

# Case Study of CLAS in Peru: Opportunity and Empowerment for Health Equity

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## ABSTRACT

Local Health Administration Communities (CLAS) in Peru are private non-profit civil associations that enter into agreements with government and receive public funds to administer primary health care (PHC) services applying private sector law for purchasing and contracting. CLAS is an example of a government strategy that effectively addresses social determinants of health (SDH), referring to the social, cultural, and economic barriers at the local level that keep people from obtaining services. Bottom-up approaches such as empowerment strategies and community participation have become important paradigms in public health and development efforts to address these local barriers and are becoming part of the discourse on SDH. Citizen participation is essential as a path to empowerment, and evidence is now available showing that empowerment strategies do have a positive effect on health outcomes and in reducing inequalities in health. Initially through a Supreme Decree, and now a national law on CLAS, the Peruvian government provides the opportunity structure for more flexible financial management with social participation that gives citizens direct control in the transparent management of primary health services, in planning and as facilitator of community development, and in promotion of healthy behaviors and lifestyles of individuals in the community, thereby building agency and empowerment. Evidence is presented showing the effectiveness, efficiency, equity, and coverage of CLAS as compared to PHC services that are administered through the cumbersome traditional public system that still operates in 70% of the Ministry of Health PHC system. “Peru’s CLAS program...is one of the world’s best demonstrations of rapid expansion with decentralization of the Alma Ata model of community-based primary health care.” (from report by H. Mahler et al. 2001).

## ACRONYMS

CHA	Community Health Agents
CLAS	<i>Comunidad Local de Administración de Salud</i> Local Community Health Administration Association
DHS	Demographic and Health Survey
DISA	<i>Dirección de Salud</i> Regional Health Office
DIRESA	<i>Dirección Regional de Salud</i> Regional Health Office
ENDES	<i>Encuesta Demográfica y de Salud Familiar</i> Demographic and Health Survey
FONCODES	<i>Fondo de Compensación para el Desarrollo Social</i> Compensation Fund for Social Development
GOP	Government of Peru
IBRD	International Bank for Reconstruction and Development (World Bank)
IADB	InterAmerican Development Bank
MOH	Ministry of Health of Peru
NGO	Non-governmental organization
PAC	<i>Programa de Administración Compartida</i> Shared Administration Program
PAHO	Pan American Health Organization
PARSalud	<i>Proyecto de Apoyo a la Reforma de Salud</i> Health Reform Support Project
PHC	Primary health care
PRORESEP	<i>Programa de Revitalización de Servicios Periféricos</i> Program for Revitalization of Peripheral Health Services
PSBPT	<i>Programa de Salud Básica para Todos</i> Basic Health for All Program
PSL	<i>Plan de Salud Local</i> Local Health Plan
PSNB	<i>Programa de Salud y Nutrición Básica</i> Basic Health and Nutrition Program
RM	<i>Resolución Ministerial</i> Ministerial Resolution
SEG	<i>Seguro Escolar Gratuito</i> Free Health Insurance for School Children
SIS	<i>Seguro Integral de Salud</i> Integrated Health Insurance
SMI	<i>Seguro Materno-Infantil</i> Maternal-Infant Health Insurance
SUTEP	<i>Sindicato Unico de Trabajadores de Educación del Perú</i> Unique Union for Peruvian Education Workers
WHO	World Health Organization

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# 1 BACKGROUND

Peru has been successful in reducing its infant mortality to a par with the Latin American average. However, maternal mortality and chronic child malnutrition are still excessively high, and inequities in access and quality remain associated with large gaps in income. The country has one of the lowest per capita expenditures on health, \$100, as compared to an average of \$262 in Latin America (Alvarado and Mrazek, 2006), and the distribution of this expenditure has been highly inequitable.

Peru delivers health care through a mix of providers. The Social Security Institute (EsSalud) provides obligatory employee health insurance with payroll deduction, serving 20 % of the population with formal employment. The Armed Forces has its own system of care for military families comprising 3 % of the population. The wealthiest 12 % utilizes private services and the private health insurance industry. The poorest 65% of the population is covered the Ministry of Health (MOH) network of primary health care (PHC) services and hospitals. Of this group about 45% have access and 20% remain excluded due to geographic, social, cultural, and economic barriers. This case study refers to the 65% nominally covered by the MOH health system, focusing on the primary level of care where 80% of all health care needs can be attended.

Peru is among the few countries in the world that has a government health program with legalized, regulated, and institutionalized community participation. The Shared Administration Program, formalized in April of 1994 by Supreme Decree 01-94-SA, gives responsibility and decision-making power over the management of public resources for the administration of, currently, 31% of the Ministry of Health (MOH) primary health care (PHC) system. Despite the fact that community participation is now universally accepted as a basic strategy for primary health care, the legalized form of participation established in the Shared Administration Program is a rare phenomenon in the Latin American region and in the world. Participation is based on specific law and regulations, and a contract signed between the community non-profit entity (called the CLAS) and the Regional Health Department. This private-public contract is based on a local health plan: the CLAS is obligated to supervise its administration and completion, and the MOH takes responsibility for financing implementation of the plan.

This program for co-management of MOH PHC services was initiated in 1994 in the upswing from a decade-long downturn of terrorism, hyperinflation, and collapse of the health sector. Decentralization was entering political discourse on governance but without clear strategies. Most Peruvian communities have strong traditions of internal organization, though their relationship with government has swung between dependency, independence, and mistrust. In the few years following the Alma Ata Declaration on Primary Health Care in 1978, the initial projects promoting PHC were better defined as community manipulation than community participation. MOH PHC services were medicalized and dominated by physicians. Government and health sector politics and the strong influence of physicians' and health workers unions were forces affecting the development of the CLAS from its beginnings.

## 1.1 HOW CLAS EFFECTIVELY ADDRESS SOCIAL DETERMINANTS OF HEALTH

This case study describes the ways in which CLAS is an example of a government strategy for managing PHC services that effectively addresses social determinants of health (SDH). SDH frequently refer to factors outside the reach of the health care sector that affect health status, particularly in regard to the social and economic conditions in which people live that affect their health. Other aspects of SDH refer to the social, cultural, and economic barriers at the community level that keep people from obtaining the services they need. Bottom-up approaches such as empowerment strategies and community participation have become important paradigms in public health and development efforts to address these local barriers and are becoming part of the discourse on SDH.

There is consensus in the literature that citizen participation is essential as a path to empowerment, given the type of participation. Experiences with development programs around the world are providing evidence that when people are assisted to assess their situation and select their own priorities based on local data and to build leadership capacity, they are able to identify creative solutions that are unique to their needs and resources and become empowered to implement and maintain the solutions on a long-term basis (Taylor-Ide and Taylor, 2002).

Evidence is now available showing that empowerment strategies do have a positive effect on health outcomes and in reducing inequalities in health (Wallerstein, 2006). Social participation and empowerment have been adopted as basic concepts by the World Bank, the InterAmerican Development Bank, the United Nations system, and bilateral agencies. The World Bank considers two attributes of empowerment: agency, in terms of the exercise of choice by marginalized communities; and opportunity structure, in terms of the design of government programs that allows people to create effective action (World Bank, 2001). CLAS provides the opportunity structure which allows for development of agency through formalized social participation in health.

Social participation in CLAS allows critical roles in the surveillance and control of health services, in planning and as facilitator of community development, and in promotion of health behaviors and lifestyles of individuals in the community, therefore building agency and empowerment. Furthermore, these roles depend on the public sector to provide the opportunity structure to promote and facilitate capacity-building, especially among the poorest members of the community and women, a view promoted by Amartya Sen (2000).

As will be described in this chapter, CLAS in Peru are composed of community members who are given legal authority to administer public funds for organizing and delivering health care. Evidence will be presented that shows how much better CLAS work in delivering services effectively and efficiently, of better quality, greater equity, and with greater health impact as compared to PHC services that are administered through the cumbersome traditional public system that still operates in 70% of the MOH PHC system.



### 1.3. HOW CLAS OPERATE

From 1994 to 2008 when new regulations went into effect, CLAS have been formed of six elected community members, organized as non-profit civil associations under rules of the Peruvian Civil Code. Candidates are nominated by community members, and democratic voting takes place for the six community members of the General Assembly in the presence of municipal and Regional Health Directorate (DIRESA) representatives. The six elected Association members have a two-year term, and among themselves vote on three members to form the Board of Directors with president, secretary, and treasurer who have a one-year term. The health facility medical chief is CLAS Manager.

The relationship between CLAS and the government through the regional DIRESA is formalized with a Shared Administration Contract, with responsibilities on both sides specified in detail. An annual operational plan and budget called the Local Health Plan (Spanish acronym – PSL), is a key instrument for co-management beyond standard clinical services to include community-identified needs.

CLAS-run health services depend primarily on government funding through: (1) direct cash transfers from the public treasury, (2) cash reimbursements from the government health insurance program (SIS) for the poor and, (3) in-kind receipt of medicines and some supplies purchased in bulk by the DIRESA. Fees collected from patients for non-covered health services are administered by CLAS as opposed to non-CLAS health services who do not control funds. Cash transfers from the public treasury and public health insurance reimbursements go into a commercial private bank account controlled by CLAS. All funds are publicly owned but under the joint stewardship of DIRESA and CLAS, which provide monthly financial reports to the DIRESA. Expenditures of public funds for acquisitions and infrastructure are faster and simpler under the CLAS system. CLAS are not required to adhere to cumbersome rules of public administration that were set up to avoid misuse of funds and instead create incapacity to spend, forcing return of funds to the central government at the end of each fiscal year. Success of CLAS is importantly due to their agility in financial management with more efficient spending on priority and community-identified needs for better quality of health care. For example, CLAS can purchase laboratory equipment or contract lab services to third parties, renovate the health facility, hire more personnel, purchase security equipment and personnel to prevent thefts, and make other improvements that increase the perception of quality of care which increases demand for services. Misuse of funds in CLAS has not been an issue: social control by the community promotes transparency.

Social control over health personnel is exercised by CLAS and the general population who are empowered to feel ownership of health services and demand accountability by health personnel. Personnel are hired and fired by CLAS under private labor contracts. In contrast, government payroll personnel's labor regimen provides permanent job stability, a six-hour work day, one-month vacation, health insurance, and a full public pension. Entitlements and lack of accountability create a shield for minimal productivity and many refuse to do work they find disagreeable such as going into communities (Webb and Valencia, 2006). The new law on CLAS signed in 2007 includes a clause to correct this problem.

### 1.3. OBJECTIVES OF SHARED ADMINISTRATION AND CLAS

The objectives of CLAS are being achieved as much for its unique legal structure as the favorable inclination of communities to become empowered. These objectives include: Contribute to modernization of public health administration by incorporating private sector law in the administration of State resources. Decentralize by allocating state resources directly to the place of budget execution. Involve elected community members in exercising management and social control of public funds, directly administering their use for contracting personnel, construction and maintenance of infrastructure, and purchase of equipment, medicines, and supplies. Improve quality and quantity of health services through a Local Health Plan based on community decisions. Improve equality by determining fee scales and identifying excluded community members who need exoneration of fees and/or increased efforts to reach them. Promote more public and private investment in public health services by expanding possible sources of funding.

### 1.4 GEOGRAPHIC DISTRIBUTION OF CLAS AMONG PRIMARY HEALTH CARE FACILITIES OF THE MINISTRY OF HEALTH

Of 6,871 PHC facilities of the MOH, 2,133 (31%) are administered by 783 CLAS. Individual CLAS administer one facility, and aggregate CLAS can administer two or more PHC facilities. The PHC system has five categories of care. These are, in descending order, Level I-3 and I-4 health centers (more than one physician, full staff, no in-patient care except normal maternity services), Level I-2 health posts (one physician, few other staff), Level I-1 or I-0 health posts (no physician). Graph 1 shows the distribution of CLAS and non-CLAS PHC facilities disaggregated by rural/urban areas and level of categorization in the year 2006. CLAS comprise 42% to 52% of large health centers in rural and urban areas, respectively, and 43% of larger rural health posts. Among small health posts in rural and urban areas, CLAS administer only 26 to 27% of them, respectively. Of the larger health posts (Level I-2) in urban areas, 33% are administered by CLAS. When the CLAS program initiated in 1994, the early CLAS tended to be small health posts with one doctor. These have been able to develop over time into larger facilities with more personnel, more infrastructure and equipment, and greater demand for services due in large part to their flexible management structure, as compared to non-CLAS.

### 1.5 PAST EVIDENCE ON THE EFFECTS OF CLAS ON THE HEALTH SYSTEM AND ON HEALTH OF THE POPULATION

Prior studies comparing CLAS and non-CLAS have findings that by and large show positive impacts of CLAS on equity, quality, and coverage of health services (Altobelli, 1998a, 1998b; Cortez 1998; Vicuña et al, 2000; Altobelli and Pancorvo, 2000; Altobelli and Sovero, 2004).

#### *Impact on Equity*

Research on equity of access in CLAS-administered primary care facilities has provided evidence that the program is more effective in delivering affordable services to the poor. One of these studies was conducted on national data from the 1997 National Living Standards Survey in Peru. As shown on Graph 2, CLAS provided significantly more full or partial exoneration of fees in each of the three lowest income quintiles in rural area, as compared to non-CLAS facilities.

These data were collected just as the school health insurance program was put into place, and prior to the maternal-child health insurance program, so those programs should not have influenced the findings on this table.

### *Impact on Efficiency*

Graphs 3 and 4 illustrate the greater efficiency of CLAS versus non-CLAS PHC services by showing the number of physicians and productivity of patient care. Graph 3 shows the mean number of physicians working in CLAS and non-CLAS health posts and health centers in both rural and urban areas. Among health posts, rural CLAS have more than twice the number of physicians than rural non-CLAS (.41 vs .16); the number of physicians is similar in urban health posts whether CLAS (.63) or non-CLAS (.74). On the other hand, urban health centers that non-CLAS have significantly more doctors on average (3.62) than either rural non-CLAS (2.8) or rural and urban CLAS (2.63 and 2.40, respectively).

Graph 4 shows coverage of health services for children from data on Integrated Health Insurance (SIS) reimbursements which was abstracted manually from records of all 675 health facilities, 200 CLAS and 475 non-CLAS in three of 24 Regions of Peru – Cusco, Huánuco, and La Libertad. Results show the number of visits per child in Plan A (0-4 years) in relation to the total number of children 0-4 years of age living in the jurisdiction of each health facility by whether it is CLAS or non-CLAS, urban or rural. CLAS in both rural and urban areas have twice or nearly twice the average number of visits per child as compared to non-CLAS.

### *Impact on Demand*

Evidence of differential utilization of health services for children in CLAS as compared to non-CLAS was assessed from Peru National Demographic and Health Survey-DHS data from 2000. As shown on Graph 5, three variables showed differences between populations living in CLAS and non-CLAS jurisdictions on utilization of health services for sick children. This graph suggests that CLAS has a positive influence on intermediate variables of access and utilization for children, and confirms findings from the year 2002 shown in Graph 4.

### *Impact on chronic malnutrition in children*

Using maternal education as a proxy indicator for socioeconomic status, the Peru DHS data showed that CLAS populations in rural areas were on average poorer than non-CLAS populations (Altobelli, 2006). Furthermore, maternal education and socio-economic status as defined by household expenditure is the most significant predictor of chronic malnutrition in children (Mercer, 1988). This can be seen clearly in Graph 6. In order to remove the effect of distributional socio-economic differences in the interpretation of the data, data on chronic malnutrition in children under age five were analyzed by stratified categories of maternal education. Results in Graph 6 show that among children whose mothers had any primary schooling, chronic malnutrition was 40.8% in those living in CLAS jurisdictions, and 44% in those living in non-CLAS jurisdictions. The difference is significant. This educational stratum is most likely to use Ministry of Health services, being neither the very poorest stratum of mothers who are frequently excluded from any use of health services (No Education category), nor the better-educated stratum that is more likely to use sources of health care other than the Ministry of

Health (Any Secondary or More category). This difference is not explained by higher educational levels of mothers in the CLAS groups.

## **2 CASE STUDY METHOD**

This case study focuses on the process of implementation, with five types of processes of particular interest: (1) going to scale – the challenges faced in moving from small pilot program to a widespread intervention; (2) managing policy change – in terms of policy formulation toward policies that are likely to benefit the poor and vulnerable, the influence of the political environment, the role of individuals as policy champions, managing opposing professional views; (3) managing intersectoral processes – including stewardship challenges in working with other sectors, difficulties in coordination, etc.; (4) adjusting design – adjustments made to the original program design during implementation, issues of sequencing elements of the program, effects of stakeholder views upon design; (5) ensuring sustainability – issues in securing ongoing financial support for the program, as well as promoting institutional sustainability.

Data collection for this study combined several methods of data collection. Qualitative data was collected through semi-structured interviews with a series of stake-holders on their retrospective and current knowledge and opinions, listed by name and title in the acknowledgements. Interviews were tape recorded, if permitted by the respondent, and transcribed.

Further qualitative data was collected through semi-structured interviews with members of 18 CLAS to determine how CLAS influence equity and social determinants of health. Three regions were selected for interviews on the basis of geographic distribution (coast, mountains, high jungle) and level of regional support to CLAS (high, low, medium). In each were selected three “good” CLAS and three “poor” CLAS utilizing the MOH classification based on management criteria. Random selection of CLAS was attenuated by accessibility so as to facilitate the field work.

Specific documentation reviewed for this case study included government legislation (law decrees, supreme decrees, regulations, administrative directives, etc.) relating to (i) the Shared Administration Program, (ii) co-management and community participation in health, and (iii) decentralization; at least 10 published and unpublished reports and evaluations on the Shared Administration Program, including quantitative analyses of program performance comparing CLAS and non-CLAS PHC facilities.

## **3 FINDINGS**

Presentation of findings on the case study of CLAS revolve around two questions. Firstly, what is the agency of CLAS in regard to mechanisms they use to improve access to care through promoting equity and quality of care. The second question looks at key political processes in the development of government policy on CLAS.

### 3.1 MECHANISMS BY WHICH CLAS IMPROVE EQUITY OF ACCESS, QUALITY OF SERVICE, AND SOCIAL CAPITAL

#### *a. CLAS Role to Promote Equity of Access*

Fees-for-services: Nearly all CLAS interviewed for this case study reported having a sliding scale of fees-for-services for the purpose of increasing access by the poor. In cases where no differential fees are allowed, it was considered that the SIS insurance program is doing the job to ensure coverage of the poor. CLAS members interviewed did not generally report having a role in deciding which families could pay less. This decision was left mainly to the CLAS manager, sometimes in conjunction with social workers and CHA.

Excluded populations: All CLAS interviewed, either alone or in coordination with the CLAS manager and health management team, made decisions on the need for and design of a strategy for providing health services to isolated and hard-to-reach communities.

SIS affiliations: All CLAS interviewed participate in strategies to increase affiliations of mothers and children in the Integrated Health Insurance (SIS) program, both to attend more patients, especially the poor. One of the main motivating factors is to increase the income of the health facility.

Community health agents (CHA): Nearly all PHC facilities, both CLAS and non-CLAS, have volunteer CHA who are generally trained and supervised by a health center nurse in period meetings at the health center. In few cases do health personnel work in communities alongside CHA. CLAS reported a variety of ways in which they provide incentives or support to the work of CHA, such as: accreditation, providing ID cards, providing refreshments during work sessions, giving gifts on special occasions, recognizing CHA as partners of CLAS, financing rotating employment of CHA in cleaning or laundry work of the health facility, ensuring free medical care to CHA, ensuring that CHA obtain training. CHA work is generally supported on an ad-hoc basis; much more systematic support is needed to sustain the work of CHA.

#### *b. CLAS Role in Promoting Quality Of Care*

CLAS members defined quality of care as shorter waiting times, nondiscrimination, no mistreatment, longer hours of attendance, having sufficient health personnel particularly medical specialists, having enough medicines, and others. Ways in which CLAS promoted quality of care included the following:

Improvements in personnel, equipment, and infrastructure: CLAS members made management decisions to: (1) motivate health personnel by increasing wages, (2) orient expenditures to improvements in infrastructure and equipment, (3) present proposals to regional or local government for financing of infrastructure and other projects, and (4) improve their own management capabilities by obtaining training in legal norms for PAC.

Improving patient-provider relationships: CLAS members report that relationships are improved since health personnel are accountable to them. They encourage personnel to be more enthusiastic and energetic with patients, and sanction any who mistreat patients or are irresponsible in completing their work (i.e. arrive late, leave early).

Channelling community feedback: Requests by the community for changes or improvements in health services are generally channeled through CLAS Association members. In the case a patient is mistreated, the line of decision-making is not standard, but nearly always involves a

collaborative decision between CLAS members and the CLAS manager, with final action sometimes referred to the DISA/DIRESA for solution.

### *CLAS Role in Building Social Capital*

Leadership development: CLAS members consider membership to be an honor, that their role is highly respected by the community, and that they are seen as having power to change what needs changing to improve health services. All report that people come to them to discuss or complain about the health services. CLAS members often go on to take other leadership roles such as elected or appointed positions in local municipal government.

Leadership development for women: In all CLAS interviewed, the number of female members of the General Assembly had increased over time. One-third of CLAS interviewed had a majority (4 or more of 6 members) of members who are female. Female CLAS members were referred to as being more responsible, more transparent, not easy to manipulate, and more knowledgeable about health, especially that of children.

## 3.2 KEY POLITICAL PROCESSES TO ESTABLISH AND EXPAND CLAS

Primary health care (PHC) was placed on the health policy agenda for the first time in Peru in 1985 by then Health Minister Dr. David Tejada, ex Deputy Secretary of WHO under Dr. Halfdan Mahler. Though many were enthused by the PHC approach, there was little support for the strategy either technically, administratively, or financially in the centralist and hospital-oriented health sector. As a result, the initial thrust for PHC faded within a year or two. Hyperinflation, Shining Path terrorist activity, and government estrangement from international financing eroded public health services to the point of total health sector collapse by 1990.

With the change of government in 1990, budgetary deficiencies and terrorist activity continued in rural areas. Also, the cholera epidemic of 1991 diverted health sector attention. Following capture of the Shining Path leader in September, 1992, Peru began to move rapidly toward a new economic model that slowed inflation and stimulated greater international investment and donor financing. A trend toward privatization was emerging. The Ministry of Economy and Finance (MEF) initiated the “Peruvian Government Reform Project” and within that the “Health Sector Reform”. The MEF commissioned development of legal norms to modernize the health sector, applying concepts of social-oriented market economics and democracy (Vera, 1994).

There was a new orientation to poverty reduction and growing political commitment to decentralization as part of the regional trend in Latin America. Dr. Jaime Freundt entered as Minister of Health in mid-1993 with the intention of strengthening PHC services: only 300 out of 3,800 health centers and posts were operational (MOH, 1992). Innovative solutions were required. A new major program financed by the public treasury, the Basic Health for All Program (Spanish acronym - PSBPT) had the goal to rapidly increase PHC coverage to the neediest populations. Over 3,000 PHC facilities were reactivated with human and material resources administered through a special quasi-public program.

Dr. Freundt saw the need for an alternative form of administration for PHC that would begin to solve the problems of lack of resources and poor quality. Decentralization had no specific proposals for implementation, and the MOH thought they could contribute to this process.

Privatization was becoming acceptable. The idea was to design a program that would involve community participation, recognizing that the State could not manage everything, that “things work when those who are most interested in having it work well are involved” (Freundt, 2007).

Dr. Freundt sought advice from international expert on community participation, Dr. Carl E. Taylor<sup>1</sup>, who was in the process of developing an evidence-based theory of community change which incorporates new roles for empowered communities, government, and outside change agents (Taylor and Taylor, 1985 and 2002). In January 1994, Carl Taylor and two Peruvian experts, Juan Jose Vera and Patricia Paredes, visited mountain communities where the Shining Path was active to find out why villages did not want to reopen MOH services. They found, listening to villagers, that doctors treated them as ignorant, were uncaring, and mainly wanted to return to the city. Villagers wanted to have medical care, but on their own terms and with a say in it.

As the legal framework for the new program in the process of design, the Peruvian Civil Code and its articles for creation of civil associations were seen as ideal for building the model of community-based health administration committees. Most relevant of prior experiences was that of the Program for Revitalization of Peripheral Health Services (Spanish acronym - PRORESEP), UNICEF-supported, that applied principals of the Bamako Initiative to a community-administered rotating drug fund.

From January to April 1994, the legal and institutional framework of the new program was drafted by a team<sup>2</sup> of experts. A Supreme Decree N° 01-SA-94 was signed by the President on May 5, 1994, that created the Shared Administration Program (Spanish acronym - PAC) with the formation of Local Health Administration Committees (Spanish acronym – CLAS), and the Shared Administration Program for Pharmaceuticals (PACFARM). PAC was set up as a sub-program of PSBPT. The PAC technical team began the identification, formation, and training of regional health staff, PHC facility personnel, and communities. The first pilots of CLAS were inaugurated in July 1994 with thirteen PHC facilities in Ayacucho, home of the Shining Path, and coastal Ica.

By the end of the first year, 250 health facilities were incorporated into the program each with a CLAS Association. CLAS expansion continued at a rapid pace. Two evaluations of CLAS were conducted in 1995 and early 1996 that had very positive findings on the progress and value of CLAS (O'Brien and Barnechea, 1996; Taylor, 1996). By mid-1997, ten percent of all MOH PHC facilities in Peru were administered by CLAS: 558 CLAS administered 611 health facilities (out of about 6000 total facilities) in 26 out of 33 Health Regions of Peru.

An important health sector reform that contributed to decentralization and improved equity was the development of two government health insurance programs that were eventually combined into the SIS (Spanish acronym for Integrated Health Insurance) program. Free School Insurance (Spanish acronym - SEG) was created in 1996 to fulfill Fujimori's 1995 reelection campaign

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<sup>2</sup> Team members were Engineer Juan José Vera, Dr. Patricia Paredes, Dr. Nicolas Velarde, Carlos Bendezú, y Nurse Roxana Pajuelo, with support from Dr. Jaime Freundt, Econ. José Carlos Vera and Dr. Augusto Meloni.

promise to provide public schoolchildren with free medical and dental care. Health facilities became quickly overwhelmed since they received no reimbursements for hiring additional personnel to meet the increased demand for health services by schoolchildren.

The second public insurance scheme began in 1997 with a pilot for the Maternal-Child Insurance Program (Spanish acronym – SMI) focused on reducing cost barriers for preventive services and childbirth. The pilot was implemented in three areas where CLAS were already well in place<sup>3</sup> building on the fact that CLAS were able to receive directly insurance reimbursements. SMI pilots proved successful in the context of CLAS financial management since CLAS could hire more personnel and enhance services to meet the increased demand. Non-CLAS facilities were not considered in the SMI pilots. This fact was not widely known or understood as a major factor in the success of the SMI pilots

By the end of 1997, resistance to CLAS was building from different sectors. Groups of regional-level health administrators complained of CLAS, physician unions and health worker unions complained and called for boycotts of CLAS, and groups of officials and technical advisors in the central Ministry diminished the value of CLAS. Technical teams working on the design of health management “networks and micronetworks” saw no way to incorporate CLAS into their proposal that in effect was consolidating the inefficiencies of traditional public administration. Under pressure to close CLAS, Minister of Health Marina Costa-Bauer, sociologist by training, decided to freeze CLAS expansion and commissioned an internal program evaluation (Vicuña et al 1999). At that point, over 150 additional CLAS were organized and waiting to be recognized, and another 200 were in stages of formation.

The IMF and World Bank were starting to take an interest in CLAS as a strategy for modernizing the public sector, improving transparency and social control of public expenditure. Other agencies were also taking an interest in CLAS and commissioned papers on the program, including the Inter American Development Bank (Altobelli, 1998a), IDRC/IADB (Cortez, 1998), and UNICEF (Altobelli, 1998b). All papers demonstrated comparative results with non-CLAS on health care coverage and equity with findings highly favorable in support of CLAS.

In January 1999, the CLAS program was reinstated. A new strategy was designed for rapid program expansion, incorporating additional health facilities into existing CLAS. These were referred to as “aggregate CLAS”, whereby one CLAS administered more than one health facility. Some had up to 40 facilities under one CLAS. The pros and cons of the aggregate CLAS model were addressed in a case management paper which suggested that community involvement declined with aggregate CLAS, though efficiency could increase (Altobelli and Pancorvo, 2000). Thereafter, it was decided to partition larger aggregate CLAS into smaller ones.

Scaling-up of the SMI insurance program also began in 1999. Now non-CLAS were included in SMI, but they could not receive directly the insurance reimbursements. In CLAS, on the other hand, SMI reimbursements were received directly into their co-managed bank accounts and became a boon to improvements in staffing, infrastructure, and equipment which allowed CLAS to enter an upward spiral of improved supply and demand.

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<sup>3</sup> SMI was piloted in CLAS-administered networks in the Regions of Tacna and Arequipa, and the Moyobamba province in the Region of San Martin.



The decision to rapidly scale-up of both CLAS and SMI in 1999 was a direct result of the IBRD Programmatic Social Reform Loan to Peru using a new mechanism in which policy decisions and benchmarks were agreed on with government social sectors (health, education, food assistance, justice) as conditionalities for loan disbursements. CLAS initiated an expansion phase to go from 10% to 33% of primary level facilities over a period of three years. See Graph 7.

Funding for SMI expansion reimbursement payments was part of a proposed 1999 funding package for \$264 million U.S. dollars from IBRD, IADB, and a consortium of bilateral funders (Britain, Canada, Japan, and others). The package was intended to subsidize all recurrent costs of the SMI for three years, after which it was expected that the GOP would begin to take over the costs. This funding proposal, in addition to the IBRD conditionalities in the health sector, reflected the close coordination among agencies to promote major progress in decentralization and improving health services to the poor.

Unfortunately, the transitional government in 2000-2001<sup>4</sup> wanted to put the SMI expansion loan package on hold until the next elected government was in place, but the delay resulted in donor withdrawal. Without these loans, the SMI insurance reimbursements were left under responsibility of the public treasury. The lack of secure financing for SMI affected CLAS by limiting the newly-found source of fresh funds reimbursed to CLAS that was utilized for improving quality of PHC services. Nor was there technical support for CLAS from the IBRD-funded technical assistance project, PARSalud, due to perceived wavering of political commitment to CLAS. Nevertheless, the dedicated national technical team of Shared Administration was a constant that provided the underpinning technical support to keep CLAS alive during this time.

A dramatic increase in CLAS during 2001-2002 can be attributed to the IBRD-PSRL conditionalities, in addition to the committed advocacy of the National Coordinator of Shared Administration, Dr. Victor Baccini, who was able to convince the Minister to not detain CLAS expansion. This was a major achievement in spite of the conservative orientation of the then Health Minister Dr. Solari who, together with his Vice Minister Dr. Carbone, represented a religious sect and reversed gains in women's access to health services (Coe, 2004). Both Drs. Solari and Carbone had a health policy discourse in support of community participation. However, when Dr. Carbone became Minister in 2002, he took overt action to detain CLAS expansion.

Under Dr. Carbone, the MOH commissioned an evaluation of CLAS with the call to propose "other models of co-management". The evaluation reports provided a positive assessment of CLAS with useful recommendations (Sobrevilla et al, 2002; Velarde and Sobrevilla, 2002). Ignoring these papers, the MOH went ahead smoothing the road toward closure of CLAS through a series of Ministerial Resolutions<sup>5</sup> in late 2002. The only donor agencies at that time with a technical interest in CLAS were DFID and USAID, though they provided little financial support. Given the political and financial environment for CLAS, it is remarkable that the whole program did not collapse. Possible reasons it did not included the solid legal basis created at the outset of

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<sup>4</sup> Installed as a result of the fraudulent Presidential elections of 2000.

<sup>5</sup> R.M. N° 895, R.M. N° 1743, and R.M. N° 1793.

the program in 1994, the committed technical support by the MOH Shared Administration team, and the on-going advocacy by external public health specialists.

Given the blockage of communication with external agencies promoted by Dr. Carbone, efforts were initiated by the private non-profit, Future Generations, in January 2003 to work directly with the Commission on Health, Population, Families and Disabled Persons of the Peruvian Congress to advocate for a law on CLAS that would provide greater legal stability and protection from the fluctuating levels of support provided by rotating leadership teams in the MOH. By the end of the year, a consortium of development agencies and NGOs, public health experts, and MOH officials<sup>6</sup> was assembled by Congressman Dr. Daniel Robles, President of the Health Commission. A “Sub-Commission for the Study of CLAS” was formed and an initial draft of the law was discussed in a series of three macroregional meetings in December 2003 and January 2004. Numerous subsequent drafts were produced during 2004 and through October 2005, but work on the law was put on hold as the 2006 Presidential election campaigns drew near and the political climate became uncertain as to how the new government would want to deal with CLAS (Future Generations, 2008).

Work on the CLAS law proposal in the Health Commission of Congress stimulated a parallel effort within the MOH, which felt that it was their role to create the law proposal. For a time, there were two parallel and competing CLAS law proposals in course.

Overt resistance to CLAS was building particularly from the Medical Federation who feared the permanence of a potential CLAS law. A national physicians strike led by the Medical Federation in late 2003 to early 2004 included the derogation of CLAS as one of their demands. Another demand was to place on government payroll all physicians working on short-term contracts in government health services. By that time the Ministry of Health leadership had passed to Dr. Álvaro Vidal who was a supporter of the physician unions, and under whom the physicians’ strike began. It fell to his successor, Dr. Pilar Mazzetti, a research neurologist, to resolve the strike, which she did by agreeing to the demand for government employment of all physicians in April of 2004. One expert described this as “the most regressive policy decision in public health to occur in the last ten or fifteen years”, damaging the health system and the health reform process. Many feared that CLAS would be debilitated by loss of social control over physician performance.

CLAS had survived the physician’s strike, but PAC was progressively dismantled as funding was cut and the PAC technical team was reduced from 35 persons to five over a period of 2-3 years. In December 2005, the remaining PAC team was transferred from PAAG to the Executive Office of Health Services Management in the MOH, with final transition of CLAS financial management to the traditionally inefficient MOH General Accounting Office. While it was widely feared that PAC could suffer in administrative efficiency and lose technical guidance from this move, this was also seen as positive action toward main-streaming PAC into general work of the MOH. On the down side, regional DIREAS remained without a specific office in charge of regional CLAS management. Responsibility for CLAS continued to be assigned in an ad-hoc manner in each region.

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<sup>6</sup> Consortium included Future Generations Peru, MOH, MEF, PAHO, UNICEF, DFID, USAID, CARE Peru, PHR Plus, Policy Project, and Pathfinder.

In his inaugural speech on July 28, 2006, Alan Garcia stated that he would extend the experience of CLAS during his presidency to the education sector. Consequently in October 2007 the Peruvian Congress approved a new “Law on Co-Management and Citizen Participation in Health for Health Facilities at the Primary Level of Care of the Ministry of Health and the Regions,” culminating five years of advocacy on CLAS from within the MOH and from outside change agents.

## **4 DISCUSSION**

Five themes addressed by this case study are discussed separately in this section. Within each theme are discussed the issues and challenges, what was done to address them, and the outcomes.

### **4.1. GOING TO SCALE: CHALLENGES IN MOVING FROM SMALL PILOT TO WIDESPREAD INTERVENTION**

The process of incorporating health facilities into PAC is illustrative of a shared management process. Communities played a role in deciding whether or not to enter the program or were approached by the MOH for strategic reasons. Once the initial group of CLAS was functioning they served as demonstration sites encouraging other communities to choose to enter the program, thus maintaining the self-selection process that was an important feature of successful implementation. The scaling-up process was demand-driven since community decision-making had to be involved from the beginning.

CLAS owes much to Dr. Freundt who was so convinced of the need to go forward with CLAS that he bypassed two signatures in the MOH before sending the original Supreme Decree on CLAS to the President in May 1994; his leadership on CLAS was unwavering though surrounded by disbelievers in the MOH. A highly-qualified multidisciplinary technical team was assembled that was committed to the idea of community participation. The first national coordinator, Ing. Juan José Vera, had significant experience working with community groups in co-managing agricultural programs, and his sustained dedication to CLAS was exemplary. Carlos Bendezú had held the highest governing role in the region where the Shining Path had been most active, bringing political astuteness and a deep understanding of community needs to the team. Together with a public health physician, Dr. Patricia Paredes, the initial group for the first four program years was a key to successful implementation, even with changes of Health Ministers and national politics. Their longevity facilitated scaling-up CLAS to the first 10 percent of all PHC services by 1997. Later national coordinators of Shared Administration were physicians with field experience as CLAS managers who could provide operational guidance to other physicians around the country who were managing CLAS on the ground.

The program was initially conducted with minimal publicity as a strategy implemented by the CLAS management team to avoid the fate of a similar community-controlled program in the education sector in 1993 which had been widely publicized, seen as a threat to teacher autonomy, and quickly brought down by the powerful teacher’s union SUTEP, which had seen the program as a threat (Ortiz de Zevallos *et al*, 1999). Repeating that same history though in the health sector, physicians were the ones who opposed CLAS, adducing that doctors should not be

obligated to respond to the communities they serve. Physicians also complained of the double work involved in co-management with copious reporting requirements. There was truth in the latter issue as there was a temporary “dual” reporting system as PHC policy shifted from the old model to the CLAS model.

The Ministry of Economy and Finance was a player with little direct decision in expansion of CLAS with the major exception of the conditionalities it accepted as part of the IBRD Programmatic Social Reform Loan, whereby MEF placed pressure on the MOH to comply with the agreed policy changes. These included expanding CLAS by a specified percent each year for three years between 1999 and 2002, as one of the conditionalities for loan disbursement to MEF.

Overall, donors have played a critical role in support of CLAS at different points in time, ranging from technical support to research to policy change conditionalities for CLAS expansion. The latter, incorporated into the IBRD loan program, qualifies as one of the most important supports to the scaling-up of CLAS. It is important to note that no major donor-funded PHC projects in the first ten years of CLAS provided technical support to CLAS, such as the major PHC projects funded by USAID, IBRD, and the European Commission. These were important lost opportunities that could have resulted in a faster scaling-up process and less political and professional resistance to CLAS. The IADB was instrumental in financing the small technical team in the MOH that established and managed the Shared Administration Program. After that, no donor agency provided recurrent cost support to CLAS.

Non-governmental organizations by and large played a small role in support of CLAS, with one exception. Most were worked on projects funded by donors that did not address CLAS. Eventually Pathfinder and CARE Peru incorporated some support to CLAS in the way of technical assistance, field work, manuals, or model development as part of larger projects on reproductive health or health rights programs. Future Generations was the only non-governmental organization that provided technical support to CLAS throughout the life of the program. Dr. Carl Taylor, founder and senior advisor of Future Generations, was involved from the design stage and throughout the years of CLAS development. In 2001 the organization created an affiliate in Peru with the mission to strengthen CLAS.

A health advocacy group representing civil society, comprised of health professionals and health-related NGOs and established in 2003, called ForoSalud, included CLAS in regional fora as part of civil society groups involved in health at the regional level. ForoSalud in general supported CLAS, though they could have been more proactive.

As an individual, Dr. Halfdan Mahler, ex-Secretary General of WHO, had an impact on professional opinion of CLAS when he visited Peru in early 2002, made site visits to several CLAS, and spoke highly in favor of CLAS to dignitaries of the medical profession and MOH.

#### 4.2 MANAGING POLICY CHANGE

Despite the rapid expansion, increasing community demand and success of CLAS in delivering health care, resistance grew from the medical profession, regional DIRESAs, and health worker unions. The Medical Federation considered CLAS as a move toward privatization of health, thus

jeopardizing their goal to have all physicians appointed to the government payroll. Physicians have long sought what they consider their lawful rights that physicians should be hired competitively for public sector jobs and that once accepted they should enter as permanent public servants with government pension to the grave. A study in Uruguay showed that doctors on government payroll are significantly less productive on the job than contracted personnel, since they have no incentives for efficiency (Webb and Valencia, 2006; Das and Pave, 2007). Equally damaging is the loss of hours worked when a contracted physician switches over to the government payroll which requires only a six-hour work day.

Resistance also came from officials in administrative units of DISA/DIREAS who lose control over resources as a result of the CLAS system that transfers funds directly to CLAS bank accounts. In addition, the use of low-cost short-term no-benefit contracts by CLAS has generated resistance especially from the non-physician health workers union FENUTSA.<sup>7</sup> CLAS are caught between needing to hire more personnel and receiving little financial support to meet the need, having to rely on fees-for-services or SIS reimbursements to hire personnel. Many DISA/DIREAS had been working under the erroneous assumption that SIS reimbursements to CLAS cannot be utilized to finance private labor contracts that would pay benefits; so they use SIS funds only for short-term no-benefit contracts.

By not admitting that a decentralized model was functioning through CLAS, teams of consultants charged with designing a decentralized model omitted CLAS from their decentralization design frameworks. Instead they preferred the idea of handing primary health care services over to management by local municipalities. As a compromise, the new law on CLAS incorporates local municipal government as one of three signatories on the co-management agreement, thereby satisfying the goal to articulate primary care services with local government while maintaining a good share of community control.

Health reform teams also designed a model called the “health management network” in which PHC facilities were regrouped into networks and smaller micro-networks related by geographic accessibility and provision for referral to a center with a higher resolute capacity, centralizing laboratory and information systems, and serving as a “budgetary executing unit”. This program was superimposed over CLAS, creating a competing organizational model that lacked the financial and human resource administration capabilities that were already consolidated in CLAS.

An error in management of PAC was its early placement in regional DISA/DIRESA Community Participation Units, frequently staffed by non-health professionals such as sociologists and anthropologists who were experts in community participation but had difficulty comprehending the decentralized financial and human resource management aspects of PAC, and were therefore ineffective in correctly representing the program to the rest of the MOH. These offices were sometimes the main source of criticism of CLAS, particularly in the first years of CLAS when power struggles occurred between communities and government as both learned new roles and ways to share power in decision-making and control over resources. Health sector employees expected to see communities easily begin to “participate”: this concept became for many a criteria for evaluation of CLAS, and they judged that CLAS did not meet the “criteria”. Criticisms flourished on the basis that CLAS was “not true community participation.” A

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<sup>7</sup> *Federación Nacional Unico de Trabajadores de Salud- FENUTSA*

population-based study of CLAS showing that 80% of those surveyed did not know what CLAS was, was taken as evidence that the community did not participate in PAC, and that CLAS was “not valid” as a program for community participation (Cortez, 1998). A policy paper attempted to clarify the concept of community participation and CLAS, after which there seemed to be less negative discussion of CLAS along these lines.

#### 4.3 ADJUSTING DESIGN: LAWS, REGULATIONS, AND RESOLUTIONS ON CLAS

A major strength of the CLAS program was that it was founded on the basis of a Supreme Decree, just below the level of a Congressional law, and structured on the Civil Code, both aspects that provided a strong legal framework for operating new financial and contractual arrangements in the health sector. There were virtually no major adjustments made in the laws and regulations guiding CLAS from 1994 up to the year 2007 given ten Ministerial Resolutions emitted throughout that period which modified only minor details of the program. Three disastrous Ministerial Resolutions in late 2002 reduced the autonomy of CLAS, delineating how the MOH could close down a CLAS, and creating a commission to revise its legal framework. This stimulated Future Generations in January of 2003 to initiate advocacy with the Health Commission of Congress on developing a new law decree to provide legal stability to CLAS that was finalized four years and 10 months later.

The new “Law on Co-Management and Citizen Participation in the Primary Level of Care of the Ministry of Health and the Regions” that goes a long way to resolve issues that have arisen and lessons learned since program initiation in 1994. It provides for wider participation from each community and representation of government on the CLAS Association, and for orientation and training of government officials, health providers, and community members who are associated with CLAS to ensure the quality of participation. CLAS addresses social determinants of health through enhancement of democratic governance.

#### 4.4. ENSURING SUSTAINABILITY OF CLAS

To ensure the program’s sustainability it would be necessary to demonstrate that CLAS was an essential component of a strengthened primary health care model, and that it would have to articulate with local government. The strategy was to start with the most successful CLAS in each region and build their capacity as Self-help Centers of Action Learning and Experimentation, using them as training centers for scaling-up. Future Generations became the first organization to develop a pilot ‘Model CLAS’ in the poor urban settlement of Las Moras in Huánuco Region on the eastern slope of the Andes beginning in late 2002. In Las Moras, PHC facility work is better organized with community leaders, volunteer health promoters, and community organizations. Promotion of home-based health behavior change is improved with check-lists for community volunteers to monitor mothers and children, and materials to extend health education and prevention to the home. The model works with a methodology of community empowerment for strengthening social control and transparency of health management, with capacity building of all actors to strengthen social capital and local ownership of the development process. Las Moras has been awarded several prizes and recognition in national competitions on quality improvement, and serves now as a model site and Self-help Center of Action learning as it was set up to do. ‘Model CLAS’ are serving their goal of helping

politicians and health officials see the value of CLAS to improve primary health care, keeping alive the idea of CLAS through periods when there was little other support, and now serving as guides and training centers to scale-up improved overall quality of primary health care services.

## 5 CONCLUSIONS

Summary of findings on CLAS:

1. Latin American governments have historically lacked transparency and participation of the citizenry in decision-making and the oversight of public programs. The CLAS program in Peru was among the first to provide the increased transparency, participation, and social control that had become priorities of the population by the beginning of the twenty-first century. Political and bureaucratic resistance to CLAS was slowly toppled through research, advocacy, and 'Model CLAS' to finally reach a political acceptance with signing of the Law on Co-Management in October, 2007.
2. Power struggles between the health sector and communities, and between medical and health worker unions and the health sector were a necessary component of maturation of each set of actors as new governing roles were learned and incorporated. To date, the unions continue their resistance against CLAS.
3. Expansion of CLAS was favored by the important role played by both internal and external champions. Internal champions were the relatively stable and committed technical team in the Ministry of Health. External champions were UNICEF, IBRD, and IADB, as well as public health researchers and several NGOs.
4. CLAS demonstrate that social participation is essential for the efficient implementation of primary health care. The watch-dog role of citizens in CLAS over use of public resources not only empowers the community, but helps to ensure transparency and efficiency. This includes the social control that citizens exert over the quality of care through the pressure placed on health care providers at the point of service delivery.

Lessons learned for public health to be drawn from CLAS experience are:

1. Trusting in the community as an active and empowered member of a co-managed "health team" promotes agency, builds social capital, and provides mechanisms to involve women and the most vulnerable groups in both utilization of the health system and in community organizing for local planning and action in health and development.
2. When communities are legally involved in managing public resources, the programs are certain to generate resistance from interest groups that stand to lose power. The lesson from CLAS is that community involvement is the surest way to ensure sustainability, in spite of resistance, as long as even a few key government officials continue to support the program and, importantly, that outside agencies are helped by donors to play a role in policy research, advocacy, and technical assistance.
3. The power struggles and difficult political pressures on CLAS over time could be one of the factors that counter-intuitively, but importantly, contributed to their success as they learned to survive under pressure. If this lesson is generalized, then it should be expected

that a longer development period is essential to achieve sustainable programs with community empowerment. A legislated health reform that provides the “opportunity structure” should not be expected to achieve the effective “agency” needed for successful participatory models from one day to the next.

4. Primary health care systems that provide the opportunity structure and facilitate community agency for empowerment can be best scaled-up after initial formation of model “Centers for Active Learning and Experimentation” that successfully apply the concepts of community empowerment in alliance with government, facilitated by outside change agents who contribute to capacity building and advocacy. These model centers with adaptations to each geo-political area can serve as useful learning centers for rapid scaling-up to other sites within the area.



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### **Present Member of Congress**

Dr. Daniel Robles, Congressman and past President of the Congressional Commission on Health, Population, Families and Persons with Disabilities

### **Past Health Minister**

Dr. Jaime Freundt, ex Minister of Health (1994-1995)

### **Past and Present National Coordinators of the Shared Administration Program**

Dra. Jackeline De La Cruz, current National Coordinator of Shared Administration Program (2006-present)

Dr. Victor Bacini, ex National Coordinator of Shared Administration Program (2000-2003)

Dr. Ricardo Díaz, ex National Coordinator of Shared Administration Program (1999-2000)

Dr. Nicolas Velarde, ex Interim National Coordinator of Shared Administration Program (1998)

Ing. Juan José Vera, ex National Coordinator of Shared Administration Program (1994-1998)

### **Past and Present General and Executive Directors in the Ministry of Health**

Dr. Carlos Acosta, Executive Director of Health Services Management, General Directorate of Personal Health, Ministry of Health (2005-present)

Dr. Luisa Hidalgo, ex General Director of Personal Health, Ministry of Health (2002-2003)

Dr. Oswaldo Lazo, ex General Director of Personal Health, Ministry of Health (2001-2002)

Dr. Augusto Meloni, ex General Director of Office of International Cooperation and Finance, Ministry of Health (1994-1999), ex Advisor to the Minister of Health (1993-1994)

### **Past Program Coordinators and Government Advisors**

Dr. Danilo Fernández, ex National Coordinator of Program for Administration of Management Agreements and Basic Health for All Program, Ministry of Health (1996-2000)

Dr. Carlos Ricse, ex General Coordinator of PARSalud Project

Dr. Wilfredo Solis, ex Advisor, National Council on Decentralization (2007)

Sr. Felix Valencia, Insurance Expert, SIS (2007)

Econ. José Carlos Vera, ex Advisor to the Minister of Health (1993-1994)

Dr. Arturo Yglesias, ex Advisor to the Minister of Health (1993)

### **Past and Present Leaders of the Physician Union and Association**

Dr. Julio Castro, past and current Dean of the Peruvian Medical Association (*Colegio Médico*)

Dr. Julio Vargas, current President of the Peruvian Medical Federation (*Federación Médica*)

### **Past and Present International Consultants and Advisors**

Dr. Carl E. Taylor, Professor Emeritus, The Johns Hopkins University, and co-Founder and Senior Advisor for Future Generations

Dr. Rigoberto Centeno, Consultant in Health Services, Pan American Health Organization

### **CLAS Associations**

CLAS Panao, Huánuco	Sr. Glicerio Aquino, President Dr. José Salas, Manager
CLAS San Francisco de Cayrán, Huánuco	Sr. Jorge Lazaro, President Dra. Helen Trujillo, Manager
CLAS Huancapallac, Huánuco	Sr. Kleber Sánchez, President Lic. Cleopatra Cervantes, Manager
CLAS Perú Corea, Huánuco	Sra. Haide Malpartido, President Dr. Edwin Morales, Manager
CLAS Umari, Huánuco	Sr. Victor Inocencio, President Dr. Dennys Talenos, Manager
CLAS Pillco Marca	Sra. Rosario Guzman, President Dr. José Rodríguez, Manager
CLAS Wanchaq, Cusco	Sr. Elio Cárdenas, President Dra. Carolina Letona, Manager
CLAS Quiquijana, Cusco	Sra. Elsa Ojeda, President Dr. Wilbert Polo, Manager
CLAS Urcos, Cusco	Sra. Angélica Gonzáles, President Dr. Dario Navarro, Manager
CLAS Ttio, Cusco	Sr. Mario Aparicio, President Dr. William Loayza, Manager
CLAS Pisac, Cusco	Sr. Francisco Rojas, President Dr. Arturo Jara, Manager
CLAS Chinchero, Cusco	Sr. Constantino Sallo, President Dr. Gabriele Bermudez, Manager
CLAS San Francisco, Tacna	Sr. Luis Llosa, President Dr. Jaime Miranda, Manager
CLAS Intiorko, Tacna	Sra. Tania Palco, President Dra. Luisa Maria Maldonado, Manager
CLAS Vista Alegre, Tacna	Sra. Justina Ramos, President Dr. Benjamin Núñez, Manager
CLAS Ciudad Nueva, Tacna	Sr. Roberto Hualpa, President Dr. José Medina, Manager
CLAS Alto de la Alianza, Tacna	Ing. Martín Paucara, President Dr. Renán Neira, Manager
CLAS Cono Norte, Tacna	Sr. Alejandro Tuyo, President Dra. Carolina Davalos, Manager

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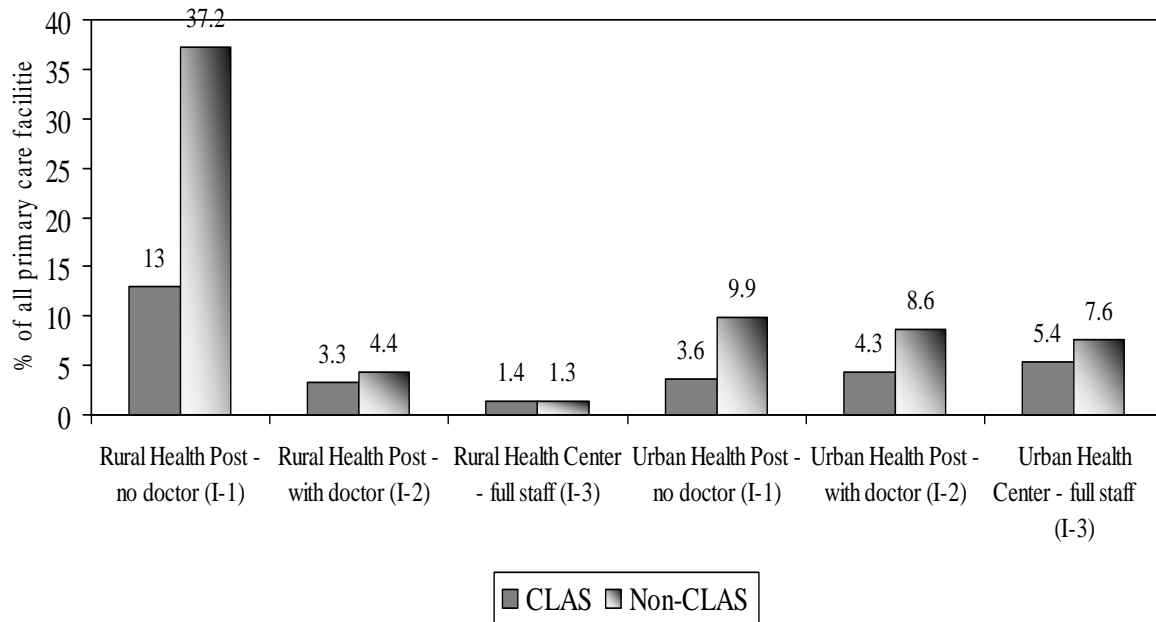
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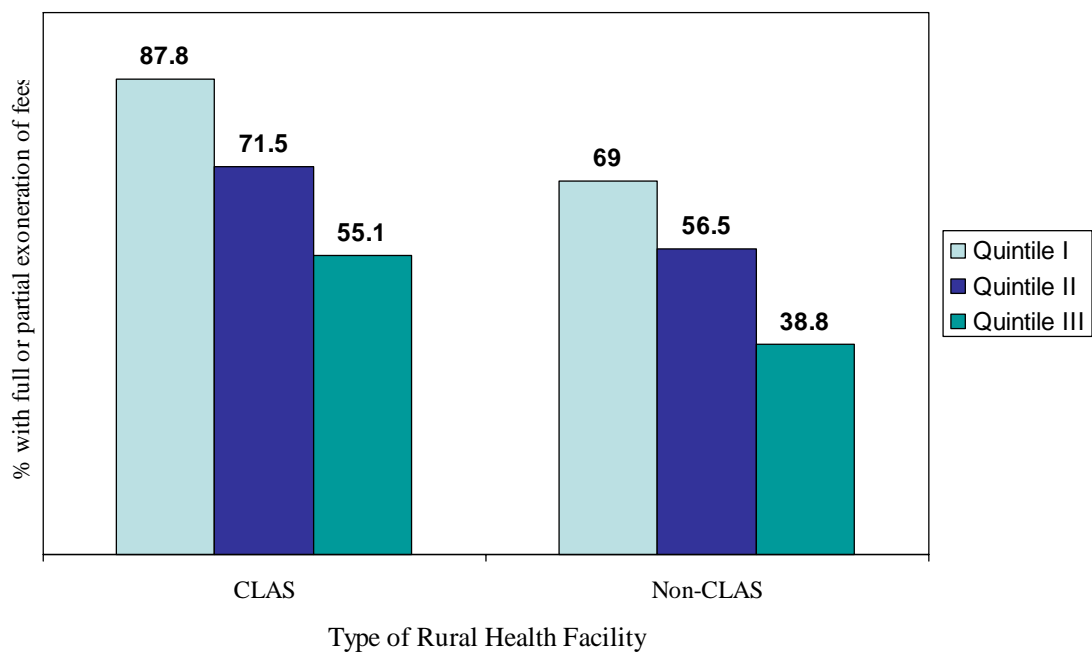
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Graph 1: Proportional distribution of 6,871 Ministry of Health primary health care facilities by level of categorization and whether CLAS or non-CLAS: 2006



Source: Prepared by author. Data from 2006 National Inventory of Infrastructure, Equipment, and Human Resources. Lima, Peru: Ministry of Health). (Category I-3 includes I-3 and I-4)

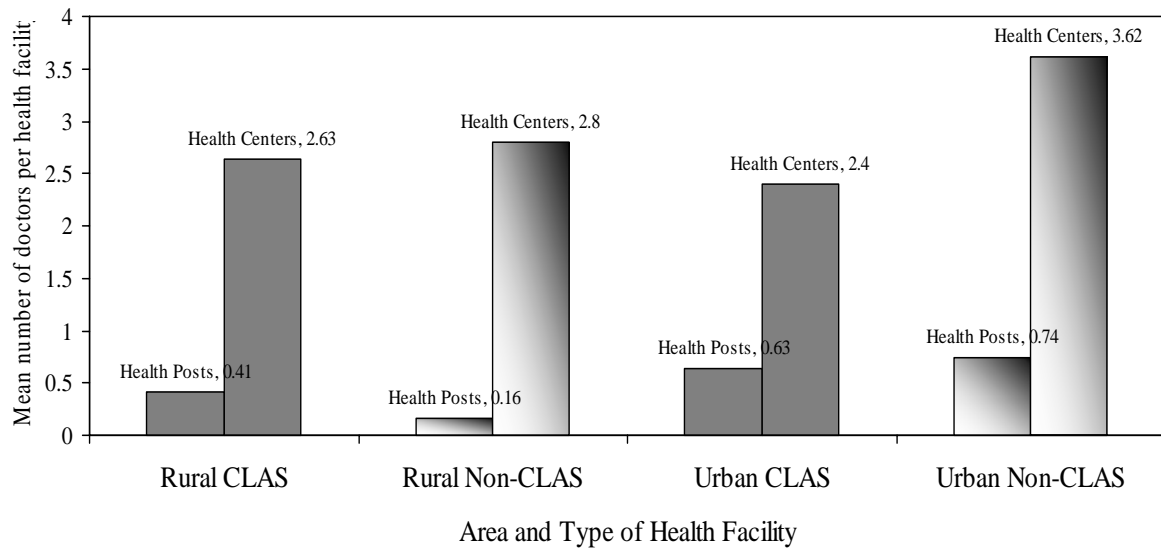
Graph 2: Percent of patients in three lowest income quintiles with full or partial exoneration of fees, by type of rural facility



Source: L. Altobelli (1998) Health reform, community participation, and social inclusion: the Shared Administration Program. Lima, Peru: UNICEF. (Data used from the 1997 National Living Standards Survey in Peru)

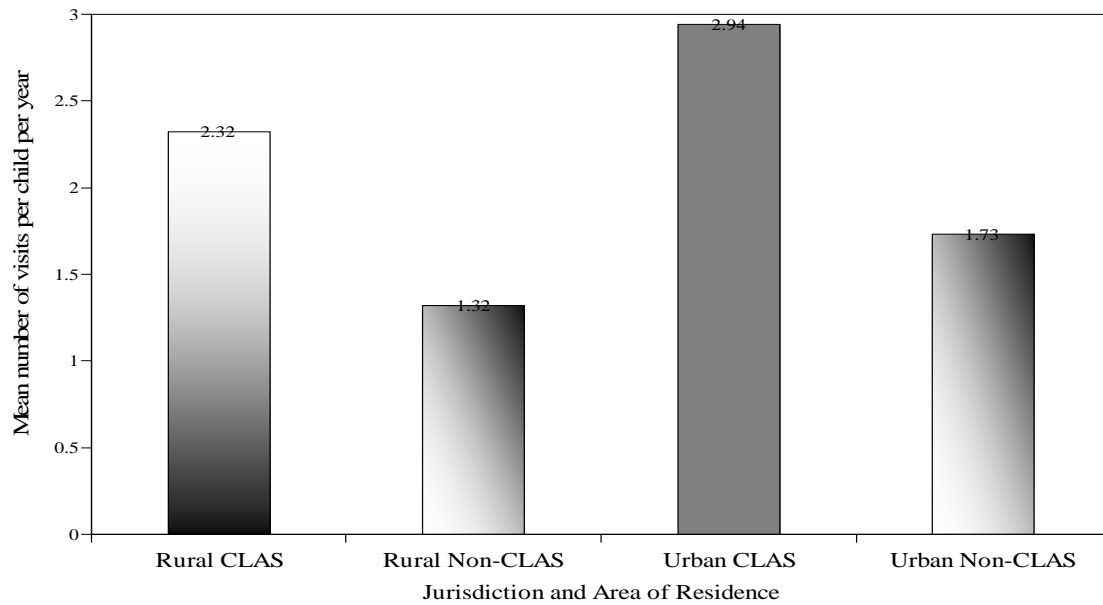


Graph 3: Mean number of physicians per facility by whether CLAS or non-CLAS, rural or urban: 2006



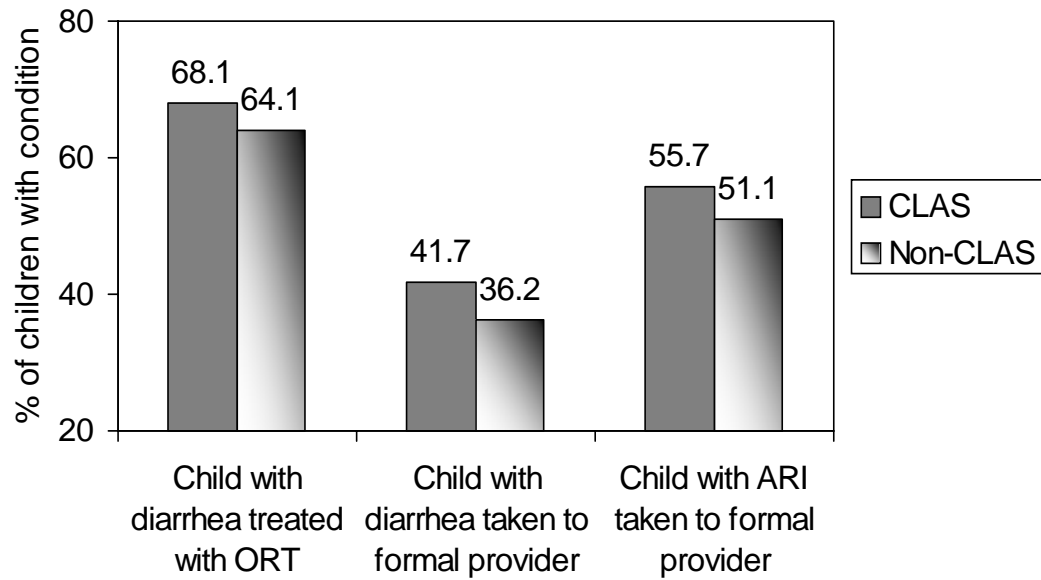
Source: Prepared by author. Data from 2006 National Inventory of Infrastructure, Equipment, and Human Resources. Lima, Peru: Ministry of Health).

Graph 4: Average number of annual clinic visits per child by residence in a jurisdiction of CLAS or non-CLAS, rural or urban: Cusco, Huánuco, La Libertad Regions 2002



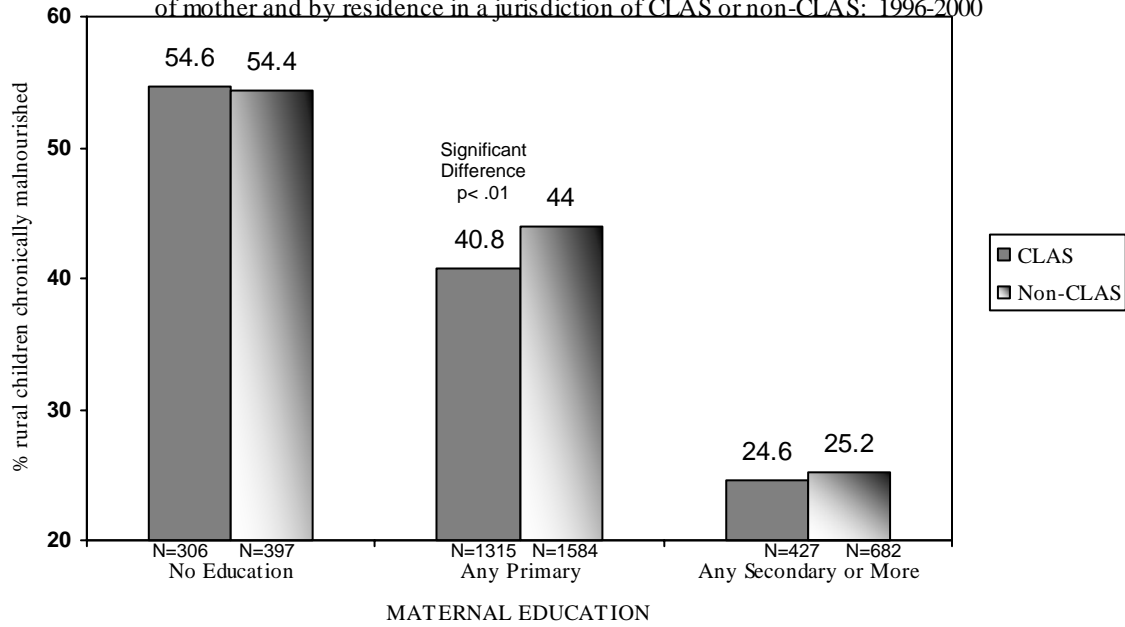
Source: Altobelli, L and A. Sovero (2004) Cost-Efficiency of CLAS Associations. Lima: Future Generations with support from DFID. [www.future.org](http://www.future.org) (Data based on Integrated Health Insurance (SIS) reimbursements for Plan A - Children 0-4 Years of Age 2002)

Graph 5: Percent of rural mothers seeking health care for a sick child under age five, by residence in a jurisdiction of CLAS or non-CLAS: 1996-2000



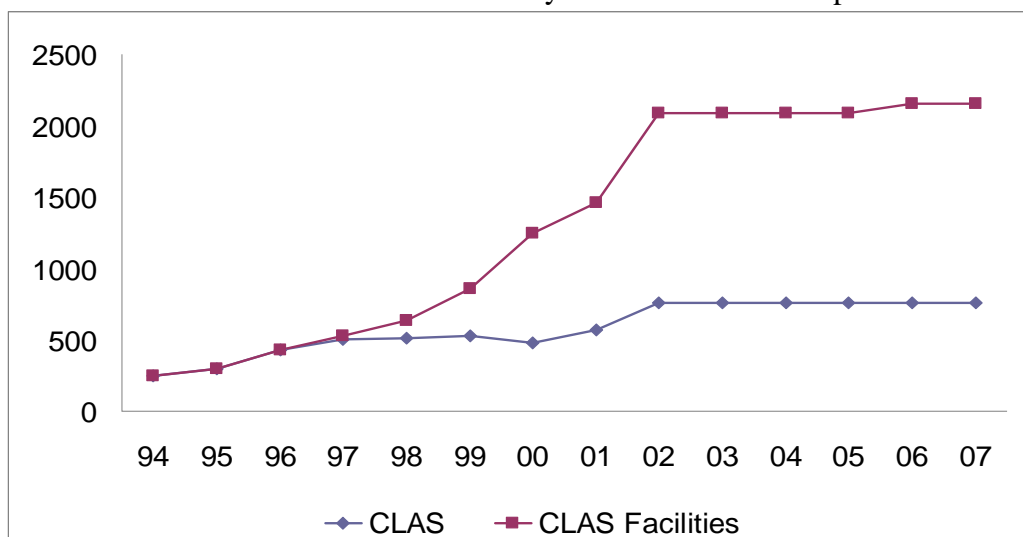
Source: Altobelli, L. (2006) Comparative Analysis of Health Impact and Health Services Utilization in CLAS and Non-CLAS Primary Health Care Services in Peru. Lima: Future Generations [www.future.org](http://www.future.org) (Data source: Peru Demographic and Health Survey IV, 2000)

Graph 6: Percent of rural children under age five with chronic malnutrition by education of mother and by residence in a jurisdiction of CLAS or non-CLAS: 1996-2000



Source: Altobelli, L. (2006) Comparative Analysis of Health Impact and Health Services Utilization in CLAS and Non-CLAS Primary Health Care Services in Peru. Lima: Future Generations [www.future.org](http://www.future.org) (Data source: Peru Demographic and Health Survey IV, 2000)

Graph 7: Growth of CLAS and Number of Primary Health Care Facilities Administered by CLAS from 1994 to present.



Source: Ministry of Health of Peru, 2007.