed to strengthen the response capacity of regional governments.
- The implementation of the Regions' contingency plans showed the need to close gaps in human resources, supplies, medications, equipment, and infrastructure. The pandemic has taught us that the health system must be prepared in advance to be able to provide an effective response to a significant increase in the demand for health services.
- Health staff is now better trained on the use of PPE and the use of protective measures. This knowledge will be crucial when the country faces similar events in the future. At the onset of the pandemic, healthcare personnel were gripped by fear, particularly when there was limited knowledge about protective measures. Over time, health staff acquired the essential knowledge and skills to safeguard themselves. The experience of the pandemic compelled healthcare workers to overcome their initial traumatic experiences and fortify their competencies, both cognitive and attitudinal, enabling them to confidently fulfill their roles on the front lines of healthcare.
- The population needs to be well-informed and provided with dependable channels through which they can access timely and continuous information. Clear information is critical to counteract misinformation and empower individuals to actively engage in self-care, look after their families, and contribute to community well-being.

BEST PRACTICES

The following are good practices that the study team identified within USAID/Peru's implementation of the intervention:

a) the use of flexible hiring mechanisms and an expedited hiring process enabled the initiation of the first activity within mere weeks after the health emergency was declared in Peru,

b) the establishment of an open and flexible working relationship between USAID/Peru and the implementing partners, starting from co-creation of activity designs,

c) creating a space for partners to coordinate and optimize resource use, geographical distribution of activities, and intervention allocation according to each implementer's capabilities and experience,

d) close coordination between partner staff and diverse authorities nationwide throughout all implementation stages. This coordination allowed intervention activities to address the priorities of those authorities and make necessary adjustments in a changing context,

e) partners' learning during activity implementation resulted in adaptations and new strategies,

f) embedding coordinators or advisors into regional government teams facilitated decision-making and overcoming of minor obstacles that hindered progress,

g) promoting intersectoral and intergovernmental coordination activities to implement actions to reach the entire population. This strategy was particularly valuable for boosting the vaccination campaign at a regional level,

h) organizing peer learning visits that resulted in learning from successful experiences and forming work networks among different health teams nationwide,

i) including specific cultural elements and using local languages in designing communication campaigns,

j) coordinating with, and raising awareness among community leaders and other social actors, like teachers, to promote communication in local languages in remote communities,

k) providing personal protective equipment (PPE) to workers to reduce contagion risks and build confidence so that they may perform their roles,

l) disseminating achievements and products (e.g., preparedness plans for future health emergencies) as models that can be used by others, thereby extending the scope of intervention to the whole country,

m) disseminating results and creating communication documents, such as milestone summaries and result fact sheets, enables the swift evaluation of activities.

CONCLUSIONS

This study aimed to answer the following three questions about USAID/Peru's intervention in response to the pandemic in Peru.

HOW DID USAID ADAPT ITS PROGRAMS AND OPERATIONS TO RESPOND TO THE DIFFERENT STAGES OF THE COVID-19 PANDEMIC AND THE CONTEXT?

1. USAID has a rich history of collaboration with the Peruvian government. Over the course of more than 60 years, this partnership has transformed from the support to basic service delivery and economic growth to fostering a strategic alliance that advances the shared interests of both the United States and Peru (USAID, 2022). The 1951 General Agreement for Technical Cooperation frames the cooperation relationship between Peru and the United States.
2. The two countries strengthened this collaboration relationship during the COVID-19 pandemic (2020-2023). Even though the Mission in Peru did not have a health office or health programs, USAID provided crucial support through five activities with the following implementing partners: Socios en Salud, CEDRO, PRISMA, Abt Associates Inc, and PAHO. This set of activities was USAID/Peru's first local health intervention in many years.
3. USAID launched the activities using processes and procedures that expedited and reduced administrative procedures. USAID's support in response to the pandemic started in April 2020 through a local cooperation agreement with Socios en Salud, just weeks after the health emergency had been declared in Peru.
4. A single AOR/Activity Manager managed all activities and ensured good geographical and thematic distribution among the five implementing partners. This AOR/Activity Manager was responsible for designing, monitoring, and accompanying the set of activities and created and led effective coordination spaces among partners.
5. The activities provided immediate emergency response, which, despite the government's emergency declaration, would have taken longer through the public sector's regular administrative path. The intervention helped mitigate negative consequences in selected regions resulting from government intervention delays.

HOW DID USAID AND IMPLEMENTING PARTNERS RESPOND TO THE PANDEMIC AND CONTEXT?

6. USAID/Peru, through its partners, promptly implemented technical cooperation activities within weeks after the health emergency had been declared in Peru (March 2020). These activities gradually started focusing on strategic aspects of the pandemic response in line with the government's established plan.
7. USAID chose organizations as implementing partners for their technical expertise and previous work experience with USAID or other cooperation agencies.
8. During the emergency's initial stage, characterized by high morbidity, high mortality, high lethality, and limited response capacity to the pandemic, partners established processes and procedures to strengthen epidemiological surveillance and diagnostic capacity. Likewise, partners provided personal protective equipment (PPE) to health facilities staff, as well as oxygen and equipment to improve their operability and performance. In the Loreto and Ucayali jungle partners provided comprehensive care services by river, including mental health care.

9. During a second stage of the emergency, when the country had a vaccination strategy, partners provided support in some regions to manage and implement the national vaccination plan. This support included strategy design and development of communication campaigns. These included important cultural elements and intersectoral and intergovernmental coordination. Finally, partners provided assistance to some regions as they developed response plans for future health emergencies.
10. The intervention's activities were extremely valuable as a result of the timing of their implementation as well as of their complementarity of actions executed by local providers. Government counterparts all over the country value USAID's support to the response to the pandemic, particularly because of how the intervention was managed, its flexibility to adapt to variations in context, the versatility of its communication component, and the cultural adequacy of its activities.

HOW DID COVID-19 FOCUSED INTERVENTIONS CONTRIBUTE TO STRENGTHENING THE NATIONAL CAPACITY TO RESPOND TO EPIDEMICS AND HUMANITARIAN CRISES?

11. USAID/Peru's support to the COVID-19 response enhanced the Peruvian government's efforts to address the health emergency.
12. USAID/Peru's activities focused on ensuring coordination with various health authorities, ensuring the prioritization of regional priorities. The activities provided care and support to those communities and establishments in greatest need. The activities were successful because their staff promoted the engagement of communities and their leaders.
13. Partners sought to complement the actions of government providers, providing care to people directly and indirectly affected by COVID-19. The activities helped optimize efforts and provide care for patients with other conditions such as tuberculosis, HIV, chronic diseases, and mental health. These patients would not have had access to care because of health facilities closures or hospital overcrowding due to COVID-19.
14. The activities significantly contributed to epidemiological surveillance and improvements in the availability of oxygen, including in rural areas through solar panels installation. The activities not only helped mitigate the effects of the pandemic but managed to generate added value in the system's capabilities, increasing the competencies and capacities of health staff in both urban and rural areas.
15. As part of their contribution to the health system, these activities helped enhance the vital information infrastructure needed for strengthening national-level epidemiological surveillance and the effective implementation of the International Health Regulations (IHR). Furthermore, the activities helped revise diagnostic procedures in regional laboratories. Nevertheless, despite the progress achieved, there remains a pressing need for a concerted effort across various sectors of the government to formulate a cohesive response plan that can ensure an effective reaction to situations akin to the challenges encountered during the pandemic.

RECOMMENDATIONS

This section presents some recommendations based on the lessons learned in the previous section. The sources of the recommendations are interviews conducted during the second stage of data collection, discussions held during the validation workshop, analysis of findings, and discussions among the study team. The recommendations focus on actions that can strengthen or maintain the strategies that facilitated the achievement of results during the implementation of the intervention in response to COVID-19.

ACTIVITY DESIGN AND COORDINATION

FOR USAID

1. Maintain a health work agenda, even if it is of low intensity. A continuous relationship between USAID/Peru and the Peruvian government will ensure there is an open channel to implement a structured, rapid, and effective response to any future health emergency. This continuous relationship must include a long-term coordination mechanism between USAID and MINSA's OGCTI, as well as other multi-sectoral level mechanisms.
2. Cultivate a transparent, articulated, and continuous relationship with implementing partners and national and regional health authorities as part of this work agenda.
3. Retain a dedicated Health Manager at USAID/Peru. This local manager must have strong technical skills and extensive knowledge of the public health apparatus. The manager must also have demonstrated skills to coordinate with different stakeholders including implementing partners, government institutions, and other international cooperation agencies. Finally, the manager must be able to transparently manage cooperation activities.
4. Ensure any future interventions are co-created with implementing partners, as they are a valuable asset in the process of activity design. Additionally, co-creation facilitates coordination among partners during activity implementation.
5. Ensure the administrative flexibility granted to partners to speed up processes is available during future health emergencies. This streamlining of processes results in expeditious design, hiring, and implementation procedures.
6. For future responses to health emergencies, use award types similar to those used during this intervention, such as fixed-amount agreements. These kinds of awards allow implementing partners to adapt and respond quickly to changes in context, freeing them from administrative tasks that do not significantly affect the quality of implementation.
7. Establish clear monitoring instruments (e.g., plans, methodologies, indicators, products) that are part of the design process of activities and based on the workplan.
8. Encourage potential implementing partners to keep their certifications (e.g., SAM, APCI) updated to expedite the implementation of an intervention in case of an emergency. To the extent that partners continue to implement any kind of activity funded by USAID, even with a small budget, they will remain updated on the necessary administrative procedures.

FOR THE IMPLEMENTING PARTNERS

9. Cultivate and maintain a transparent and close relationship with USAID/Peru. Also, cultivate and maintain an effective working relationship with other implementing partners and with authorities at national and regional levels.
10. Proactively engage counterparts MINSA and DIRESA when developing health intervention proposals. This engagement eases the start of implementation and ensures that activities are aligned with the priorities and needs of government counterparts.
11. Continuously participate in consultation spaces and health policy advisory councils on health issues pertinent to your organization.
12. Keep certifications needed to work with USAID such as SAM and APCI, active. In general, stay abreast of any modifications USAID makes to its hiring and other administrative processes.
13. Maintain relationships with networks of professionals with the technical skills and relevant professional experience for the execution of health activities. Sporadic engagement with those networks will allow partners to quickly form work teams to implement activities in an emergency context.
14. During implementation, include staff responsible for monitoring the implementation of activities at the regional level. Local monitoring staff will effectively collect and report the data needed for the effective management of USAID funds and document opportunities and risks that arise during the implementation of activities.
15. Draft a monitoring plan for each activity proposal. These monitoring plans should be detailed, with a clear definition of processes, indicators, and information flows.

FOR THE GOVERNMENT OF PERU

16. Cultivate and maintain a transparent and close relationship with USAID and its implementing partners, even during periods when there is no ongoing USAID activity.
17. Establish and strengthen mechanisms that allow for continuous and structured relationships with agencies of international cooperation. These mechanisms must be operational both at the national level through MINSA and at the regional level.
18. Strengthen MINSA's General Office of International Technical Cooperation (OGCTI). Working with this office, USAID may be able to maintain a health work agenda even during periods where a large portfolio of activities does not exist.
19. Strengthen coordination with international cooperation agencies. This coordination should not be the OGCTI's sole responsibility but that of officials at every level of government.
20. Organize, promote, and participate in consultation spaces and advisory councils on health policy or on pertinent health issues.
21. Promote the recognition of USAID's support by publicizing it when implementing any activity funded by USAID. Acknowledge that the work is only possible thanks to the support of the American people.

ACTIVITY MANAGEMENT AND ADMINISTRATION

FOR USAID

1. Encourage joint activity design with national and regional authorities.
2. Provide institutional support to implementing partners for during activity start up and facilitate coordination with national and regional authorities.
3. Offer flexibility during activity start up if a dearth of qualified personnel, especially at the regional level, causes delays in implementation. Maintain an transparent and close relationship between USAID/Peru and its partners that allows for timely identification of this dearth and make the necessary adjustments.
4. Provide feedback to partners whenever a learning opportunity is identified. Encourage partners to engage in critical analysis of their efforts during activity implementation. This will allow them to learn from their experience and make necessary adjustments and improvements in response to rapid contextual changes.

FOR THE IMPLEMENTING PARTNERS

5. Maintain an ongoing working relationship with national authorities, even when activities are implemented directly at regional level. This approach ensures that successful experiences garner national recognition and serve as management models. Ongoing coordination with national authorities also streamlines the implementation of certain activities at the regional level, particularly when it is necessary to abide by national regulations or directives.
6. Actively involve government counterparts MINSA and DIRESA in the design and operational evaluation of activities. Likewise, have procedures and tools available to modify plans according to emerging needs in a changing emergency environment, such as a pandemic, so activities can align with the changing priorities and needs of government counterparts.
7. Maintain a transparent and open relationship with regional authorities during activity implementation to coordinate on necessary adjustments to planned activities. In some cases, embedding a regional coordinator or advisor into the government office facilitates such coordination because they become the main the point of contact between the health authority and the partner. The partners' staff in Lima must empower the local regional coordinator or advisor to engage directly with their government counterparts.
8. Proactively recruit staff. Partners need professionals with experience, technical knowledge, management capacity, and relationship management, and a good reputation. Professionals with this profile are hard to find and competition is high. In absence of such professionals, partners might consider hiring individuals willing to learn on the job but should plan for close human resource management to enhance the selected individual's capabilities.
9. Have procedures in place for rapid recruitment. Maintain contact with a network of professionals, especially those experienced in USAID processes, to ease their hiring process.
10. Promote learning and innovation through critical reflection during activity implementation. USAID highly values these approaches as they are necessary for adaptation during times of uncertainty and change and the development of new solutions.
11. Promote intersectoral and intergovernmental coordination. Given the limited intersectoral and intergovernmental coordination in the public sector, partners should take on the role of catalysts for effective coordination. Partners may even create coordination spaces, but they

should find a government entity that can provide sustainability to the space. Throughout activity implementation, and even if they do not lead the coordination spaces, partners should actively participate and ensure the spaces' effectiveness and sustainability.

12. Promote learning exchanges, especially peer learning opportunities, to strengthen the technical, managerial, and organizational capacities of national and regional officials. Learning exchanges also result in cooperation networks among peers. Exchanges and networks promote knowledge acquisition and modification of local practices.
13. Provide technical support to the public sector to strengthen the health information system. Promote interoperability between subsystems. Avoid supporting initiatives that generate ad-hoc systems, especially if these operate parallel to existing systems and generate overload on health personnel.
14. Establish mechanisms to document activity implementation best practices to improve management transitions, even when not required in the agreement with USAID.

FOR THE GOVERNMENT OF PERU

15. Maintain a relationship with international cooperation agencies and its partners, including at a regional level. Develop an agenda of priority issues that outlines the needs of the Peruvian government as related to technical assistance and use it to guide the relationship with those international cooperation agencies. Having such an agenda will help expedite the implementation of USAID activities.
16. Designate the responsibility of coordinating international cooperation activities to a high-level official. This appointed official will serve as the point of contact for all coordination right from activity startup. Although this coordinator may not hold the highest authority, they should possess internal decision-making capacity, have direct access to relevant authorities, and liaise with various operational teams simultaneously. Furthermore, the official must have operational proficiency, technical competence, and a comprehensive understanding of the realities in the field.
17. Support implementing partners in the search for professional staff for activity implementation. National and regional authorities can help expand the partners' network of professionals who have ideal backgrounds for the intervention.
18. Establish well-structured relationships to streamline inter-institutional and intergovernmental coordination. Endorsed by political authority, formalize these relationships through agreements, worktables, committees, or regulations. Ensure that there are budgetary resources assigned for their effective operation. Gaining political support for these initiatives is easier to do when authorities identify their political benefits.
19. Ensure peer learning activities take place. MINSA must monitor and publicly recognize successful efforts throughout Peru. Assign this responsibility to a directorate or office.
20. Hire experienced professionals to create and maintain information systems and strengthen statistical offices. Extend connectivity throughout the country to areas that have no access to Internet.
21. Ensure the improvement of the information system is seen as a priority and make it a state policy. Having a comprehensive, reliable, and timely information system of the health system will streamline activity management and decision-making.

OPERATION AND SUSTAINABILITY OF ACTIVITIES

FOR USAID

1. Maintain a work agenda in different regions to enhance staff competencies, address health determinants, and improve health conditions, prioritizing vulnerable populations. The health needs of various populations persist, so it would be advisable for USAID to maintain technical and financial cooperation at the regional level.
2. Promote cooperation mechanisms to develop the skills in the private sector so that, in times of need, they can produce the necessary materials to address future pandemics: Personal Protective Equipment (PPE), oxygen, cleaning supplies, etc.
3. Facilitate collaboration between the private sector and MINSA to coordinate prevention and response actions against health risks, not only in emergency or disaster situations but also in the face of periodic threats such as epidemics or climatological phenomena.

FOR THE IMPLEMENTING PARTNERS

4. Consult and incorporate social actors in the design and implementation of activities.
5. Maintain good communication with agents and community leaders to develop activities not only in emergency situations. Working with vulnerable populations often requires coordination with their leaders, a strategy that was very effective in vaccinating some vulnerable communities.
6. Design activities taking into account the availability of critical health personnel. In a situation of high demand for health services, it is not possible to remove a specialist from a hospital or health center (for training that takes several days).
7. Include a communication component into every activity to disseminate messages that encourage target populations to participate in interventions.
8. Coordinate closely with other cooperation agencies to complement efforts and resources.

FOR THE GOVERNMENT OF PERU

9. Establish formal coordination spaces with social actors for the design, planning, and implementation of health interventions. Additionally, allocate resources for training and operational expenses in the institutional budget.
10. Always show openness and willingness for collaborative work with cooperation activities. Likewise, guide staff in procedures that allow taking advantage of the support offered by cooperators.
11. Ensure the operation of essential health services and public health programs, even during a pandemic situation. Hire personnel to meet the increased demand and collaborate with other public and private providers. Revise the procedure for contracting private services to facilitate service exchange.
12. Address the mental health needs of health personnel, implement stress management protocols, and enforce rest periods during situations of high demand.
13. Continuously update epidemiological information and information on critical equipment and share them transparently through publicly accessible channels.

14. Establish agreements for emergency purchases and ensure the procurement of essential products through the emergency supply chain. Additionally, implement an effective control system tailored for emergency situations, and consider the redesign of PP 068 and related standards.
15. Design strategies and methodologies to generate skills without neglecting patient care, strengthening in-service training, pyramidal organization with specialists, and mentoring through multidisciplinary teams.
16. Design and implement better virtual work protocols to ensure their effectiveness. Ensure virtual training activities improve participants' capacities.
17. Implement gap closure plans and manage resources to strengthen the response system, as well as intersectoral preparedness for the International Health Regulations (IHR).
18. Design and implement social communication strategies that respond to local contexts and realities at national, regional, and local levels. Use the most appropriate methodologies and media for the target population and use experts and/or local actors (teachers, health promotion staff, community agents, communicators).
19. Strengthen communication offices, both within MINSA and DIRESAs, so that they can effectively conduct communication campaigns.
20. Develop preparedness and response plans and implement them comprehensively.
21. Institutionalize good practices identified during the pandemic, such as intersectoral work, territorial management, and collaboration between public and private sectors; this will allow capitalizing on learning and improving health indicators.

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ANNEX 1: STUDY TEAM

The study team included:

- Giovann Alarcón, main researcher,
- Gustavo Rosell, co-researcher, and
- Rafael Lopez, research assistant.

Giovann Alarcón is a health services researcher and evaluator of programs and public policies. He holds a master's degree in public policy and a doctorate in applied economics, with a minor in health services research, administration, and policy. Both degrees were earned at the University of Minnesota - Twin Cities. She has more than 15 years of international experience conducting rigorous quantitative and qualitative health research, and extensive experience in data collection and systematization of experiences as part of program evaluations.

Gustavo Rosell De Almeida He is a physician-surgeon with extensive experience in public management, operations research, and public health interventions. He has held different positions such as Deputy Minister of Public Health, Deputy Superintendent of Health, Director General in Public Health, Regional Director of Health, Director of Hospital, Director of Health Networks, national and international consultant. She holds a master's degree in public health from the Institute of Tropical Medicine (Antwerp-Belgium), a Diploma in International Health from Harvard University (Boston-USA), a Leaders in International Health Program (PAHO/WHO), a Specialization Program in Epidemiology (Lima-Peru), a Diploma of Specialization in Government Sciences and Global Governance from the International Institute of Government - IGOB (Lima-Peru), among others.

Rafael López Lozano He is an anthropologist, specializing in project development and evaluation. He has a degree in anthropology from the Universidad Nacional Mayor de San Marcos in Lima and a master's degree in social anthropology from the Colegio de Michoacán A.C. in Mexico. With nearly 10 years of experience in development, he has focused his research on the Andes and the Amazon.

ANEXO 2: ACTIVITIES FACT SHEETS

IMPLEMENTING PARTNERS:

Three local organizations:

1. Socios en Salud
2. CEDRO
3. PRISMA

Two centrally managed mechanisms (one of them a PIO):

1. Abt Associates - Local Health System Sustainability Project
2. Pan American Health Organization (PIO)

AOR/ACTIVITY MANAGER

Jaime Chang

PORTFOLIO HIGHLIGHTS

Used emergency funding, received in successive increments - A challenge for establishing and modifying implementing mechanisms.

Up to eight modifications in one award (four to increment funding)

Final investment:

PARTNER	US$
SES	SES
8,261,090	8,261,090
LHSS	LHSS
2,840,240	2,840,240
CEDRO	CEDRO
3,000,000	3,000,000

72.5% of the total amount was invested through local institutions.

Video portraying activities: Acciones de USAID y sus socios para enfrentar la COVID-19
https://youtu.be/kH-kYfRMfas

SOCIOS EN SALUD

PROJECT: COVID-19 RESPONSE IN PERU

The purpose of this activity is to improve the capacities for epidemiological surveillance and response, the provision of oxygen treatment, COVID-19 management, infection prevention and control, care for non-COVID-19 patients.

SES Director: Leonid Lecca

Project Director: Marco Tovar mtovar_ses@pih.org

ESSENTIAL AWARD DATA:

Start date: April 21, 2020

Initial FAA amount: US$3,500,000

USAID contribution: US$2,500,000

Leverage: US$1,000,000

Final closing date: November 30, 2022

Final USAID contribution: US$ 8,261,090

Final FAA amount: US$ 9,261,090

HIGHLIGHTS:

Geographic coverage: Ancash, Arequipa, Callao, Cajamarca, Cusco, Huanuco, Ica, Junin, Lima, La Libertad, Lambayeque, Loreto, Madre de Dios, Moquegua, Pasco, Piura, Puno, San Martin, Tumbes, and Ucayali.

- 30 rapid response teams for epidemiological surveillance and contact tracing.
- 24,555 home visits performed by epidemiological surveillance teams.
- Four containers for temporary storage of corpses installed.
- 116,603 rapid tests and 31,812 PCR tests performed in support of local health authorities.
- One mobile diagnostic laboratory with PCR capacity.
- 87 health centers and 27 hospitals with improved capacities to provide oxygen therapy benefitting 31,341 patients.
- 473,571 teleconsultations for COVID and non-COVID patients.
- 2,439 persons screened for mental health.
- 176 Tuberculosis cases detected (six of them multi-drug resistant) among 6,490 screening tests done.
- Oxygen equipment inventory assessment and maintenance plans delivered to 15 hospitals and health centers.

- Photovoltaic systems installed in five rural health centers to ensure power supply for oxygen equipment.
- Training program in the operation and maintenance of oxygen equipment established with the National School of Public Health.
- Local level epidemiological surveillance model tested.

CENTRO DE INFORMACIÓN Y EDUCACIÓN PARA LA PREVENCIÓN DEL ABUSO DE DROGAS (CEDRO)

PROJECT: COVID-19 RESPONSE – ALLIANCE FOR SOCIAL AND ECONOMIC RECOVERY IN THE PERUVIAN AMAZON

The purpose of this activity was to mitigate the adverse social and economic impacts of the COVID-19 pandemic on vulnerable populations in Peru, particularly indigenous communities in the Peruvian Amazon, and to support the vaccination against COVID-19.

CEDRO Executive Director: Carmen Masias

Project Director: Alberto Hart ahart@cedro.org.pe

ESSENTIAL AWARD DATA:

Start Date: May 18, 2020

USAID contribution: US$3,000,000 (COVID funds) and US$ 1,164,000 (non-COVID funds)

End date: Ongoing

HIGHLIGHTS:

Geographic coverage: Loreto and Ucayali.

- 378 communities reached.
- 26 fluvial medical expeditions performed.
- 123 community agents' and community leaders' knowledge about COVID-19 strengthened to promote vaccination.
- 58 health technicians trained in COVID-19 prevention and vaccines use.
- 9,073 doses of vaccine against COVID-19 administered.
- 7,009 doses of vaccines against other diseases administered.
- 228,890 physical health consultations.
- 6,135 mental health consultations.
- 5,452 women received prenatal care consultations.

PRISMA NGO

PROJECT: SUPPORT FOR COVID-19 VACCINATION IN PERU

The purpose of the project was to strengthen the Government of Peru (GOP) Ministry of Health's (MINSA) management in the timely and equitable implementation of the National Vaccination Plan against COVID- 19.

Prisma Executive Director: Marilu Chiang

Project Director: Carlos Gutierrez cgutierrez@prisma.org.pe

ESSENTIAL AWARD DATA:

Start Date: March 17, 2021

USAID contribution: US$ 4,443,010

End date: October 15, 2022

HIGHLIGHTS:

Geographic coverage: Ancash, Ayacucho, Cajamarca, Cusco, Huancavelica, Junín, Lambayeque, Piura, and Ucayali.

- Nine Regional plans for vaccinating against COVID-19 formulated.
- Five vaccination plans for Andean and Amazon populations.
- Communication materials produced in indigenous languages (Quechua, Machiguenga, Asháninca, Shipibo Konibo and Awajún).
- 83% of the population of the nine regions received at least two doses.
- Supported public-private cooperation in Ancash (Antamina, Sider-Peru) Cusco (Hudbay, PlusPetrol).
- 2,264 persons trained through eight vaccination-related training activities implemented with the National School of Public Health.
- 523 training events implemented in nine regions addressing micro-planning with a territorial approach, cold chain, pharmacovigilance, vaccination services.
- 1,303 technical assistance visits performed.
- Donated 5,884 pieces of equipment for an approx. value of $350,000 (data loggers, digital and alcohol thermometers, thermo-hygrometers, transportation boxes and coolers for vaccines, power stabilizers, lithium batteries, etc.).
- 2,181,100 pieces of printed communication materials produced.
- 8,826,091 persons reached through digital means of communication.
- 492 persons trained to carry out oversight activities.

LOCAL HEALTH SYSTEM SUSTAINABILITY PROJECT - PERU (LHSS-PERU) BY ABT ASSOCIATES

PROJECT: LHSS – PERU

LHSS will strengthen MOH capacity for surveillance, tracking, and monitoring of COVID-19 vaccination efforts and for data analysis and use, to ensure data-based decision making to increase vaccine demand and coverage at the national level.

Strengthen clinical management of COVID-19, improve COVID-19 services; work with the MOH to improve the COVID-19 surveillance and information systems: provide technical assistance for laboratory strengthening, support GOP efforts towards equitable access to telehealth; improve MOH communications capacity to manage, coordinate and share information on the COVID-19 response.

Project Director in Peru: Paulina Giusti mariapaulina_giusti@abtassoc.com

Project Technical Officer: Edgardo Nepo

ESSENTIAL AWARD DATA:

Start Date: August 2021

USAID contribution: US$2,840,240

End date: February 28, 2023

HIGHLIGHTS:

Geographic coverage: National level, Arequipa, Ayacucho, Huanuco, Madre de Dios, Moquegua, Puno and Tacna.

- Regional communication strategy developed for five regional health directorates.
- Two regional communication campaigns adapted to local culture and languages implemented (Puno and Madre de Dios).
- Six workshops to strengthen skills in community communication at the local level conducted. Participants included 102 health personnel, 68 local leaders and 33 local communicators (148 women, 55 men).
- Recommendations formulated to improve the functionality, usability, security, and data quality of the COVID-19 vaccination information system of the MOH.
- Surveillance guidelines for COVID-19 and other potential viral respiratory epidemic updated.
- Improved COVID-19 management, focusing on closing vaccination gaps, in Ayacucho and Huanuco.
- Support provided to National Institute of Health to strengthen laboratory capacity to improve PCR and genomic testing availability and accuracy at national level.

PAN AMERICAN HEALTH ORGANIZATION (PAHO)

PROJECT: USAID-PAHO UMBRELLA GRANT

The purpose of the investment is to:

Support comprehensive country readiness to administer COVID-19 vaccines, including efforts to ensure uptake and access among all eligible populations, address vaccine hesitancy, and combat mis- and disinformation; and

Support the delivery of evidence-based clinical interventions and expand access to diagnostics and therapeutics to detect, manage, and treat COVID-19.

PAHO Representative in Peru: Carlos Garzon

Project manager: Manuel Loayza loayzaman@paho.org

ESSENTIAL AWARD DATA:

Start Date: September 2021

USAID contribution: US$ 3,093,560

End date: June 2023

Note: PAHO also received US$2,548,954 in BHA funds

HIGHLIGHTS:

Geographic coverage: Arequipa, Ica, Moquegua, Puno, and Tacna.

- Focused on strengthening regional health authorities' capacities to provide q comprehensive response to COVID-19.
- Regional laboratories capacities to perform PCR testing improved.
- Hospital capacities to perform microbiological tests strengthened.
- Regional situation rooms implemented, and information centers equipped.
- Health staff trained in infection prevention and control.
- Communication strategies to support vaccination against COVID-19 implemented.
- Community level stakeholders in the promotion of vaccination against COVID-19 trained in the management of information and of dis-information.

ANNEX 3: IN-DEPTH INTERVIEWS GUIDES

Below is the set of questions that were asked during the second stage of data collection. Each question had a series of sub-questions that sought to elicit more detailed information. Additional description was also included so the interviewer could check if the answer was sufficient or if additional information was required.

As the study considered different perspectives, three sets of questions are presented: those used in the interviews with the USAID/Peru team, the implementing partners who led the activities, and the government officials.

INTERVIEW GUIDES FOR USAID/PERU TEAMS

QUESTION 1:

HOW DID USAID ADAPT ITS PROGRAMS AND OPERATIONS TO RESPOND TO THE DIFFERENT STAGES OF THE COVID-19 PANDEMIC AND THE CONTEXT?

- SUB-QUESTIONS (IN SPANISH)

1. Antes de la pandemia, ¿USAID/Perú tenía alguna política, procedimiento o planes para poner en marcha una intervención de respuesta a una crisis como la pandemia por COVID-19?

   Indagar sobre cómo se aplicaron estas políticas, procedimientos y planes antes de la pandemia

2. ¿Cuáles fueron los ajustes de políticas, procedimientos y planes que hizo USAID para responder a la emergencia de la COVID-19 y el contexto?, ¿cómo fue la respuesta de la organización a estos cambios o ajustes?

   Es importante hacer hincapié en los diferentes contextos epidemiológicos, político en el Perú y en EE.UU. (p. ej., en relación a la prioridad asignada a la equidad de género e inclusión de poblaciones vulnerables como ejes de la intervención)

3. ¿USAID/Perú tenía los mecanismos organizacionales que facilitaban una respuesta rápida a una situación como la pandemia?

   Algunos aspectos que resultan importantes son: los RR.HH., las habilidades en el líder para ejecución de fondos de emergencia, los procedimientos para ejecución de fondos de emergencia, la preparación del área técnica

4. ¿Cuáles fueron los ajustes a los mecanismos organizacionales que hizo USAID para responder a la emergencia de la COVID-19 y el contexto?, ¿cómo fue la respuesta de la organización a estos cambios o ajustes?

   Es importante recoger información diferenciada por tipo de instrumentos sobre los procesos de adjudicación, transferencia de fondos, supervisión de las actividades y rendición de cuentas

5. ¿Qué factores facilitaron o dificultaron el manejo de estos ajustes?
6. ¿Estos cambios institucionales siguen en pie para responder a futuras emergencias? ¿Qué cambios o ajustes hacen falta?
7. ¿Cómo respondió USAID a cambios en el contexto?

Es importante hacer hincapié en los diferentes contextos epidemiológicos, político en el Perú y en EE.UU. (p. ej., en relación a la prioridad asignada a la equidad de género e inclusión de poblaciones vulnerables como ejes de la intervención)

8. ¿Qué criterios se utilizaron para definir el alcance de la intervención de USAID y distribuir este alcance entre los socios implementadores?

   Indagar si factores como tendencias regionales, cambios políticos en Perú y EE.UU, prioridades de política afectaron la definición del alcance de la intervención

9. ¿Cómo se seleccionaron los socios para la conducción de los proyectos? ¿Cómo se elaboraron las propuestas?

   Es importante recoger información diferenciada por tipo de instrumento: contratos de fondo monto fijo (p. ej., la presentación de una nota conceptual) o acuerdos de cooperación tradicionales

10. ¿Ha cambiado la capacidad de respuesta ante emergencias de USAID/Perú postpandemia?

QUESTION 2

HOW DID USAID AND IMPLEMENTING PARTNERS RESPOND TO THE PANDEMIC AND CONTEXT?

- SUB-QUESTIONS (IN SPANISH)

11. ¿Qué cambios se llevaron a cabo entre los socios implementadores para responder a las necesidades locales durante la pandemia?

    Los cambios se refieren a cambios institucionales, organizacionales (en RR.HH., operacionales) y la adaptación del equipo técnico

    Las necesidades locales se refieren a las necesidades en los departamentos y comunidades donde se concentró la intervención

12. ¿Qué procesos se siguieron para la implementación de las intervenciones? ¿Algunos de estos fueron especiales o extraordinarios?
13. ¿Qué hitos, cambios e innovaciones se dieron en el proceso de implementar la respuesta a la pandemia a través de los socios implementadores ?
14. ¿Qué enfoque, metodologías, estrategias, materiales o herramientas de intervención se desarrollaron o implementaron? ¿Cómo fueron éstas seleccionadas?
15. ¿Fueron considerados de manera intencional y proactiva la equidad de género y desarrollo inclusivo desde la concepción de las intervenciones?
16. ¿Qué mecanismos de comunicación se establecieron con otros actores para lograr una respuesta efectiva?
17. ¿Se crearon sinergias con otras agencias de cooperación internacional para lograr una respuesta efectiva?
18. ¿Fueron los sistemas de monitoreo y evaluación apropiados para las intervenciones y la oportuna toma de decisiones?
19. ¿Fueron suficientes los recursos humanos y financieros para la intervención?
20. ¿Qué factores facilitaron o dificultaron la implementación de los distintos proyectos ?

Es importante hacer hincapié en los diferentes contextos epidemiológicos, político en el Perú y en EE.UU. (p. ej., en relación a la prioridad asignada a la equidad de género e inclusión de poblaciones vulnerables como ejes de la intervención)

21. ¿Se manifestaron resultados involuntarios que afectaron a comunidades marginales o poblaciones excluidas?

QUESTION 3

HOW DID COVID-19 FOCUSED INTERVENTIONS CONTRIBUTE TO STRENGTHENING THE NATIONAL CAPACITY TO RESPOND TO EPIDEMICS AND HUMANITARIAN CRISES?

- SUB-QUESTIONS

22. ¿Qué se logró debido a la intervención en términos de idoneidad, rapidez de respuesta, cobertura, calidad, coordinación interinstitucional y participación?

    Es posible separar esta pregunta de manera independiente por cada uno de los aspectos listados

    La participación se refiere a cuán involucrados estuvieron otros actores (p. ej., entidades gubernamentales, sociedad civil y organizaciones comunitarias) en la intervención

23. ¿Qué se logró debido a la intervención en términos de idoneidad, rapidez de respuesta, cobertura, calidad, coordinación interinstitucional y participación?
24. ¿Qué capacidades institucionales en el MINSA o GERESA/DIRESA se fortalecieron para el diagnóstico, tratamiento, inmunización, vigilancia epidemiológica y trabajo interinstitucional?
25. ¿Qué capacidades se lograron fortalecer entre los socios implementadores, instituciones públicas y comunidades para responder a futuras emergencias similares?

PREGUNTA 4

WHAT ARE THE LESSONS LEARNED?

- SUB-QUESTIONS

26. Pensando en el futuro ¿qué factores en la organización de USAID/Perú que facilitaron las intervenciones se deben mantener?
27. ¿Qué se puede mejorar o cambiar en USAID/Perú para facilitar una respuesta oportuna frente a futuras crisis humanitarias?
28. ¿Qué se puede mejorar o cambiar en los socios implementadores para facilitar una respuesta oportuna frente a futuras crisis humanitarias?
29. ¿Qué se puede mejorar o cambiar en otras instituciones para facilitar una respuesta oportuna frente a futuras crisis humanitarias?

    Estas otras instituciones se refieren a entidades gubernamentales y otros actores clave

INTERVIEW GUIDE FOR IMPLEMENTING PARTNERS TEAMS

QUESTION 1

HOW DID USAID ADAPT ITS PROGRAMS AND OPERATIONS TO RESPOND TO THE DIFFERENT STAGES OF THE COVID-19 PANDEMIC AND THE CONTEXT?

- SUB-QUESTIONS

1. ¿Cuáles fueron los ajustes de políticas, procedimientos y planes que hizo USAID para responder a la emergencia de la COVID-19 y el contexto?, ¿cómo fue la respuesta de la organización a estos cambios o ajustes?

   Es importante hacer hincapié en los diferentes contextos epidemiológicos, político en el Perú y en EE.UU. (p. ej., en relación a la prioridad asignada a la equidad de género e inclusión de poblaciones vulnerables como ejes de la intervención)

2. ¿Cuáles fueron los ajustes a los mecanismos organizacionales que hizo USAID para responder a la emergencia de la COVID-19 y el contexto?, ¿cómo fue la respuesta de la organización a estos cambios o ajustes?

   Es importante recoger información diferenciada por tipo de contrato sobre los procesos de contratación, transferencia de fondos, supervisión de las actividades y rendición de cuentas

3. ¿Qué factores facilitaron o dificultaron el manejo de estos ajustes?
4. ¿Estos cambios institucionales siguen en pie para responder a futuras emergencias? ¿Qué cambios o ajustes hacen falta?
5. ¿Cómo respondió USAID a los cambios en el contexto?

   Es importante hacer hincapié en los diferentes contextos epidemiológicos, político en el Perú y en EE.UU. (p. ej., en relación a la prioridad asignada a la equidad de género e inclusión de poblaciones vulnerables como ejes de la intervención)

6. ¿Qué criterios se utilizaron para definir el alcance de la intervención de USAID y distribuir este alcance entre los socios implementadores?

   Indagar si factores como tendencias regionales, cambios políticos en Perú y EE.UU, prioridades de política afectaron la definición del alcance de la intervención

7. ¿Ha cambiado la capacidad de respuesta ante emergencias de USAID/Perú postpandemia?

QUESTION 2

HOW DID USAID AND IMPLEMENTING PARTNERS RESPOND TO THE PANDEMIC AND CONTEXT?

- SUB-QUESTIONS

8. ¿Qué cambios se llevaron a cabo entre los socios implementadores para responder a las necesidades locales durante la pandemia?

   Los cambios se refieren a cambios institucionales, organizacionales (en RR.HH., operacionales) y la adaptación del equipo técnico

Las necesidades locales se refieren a las necesidades en los departamentos y comunidades donde ser concentró la intervención

9. ¿Qué procesos se siguieron para la implementación de las intervenciones? ¿Algunos de estos fueron especiales o extraordinarios?
10. ¿Qué hitos, cambios e innovaciones se dieron en el proceso de implementar la respuesta a la pandemia a través de los socios implementadores?
11. ¿Qué enfoque, metodologías, estrategias, materiales o herramientas de intervención se desarrollaron o implementaron? ¿Cómo fueron éstas seleccionadas?
12. ¿Fueron considerados de manera intencional y proactiva la equidad de género y desarrollo inclusivo desde la concepción de las intervenciones?
13. ¿Qué mecanismos de comunicación se establecieron con otros actores para lograr una respuesta efectiva?
14. ¿Se crearon sinergias con otras agencias de cooperación internacional para lograr una respuesta efectiva?
15. ¿Fueron los sistemas de monitoreo y evaluación apropiados para las intervenciones y la oportuna toma de decisiones?
16. ¿Fueron suficientes los recursos humanos y financieros para la intervención?
17. ¿Qué factores facilitaron o dificultaron la implementación de los distintos proyectos?

    Es importante hacer hincapié en los diferentes contextos epidemiológicos, político en el Perú y en EE.UU. (p. ej., en relación a la prioridad asignada a la equidad de género e inclusión de poblaciones vulnerables como ejes de la intervención)

18. ¿Se manifestaron resultados involuntarios que afectaron a comunidades marginales o poblaciones excluidas?

QUESTION 3

HOW DID COVID-19 FOCUSED INTERVENTIONS CONTRIBUTE TO STRENGTHENING THE NATIONAL CAPACITY TO RESPOND TO EPIDEMICS AND HUMANITARIAN CRISES?

- SUB-QUESTIONS

19. ¿Qué se logró debido a la intervención en términos de idoneidad, rapidez de respuesta, cobertura, calidad, coordinación interinstitucional y participación?

    Es posible separar esta pregunta de manera independiente por cada uno de los aspectos listados

    La participación se refiere a cuán involucrados estuvieron otros actores (p. ej., entidades gubernamentales, sociedad civil, cooperación internacional y organizaciones comunitarias) en la intervención

20. ¿Qué se logró debido a la intervención en términos de idoneidad, rapidez de respuesta, cobertura, calidad, coordinación interinstitucional y participación?
21. ¿Qué capacidades institucionales en el MINSA o GERESA/DIRESA se fortalecieron para el diagnóstico, tratamiento, inmunización, vigilancia epidemiológica y trabajo interinstitucional, entre otros?

22. ¿Qué capacidades se lograron fortalecer entre los socios implementadores, instituciones públicas y comunidades para responder a futuras emergencias similares?

QUESTION 4

WHAT ARE THE LESSONS LEARNED?

- SUB-QUESTIONS

23. Pensando en el futuro ¿qué factores en la organización de USAID/Perú que facilitaron las intervenciones se deben mantener?
24. ¿Qué se puede mejorar o cambiar en USAID/Perú para facilitar una respuesta oportuna frente a futuras crisis humanitarias?
25. ¿Qué se puede mejorar o cambiar en los socios implementadores para facilitar una respuesta oportuna frente a futuras crisis humanitarias?
26. ¿Qué se puede mejorar o cambiar en otras instituciones para facilitar una respuesta oportuna frente a futuras crisis humanitarias?

    Estas otras instituciones se refieren a entidades gubernamentales y otros actores clave

INTERVIEW GUIDE FOR OFFICIALS AND PUBLIC SERVANTS OF MINSA, GERESA/DIRESA AND OTHERS

QUESTION 2

HOW DID USAID ADAPT ITS PROGRAMS AND OPERATIONS TO RESPOND TO THE DIFFERENT STAGES OF THE COVID-19 PANDEMIC AND THE CONTEXT?

- SUB-QUESTIONS

1. ¿Qué hitos, cambios e innovaciones se dieron en el proceso de implementar la respuesta a la pandemia a través de los socios implementadores?
2. ¿Qué enfoque, metodologías, estrategias, materiales o herramientas de intervención se desarrollaron o implementaron? ¿Cómo fueron éstas seleccionadas?
3. ¿Fueron considerados de manera intencional y proactiva la equidad de género y desarrollo inclusivo desde la concepción de las intervenciones?
4. ¿Qué mecanismos de comunicación se establecieron con otros actores para lograr una respuesta efectiva?
5. ¿Se crearon sinergias con otras agencias de cooperación internacional para lograr una respuesta efectiva?
6. ¿Fueron los sistemas de monitoreo y evaluación apropiados para las intervenciones y la oportuna toma de decisiones?
7. ¿Fueron suficientes los recursos humanos y financieros para la intervención?
8. ¿Qué factores facilitaron o dificultaron la implementación de los distintos proyectos ?

   Es importante hacer hincapié en los diferentes contextos epidemiológicos, político en el Perú y en EE.UU. (p. ej., en relación a la prioridad asignada a la equidad de género e inclusión de poblaciones vulnerables como ejes de la intervención)

9. ¿Se manifestaron resultados involuntarios que afectaron a comunidades marginales o poblaciones excluidas?

QUESTION 3

HOW DID COVID-19 FOCUSED INTERVENTIONS CONTRIBUTE TO STRENGTHENING THE NATIONAL CAPACITY TO RESPOND TO EPIDEMICS AND HUMANITARIAN CRISES?

- SUB-QUESTIONS

10. ¿Qué se logró debido a la intervención en términos de idoneidad, rapidez de respuesta, cobertura, calidad, coordinación interinstitucional y participación?

    Es posible separar esta pregunta de manera independiente por cada uno de los aspectos listados

    La participación se refiere a cuán involucrados estuvieron otros actores (p. ej., entidades gubernamentales, sociedad civil y organizaciones comunitarias) en la intervención

11. ¿Qué se logró debido a la intervención en términos de idoneidad, rapidez de respuesta, cobertura, calidad, coordinación interinstitucional y participación?

12. ¿Qué capacidades institucionales en el MINSA o GERESA/DIRESA se fortalecieron para el diagnóstico, tratamiento, inmunización, vigilancia epidemiológica y trabajo interinstitucional, entre otros?
13. ¿Qué capacidades se lograron fortalecer entre los socios implementadores, instituciones públicas y comunidades para responder a futuras emergencias similares?

QUESTION 4

WHAT ARE THE LESSONS LEARNED

- SUB-QUESTIONS

14. Pensando en el futuro ¿qué factores en la organización de USAID/Perú que facilitaron las intervenciones se deben mantener?
15. ¿Qué se puede mejorar o cambiar en USAID/Perú para facilitar una respuesta oportuna frente a futuras crisis humanitarias?
16. ¿Qué se puede mejorar o cambiar en los socios implementadores para facilitar una respuesta oportuna frente a futuras crisis humanitarias?
17. ¿Qué se puede mejorar o cambiar en otras instituciones para facilitar una respuesta oportuna frente a futuras crisis humanitarias?

    Estas otras instituciones se refieren a entidades gubernamentales y otros actores clave

ANNEX 4: INSTITUTIONS AND POSITIONS OF INTERVIEWEES

The following is a list of actors interviewed during the second stage of data collection.

	INSTITUTION	INTERVIEWEE POSITION	DATE
1	USAID	Oficina de Acuerdos y Contratos*	11-Jul
2	USAID	Analista financiero de la Oficina Regional de Gestión Financiera	12-Jul
3	USAID	Analista financiero de la Oficina Regional de Gestión Financiera	12-Jul
4	USAID	Facilitadora de apoyo a la PCM	13-Jul
5	USAID	Especialista en Desarrollo	14-Jul
6	USAID	Mission Disaster Relief Officer*	20-Jul
7	USAID	Soporte y Evaluación	21-Jul
8	USAID	Jefe del Área de Migración y Salud	25-Jul
9	CEDRO	Director de Alianza por la Amazonía	14-Jul
10	LHSS	Jefa de Proyectos	17-Jul
11	LHSS	Coordinador Técnico para COVID-19	17-Jul
12	LHSS	Equipo técnico	17-Jul
13	PRISMA	Directora	18-Jul
14	PRISMA	Director del proyecto	18-Jul
15	OPS	Consultor Nacional en Emergencias en Salud	21-Jul
16	Socios en Salud	Representante de Socios en Salud	26-Jul
17	Esperanza Amazónica	Gerente administrativa del programa médico	3-Aug
18	PRISMA	Representante en Cajamarca*	14-Aug
19	Cámara de Comercio Cajamarca	Comunicación e Imagen	17-Aug
20	Cámara de Comercio Cajamarca	Presidente del Comité de Salud	17-Aug
21	LHSS	Coordinador en Ayacucho*	21-Aug
22	GERESA Loreto	Responsable de Cadena de Frío	3-Aug
23	GERESA Loreto	Coordinadora de Inmunizaciones	3-Aug
24	GERESA Loreto	Especialista en comunidades indígenas	3-Aug
25	GERESA Loreto	Responsable de Salud Mental	4-Aug
26	MINSA	Asesora*	9-Aug
27	GERESA Arequipa	Responsable de Vigilancia Epidemiológica	10-Aug

28	GERESA Arequipa	Jefa de la Oficina de Epidemiología	10-Aug
29	GERESA Arequipa	Área de Estadística	10-Aug
30	Hospital Goyeneche	Unidad de Oncología	10-Aug
31	Hospital Honorio Delgado	Director General	11-Aug
32	DIRESA Cajamarca	Oficina de Inmunizaciones	16-Aug
33	DIRESA Cajamarca	DESEP	14-Aug
34	INS	Dirección de Laboratorios	15-Aug
35	DIRESA Cajamarca	DIREMID	16-Aug
36	Hospital Regional de Cajamarca	Director	16-Aug
37	Hospital Regional de Cajamarca	Encargado de Farmacia	16-Aug
38	ESSALUD Cajamarca	Coordinadora Inmunizaciones	16-Aug
39	DIRESA Cajamarca	Directora ITE	15-Aug
40	DIRESA Cajamarca	Oficina de Comunicaciones	15-Aug
41	DIRESA Cajamarca	Coordinador de Cadena de Frio	15-Aug
42	QALIWARMA	Especialista en Comunicaciones	17-Aug
43	DIRESA Ayacucho	Director Servicios de Salud	22-Aug
44	DIRESA Ayacucho	Servicios en Salud	22-Aug
45	DIRESA Ayacucho	Dirección Ejecutiva	22-Aug
46	DIRESA Ayacucho	Subdirector	23-Aug
47	GORE Ayacucho	Gerente del Área Social	22-Aug
48	DIRESA Ayacucho	Área de Cadena de Frío	23-Aug
49	DIRESA Ayacucho	Jefa del área de inmunizaciones	23-Aug
50	DIRESA Ayacucho	Farmacovigilancia	23-Aug
51	MINSA	CDC	24-Aug

Note: The symbol "*" notes that the interviewee is no longer in that position.

ANNEX 5: CONFLICT OF INTEREST DISCLOSURES

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	Giovana Alarcón Espinoza
Title	Investigador Principal
Organization	
Evaluation Position?	☑ Team Leader ☐ Team member
Evaluation Award Number *(contract or other instrument)*	72052719D00001
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Análisis de la Respuesta de USAID a la pandemia de la COVID
I have real or potential conflicts of interest to disclose.	☐ Yes ☑ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	6/15/2023

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	Rafael Baldomero Lopez Lozano
Title	Asistente de Investigacion
Organization	
Evaluation Position?	☐ Team Leader ☒ Team member
Evaluation Award Number *(contract or other instrument)*	72052719D00001
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Analisis de la respuesta de USAID a la pandemia del COVID-19
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* 1. *Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* 2. *Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* 3. *Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* 4. *Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* 5. *Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* 6. *Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	[signature]
Date	06-15-2023

DISCLOSURE OF ANY CONFLICTS OF INTEREST

Name	Gustavo Martín Rosell de Almeida
Title	
Organization	
Evaluation Position?	☐ Team Leader ☒ Team member
Evaluation Award Number *(contract or other instrument)*	72052719D00001
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* *1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* *2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* *3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* *4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* *5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* *6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	June 22, 2023