COMPARATIVE ANALYSIS OF PRIMARY HEALTH CARE FACILITIES WITH PARTICIPATION OF CIVIL SOCIETY IN VENEZUELA Y PERU

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TABLE OF CONTENTS

Table of Contents i

I. INTRODUCTION 1

II. CREATION AND DEVELOPMENT OF HEALTH PROGRAMS WITH CIVIL SOCIETY PARTICIPATION 1
- A. Case of Peru – The Shared Administration Program (PAC) and Local Health Administration Committees (CLAS)
- B. Case of Venezuela – FUNDASALUD in the State of Lara

III. THE PROCESS OF COMMUNITY PARTICIPATION 5
- A. CLAS in Peru
- B. FUNDASALUD in Venezuela

IV. EFFICACY OF THE PROGRAMS 7

V. EFFICIENCY OF THE PROGRAMS 8

VI. SOCIAL, CULTURAL, AND ECONOMIC IMPACT 9

VII. ISSUE OF EQUITY 10

VIII. SUSTAINABILITY OF THE PROGRAMS 10

IX. CONDITIONS FOR SUCCESS 11

X. LESSONS LEARNED 13

XI. CONCLUSIONS 15

XII. INFORMATION SOURCES 16

ANNEXES

I - Comparison of health services administration with participation of civil society in Venezuela and Peru 18

II - Proportion of health facilities that satisfy selected indicators of community participation, based on subjective rating by health personnel in each facility, by type of facility and presence of CLAS - Arequipa, Peru 19

III - Forms of community participation in health facilities co-administered with civil society in Venezuela and Peru 20

IV - Comparison of health services production data in health facilities with and without CLAS by poverty classification of Department – Peru, 1997 22

I. INTRODUCTION

The writing of this document was solicited by the Division of State and Civil Society (DPP/SCS) of the Inter-American Development Bank (IDB), for presentation at the annual meeting of the Assembly of Governors of the Bank in Cartagena, Colombia in March, 1998.

The broad vision of the meeting's organizers to identify and analyze experiences of the interface between the public sector and civil society in the delivery of human services fits within social sector reform movements and decentralization occurring in many Latin American countries. It is also in perfect accordance with a framework of ideas on poverty and social development that have been developing over the past years among major international agencies which stress the balance between what governments can do and what people can do for themselves.

The accumulated experience of the Bank and other international agencies has demonstrated that participation of civil society in the design, implementation, and monitoring of social programs makes an important contribution to the impact and sustainability of those programs. However, there is a great need for this rich experience to be analyzed, evaluated, and disseminated in a systematic way that would allow for its wider and more objective discussion. In this way, there could be a more frequent utilization of the strategy as a more transparent and effective mechanism for using social sector resources.

This is a comparative case study of two programs, one in Peru and the other in Venezuela, which have as a common element the active participation of organized civil society in the administration of primary level health care facilities.

In the case of Venezuela, a study was commissioned by IDB to collect primary data from a random sample of public health facilities with participation of civil society in management and administration and others under traditional public sector administration. Interviews and secondary data sources were also utilized. The Venezuela study, focusing on an experience in the State of Lara, was conducted by Carlos Mascareño, and is reported on in a separate document cited in the bibliography.

The Peru case study, also commissioned by IDB, was based exclusively on existing reports, evaluations, secondary data sources, and interviews. The author of the current report was responsible for assessing the Peru experience and developing the comparative analysis between the two country programs.

II. CREATION AND DEVELOPMENT OF HEALTH PROGRAMS WITH CIVIL SOCIETY PARTICIPATION

A. Case Of Peru - The Shared Administration Program and Committees for Local Health Administration (CLAS)

The Peruvian population has a long history of community organizing for survival through many years of poor economic growth and chronically under-funded and inefficient government services. Private non-profit and grass-roots organizations have been widespread throughout Peru to fill the vacuum of public support in helping to meet basic needs of the people. Ironically, these organizations had nearly always met with a level of distrust by the public sector.

By the second half of 1993, some parts of the economy and government were beginning to liberate themselves from the multiple tolls of hyperinflation, terrorism, and international isolation. Peripheral health services were in a state of collapse, being understaffed, under-equipped, and underutilized. National authorities began to recognize that governmental efforts in the social services were not going to advance without substantial increase in funding and/or new mechanisms for administration.

The newly-instated Minister of Health, Dr. Jaime Freundt, organized a team of advisors to develop a strategy to administer primary health care services with the active participation of the community through transference of resources to a non-public entity. The goals were not only to increase coverage, but also principally to improve the quality of expenditure, improve quality of care, and establish participation of the community in the co-administration and social control of health services.

The original outline of such a strategy was further elaborated by a team of consultants[1] financed by the IDB-supported Program for Strengthening of Health Services, and validated by an international expert on community participation and health[2].

What developed was the Shared Administration Program (PAC), with its principal strategies the formation of a Committee for Local Health Administration (CLAS) composed of community members, and the legal contract between the Ministry of Health and the CLAS based on a Local Health Plan (*Programa de Salud Local*). PAC was designed on the basis on successful experiences with community participation in Peru and elsewhere, but with a new legal basis and guidelines for such participation. In Peru, national policy was just beginning to outline a new process of decentralization. This new strategy was in step with that process.

The incorporation of health facilities into PAC is illustrative of a shared management process. In the first year of the program, orientation was provided to regional health authorities, who in turn convoked health personnel from communities known to have a strong sense and history of community organizing. Individual community meetings called by these health workers to present this new administrative option resulted in joint decisions between each community and health facility to form a CLAS. The self-selection process was the first step to community empowerment.

Each CLAS is formed of seven selected members. Three are selected by community voting on candidates who represent local health-related community organizations; three are chosen from the community by the health facility manager; and the innate seventh member is the health facility manager, usually the chief physician. The CLAS is inscribed in the public registry as a private non-profit entity under private law. Its relationship with the public sector is formalized through a legal contract between CLAS and the Regional Health Director. The contract is based an annual Local Health Plan. Contractual responsibilities on both sides are specified in detail in the legal basis for the program, Supreme Decree N° 01-94-SA.

Since 1994, a total of 548 CLAS covering 611 health facilities have been organized and officially recognized in 26 of 33 Health Regions of Peru, representing coverage of approximately 10% of the Peruvian population. As news of the benefits of CLAS spreads to other communities, more want to join the program. Over 150 more CLAS are organized and waiting to be recognized, while another 200 are in stages of formation.

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[1] Team included Ing. J.J. Vera del Carpio, Dra. P. Paredes, Lic. Carlos Bendezú, and Lic. Rosanna Pajuelo.
[2] Dr. Carl E. Taylor, The Johns Hopkins University School of Hygiene and Public Health.

Parallel to the development of PAC, the government was creating new programs in the health, education, and judicial sectors to reorient government social expenditures to areas of greatest poverty. In the health sector, the "Programa de Focalización del Gasto Social Básico en Salud" (now referred to as PSBPT) was created in 1994 with a large funding base from the public treasury. It was designed with a strictly-managed vertical administrative structure within, but parallel to, the traditional public health administration system. As for PAC, the goal was to increase health care coverage to the most needy populations. Over 5,000 primary health care facilities were reactivated by contracting health personnel, increasing the hours worked daily from 6 to 12, reorienting health care toward integrated delivery of a basic health package, and improving training, equipment, supplies, and infrastructure. For the first time, wages were scaled on the poverty classification of each district to provide incentive for work in under-served areas. Utilization of health services has increased by ten-fold in the years since then. Data from PSBPT is used in this document as a comparison group to CLAS.

B. Case of Venezuela – FUNDASALUD in the State of Lara

The State of Lara is one of 24 federal entities that comprise the Republic of Venezuela. It is the fourth most populous state with 1.5 million inhabitants. The state capital of Barquisimeto, which holds 60% of the state population, is one of the major cities of Venezuela. Civil society in this state has a tradition of association, extending from many types of comercial groupings, to a variety of agricultural associations. Civil associations have been formed around many other issues such as education, child care, culture, environmental protection, and health. Over 3,500 civil organizations are part of CENDAL, Center for Development and Support by Civil Society of the State of Lara (*Centro para el Desarrollo y Apoyo de la Sociedad Civil del Estado Lara*), established in 1993. All of this resulted in the approval in 1996 of the "Law for Planning and Participation of Civil Society in Public Administration" (*Ley de Planificación y de Participación de la Sociedad Civil en la gestión pública*).

Decentralization was a legal reality in Venezuela by the late 1980's. The Presidential Commission for State Reform (COPRE) had affirmed, "...the time has come to initiate the process of reform leading to the expansion of societal participation in decision-making by political powers... because society has reached a level of culture and degree of civic consciousness that permits them to incorporate into this process..." (COPRE, 1987).

In 1990, within one year of Venezuelan decentralization, the Government of the State of Lara, through Decree 078, created the Foundation for Health Promotion (*Fundación para la Promoción de la Salud* – FUNDASALUD). The designer and founding president of FUNDASALUD was Dr. Bartolomé Finizola, who based this institution on the same lines of "ASCARDIO", an entity created in 1976 to attend to matters of cardiovascular health, run on the key premise of participatory management with the community. ASCARDIO, in turn, had been designed on the basis of Dr. Finizola's experience in 1971 as a rural physician. Together with the local community, he had founded a home for the elderly (A*ncianato*) based on two ideas. The first idea was that sustainability of the center would depend on active presence of society, and second, that it was necessary to develop alliances between society and the state. To this day, the *Ancianato* is still operating in hands of civil society.

FUNDASALUD was a proposal of the Sub-commission for Health Decentralization, coordinated by Dr. Finizola, within the Reform Commission for the State of Lara (COPREL), advisory entity to the government of that state. FUNDASALUD is a public institution that foments a progressive incorporation of civil society into all public matters related to the protection of people's health. It has the role of coordinator between society and the Venezuelan Ministry of Health (*Ministerio de*

Sanidad) in the decentralization of health in the State of Lara. Through FUNDASALUD, more than 600 civil organizations now participate in the administration of public funds in programs as diverse as hospitals, ambulatory primary health care facilities, homes for the elderly, milk distribution (*vaso de vida*) for 300,000 low-income children, and others.

The current study of FUNDASALUD contemplates only its program for ambulatory clinics. The program is present in 60 of these facilities among the 294 in the State of Lara, 19.7% of the total. Thirty-one (31) are located in the most highly populated urban centers. Of all ambulatory clinics, 196 are rural and 64 are urban. The effect of the FUNDASALUD strategy, therefore, is most clearly felt in urban areas, where nearly half of all ambulatory clinics are administered by civil society (31 of 64), covering 64% of the total number of inhabitants of the State of Lara (approx. 1 million of 1.5 million inhabitants).

FUNDASALUD builds on the propensity of civil society since the 1980's to organize for the solution of health problems. Its principal tenets are:

- FUNDASALUD serves as facilitator of civil participation, not to intervene in the organization of the community.
- FUNDASALUD only provides incentives and institutional support (financial, technical, and legal) for communities to participate in the program. Only those communities with a strong propensity for participation will achieve incorporation and will persist.
- Organizations must comply with a series of requirements regarding: legal registration, presentation of a technical and financial proposal for participation in the health facility, a 6-month probationary period, strict monthly administrative accounting, and undertaking of management with transparency and participatory spirit, without adherence to any political party.

The process of incorporation of civil society into public matters is a complex matter. If it depended only on external stimuli, FUNDASALUD would have quickly incorporated nearly all ambulatory facilities in the State of Lara. It was impossible to discover the reasons why only 60 of nearly 300 facilities had achieved initial incorporation, but the process appears to have been similar to that of CLAS involving self-selection. Three basic characteristics were present in the organizations that were incorporated into the FUNDASALUD network that distinguished them from non-incorporated facilities:

- The presence of natural leaders in the community that pushed the organization with vision and persistence.
- Existence of skills for resource management and administration in the persons that form the association.
- On the side of the health facility, the propensity of the medical coordinator to accept civil participation.

Similarly, nearly all CLAS evaluated have members who are retired school teachers, accountants, or other professional with the time and desire to contribute voluntarily to community well-being. Also, CLAS that develop a high level of functioning in a short period of time are those which have a highly supportive and motivated physician.

We can summarize some further similarities and differences in the creation and development of the two country programs. Both programs are based on similar premises of management with social projection, active community control of finances and quality of care, participatory administration by the health team, integration of services, improvement of community information systems for decision-making, and others.

The differences are in the source of program creation, the regulatory framework, the origin of community organizations they each work with, and the type of population served. On one hand, FUNDASALUD was founded within the cradle of explicit national and state decentralization mandates, and has flexibility to channel public funds to many different types of health-related organizations. Community organizations that administer public health facilities were pre-existing, and the program tends to serve highly urbanized populations. In contrast, PAC and CLAS were created on the margin of nascent and only implicit national decentralization plans. Its regulatory framework was specifically tailored to the peculiar management and administrative needs of primary health care facilities. CLAS are explicitly organized by the health sector with members elected from a variety of community organizations. The majority (62%) of health facilities incorporated into the program serves poor and extremely poor populations.

III. THE PROCESS OF COMMUNITY PARTICIPATION

A. Community Participation in CLAS - Peru

The principal strengths of CLAS are the involvement of community members in: 1) identification and prioritization of community problems based on a community health assessment (via household survey); 2) planning of solutions in ways that are unique to community needs and resources; and 3) decisions on use of funds for running the facility. The Local Health Plan and budget instruct financial and technical direction, monitoring, and evaluation. The tailoring of the Plan to local needs is the basis for efficacy, efficiency, and equity.

To evaluate the process of community participation through CLAS, we obtained illustrative data from the Health Region of Arequipa. There, 66 health centers and health posts in low-income communities surrounding the city of Arequipa conducted a management self-evaluation. This exercise provided a comparison of various indicators of community participation in health facilities with and without CLAS.

The data in Annex II represent the consensus opinion of professional and non-professional personnel in each health facility evaluated. [3] As a region, Arequipa has a tradition of community organization and work by local health authorities to generate community participation in health. Even so, the data show that facilities with CLAS were more successful in garnering direct involvement of the community in specific activities in the administration and management of health services, as compared to facilities without CLAS. Greater differences are seen among health centers than among health posts. We can point out the greater participation of women in CLAS, the greater role of CLAS in assessing community needs, setting priorities, planning activities, policy making, and decision-making on financial and logistic management issues.

CLAS had consistently better assessments than non-CLAS facilities. Nevertheless, we can identify areas for needed improvement. For example, there is need for greater representation in CLAS of community members from the most disadvantaged sectors of the community, especially in health posts. While there is a tendency for elected CLAS members to be the more talented and involved individuals in the community, the health facility manager should ensure that at least one CLAS member comes from the ranks of the disadvantaged.

[3] The instrument utilized to evaluate indicators of community participation is part of a series of modules on primary health care facility management training (Aga-Khan Foundation and University Research Corporation, 1994).

The CLAS system develops management skills on the part of health workers and CLAS members. Two years into the program, an evaluation of PAC with visits to 16 CLAS had highly positive findings. Nearly all CLAS evaluated had gone through difficult negotiations in the first year between community and health staff, but had resolved their initial problems through a mutual learning of management processes that made the shared administrative functions stronger and more viable in the end. The evaluation report stated:

"All committee members had been very active in local organizations such as Mothers Clubs and they admit now they had assumed that the CLAS could be run as simply as they had done with their previous voluntary activities. They admit that it has proved much more complicated than expected and it has taken much more time. They now say they have learned a great deal about management and organization. They still remain firm and strong in expressing opinions." CLAS Esperanza, Region of Tacna (Taylor, 1996).

The report also stated, "The first lesson is that when you trust in the local people to make decisions, they find innovative ways to solve local problems, much more rational and effective... The fact that this occurred in all the establishments of CLAS in just one year through local initiative, is much more than what we could have hoped" (Taylor, 1996).

B. Community Participation in FUNDASALUD - Venezuela

Participation of civil organizations in the State of Lara takes various forms. These forms are classified in a matrix of evaluation designed by F. Reimers suggested by the Inter-American Development Bank for the present comparative analysis. The matrix considers management functions of administration of resources, supervision and control, evaluation of management, planning, contracting of personnel, mobilization of resources, participating in the design of policies, maintenance and construction, and security. The two country experiences are compared on these functions in Annex III. On all counts, both have a high degree of participation of civil society.

On other characteristics of community participation, we can identify some distinctions between FUNDASALUD in Venezuela and CLAS in Peru. First, the degree of community representation in the civil associations incorporated with FUNDASALUD is as varied as the types of organizations and populations served. Rural facilities are mainly affiliated with "neighborhood associations" which may have representatives from the entire community. Urban associations, in contrast, are pre-existing and self-selected groupings of interested citizens. Most are a "Society of Friends of the ambulatory clinic". In comparison, there is a potential for truer representation of the community in CLAS, though that system is still subject to vagaries of community elections and designations by the health facility manager.

Second, FUNDASALUD associations seem to be stable entities that may or may not have rotating leadership. The strength of this system is its stability. It may have the weakness of monopoly and tendency to personal interests, as identified by Mascareño (1997). CLAS members, in contrast, rotate every two years; the CLAS president changes every year. This system is more ideal since it allows for greater representation and democracy. However, the frequent turnover signifies a continual relearning of the necessary management skills.

One of the principal areas of complaint of civil associations' boards of directors in Venezuela and of health authorities and health workers in Peru, is the lack of "participation" of the full community. Some observers define community participation as the active involvement of many community members, and we can cite many experiences with CLAS that have found creative marketing

strategies to involve the extended community in health-related activities. We should not confuse, however, the two concepts of "co-management of health services" with "community participation in health".

The participation of FUNDASALUD civil associations and societies, and of CLAS, in the "co-management of health services" are reflected clearly in specific discussion of their positive impact on the efficacy, efficiency, equity, and sustainability of the health facilities, as presented below.

IV. EFFICACY OF THE PROGRAMS

A. Efficacy of CLAS in Peru

The overall goal of CLAS is to improve community health. This long-term goal has not yet been measured on a wide scale since a systematic means of aggregating community level data on morbidity and mortality is not yet in place. Nevertheless, CLAS communities do have data from their local health surveys, and some have reported major reductions in infant, child, and maternal mortality since CLAS was instituted. This is another major strength of CLAS: local information systems to inform local decision-making. Under public sector administration, this does not occur. Also, strict legal requirements for accountability on the part of CLAS for financial reporting and completion of the Local Health Plan provide the framework for ensuring that PAC objectives are met.

The following intermediate objectives of PAC are being successfully accomplished as much a result of the legal structure created for those purposes, as the favorable inclination of communities to become empowered:

- **Contribute to modernization of public health administration** - Private sector law is incorporated into the administration of Public Treasury resources. By means of the Local Health Plan, CLAS prioritizes management results over procedures.

- **Contribute to administrative decentralization** - Current law allows private sector health organizations, in this case CLAS, to contract with the State to provide services, permitting the assignment of resources directly to the place of execution.

- **Increase community participation and social control of health services** - The elected community members in CLAS exercise functions of management and social control of public funds, directly administering and evaluating the use Public Treasury.

- **Improve the quality and quantity of health services** - Quality of care is motivated by financial incentives for health workers, and ensured through social control by CLAS members and the general population who are empowered by the system to feel ownership of the health services.

- **Promote co-participation in the sustainability of health services** - CLAS are authorized to organize systems to channel private funds into health services. Some CLAS have created pre-payment systems and mutual funds to optimize the use of local resources, which potentiates public investment, and over time, improves the sustainability of both preventive and curative health services delivery.

B. Efficacy of FUNDASALUD in Venezuela

A composite indicator of the maintenance and protection of infrastructure and equipment measured the efficacy of FUNDASALUD health facilities. This is a general indicator that could represent how actively and effectively civil society is acting to preserve and protect their service. An observational rating of six FUNDASALUD facilities compared with six public sector-administered facilities showed a nearly perfect rating of 86 out of 90 possible points for the former, while the latter control group scored 56. What else but self-interest of users and their capacity to intervene, could overcome the inertia of a traditional administrative structure that built the infrastructure for the country but was unable to control its maintenance? In a similar way, CLAS have been noted to address infrastructure and equipment needs as initial priorities, using revenues to purchase equipment, supplies, and infrastructure improvements that had been neglected for many years.

V. EFFICIENCY OF THE PROGRAMS

A. Productivity of Health Facilities with Civil Society Participation in Peru

Data in Table I show production of services by health facilities with CLAS versus health facilities in the larger Program for Basic Health for All (PSBPT). As compared to CLAS, PSBPT facilities are more frequently health posts (87% PSBPT vs. 71% CLAS), are somewhat more concentrated in areas classified as poor and very poor (72% vs. 62%), and therefore, have a significantly lower average number of inhabitants per health facility (2,643 vs. 4,341).

Table I
Comparison of Health Services Production Data* in Health Facilities With and Without Civil Participation through CLAS+ - Peru, 1997

	Facilities with CLAS	Facilities in PSBPT without CLAS**
N° of Health Centers	175 (29%)	598 (13%)
N° of Health Posts	436 (71%)	3851 (87%)
Distribution of facilities by socioeconomic strata:	%	%
Level D (Extremely poor)	22	38
Level C (Poor)	40	34
Level B (Regular)	35	18
Level A (Acceptable)	2	10
N° of inhabitants within jurisdiction of facilities (T)	2,652,442	11,759,002
Average n° of inhabitants per health facility	4,341	2,643
Total n° of persons attended:	1,980,658	7,014,621
% of total population that received any services	74.7%	59.7%
Intramural services delivered:		
Total n° of services (IN)	4,474,405	17,338,849
Average rate of services per inhabitant (IN/T)	1.69	1.50
Extramural services delivered:		
Total n° of services delivered (EX)	284,252	2,658,797
Average rate of services per inhabitant (EX/T)	0.11	0.23
Preventive and promotional activities:		
Total no of services delivered (PPA)	1,880,410	8,188,078
Average rate of services per inhabitant (PPA/T)	.71	.70

* These data were obtained due to the cooperation of the Program for Basic Health for All (PSBPT).
** The comparison group of non-CLAS facilities are those supported by the PSBPT program.
+ Committees for Local Administration of Health.

CLAS has a higher concentration of intramural services (1.69 versus 1.50 in PSBPT) while PSBPT has a higher rate of extramural services (.23 vs. .11 in CLAS). The per capita rate for preventive and promotional activities (PPA) is the same for both programs. In summary, one CLAS health facility has roughly the same average number of services delivered per inhabitant as one PSBPT facility, while covering a much larger population. The fact that CLAS has 25% greater coverage of the inhabitants within its jurisdiction (74.7% versus 59.7%) leads us to the conclusion that CLAS facilities are significantly more productive than non-CLAS facilities. Annex IV shows a breakdown of the same data by strata of poverty classification. Findings are similar to Table I.

B. Efficiency of Health Facilities with Civil Society Participation in Venezuela

The study by Mascareño (1997) showed that cost per patient attended in facilities managed by civil societies under FUNDASALUD was significantly lower than in control facilities. As shown in Table II, the reason for differences in efficiency does not lie in the total cost of delivering services, but in the number of patients attended. The cost per patient in a random sample of six (06) facilities co-administered with civil society is one-third the cost estimated in six (06) randomly selected traditionally-administered services in the State of Lara.

Table II
Comparison of Health Services Production and Cost Data* in Health Facilities With and Without Civil Participation – State of Lara, Venezuela, 1997

	Facilities with Civil Participation	Facilities without Civil Participation
Average total cost per month	2,928,832	2,336,833
Average number of patients per month	1,730	423
Average cost per patient	1,693 Bs.	5,524 Bs.

* Data adapted from the report on FUNDASALUD -Venezuela, by C. Mascareño (1997).

VI. SOCIAL, CULTURAL, AND ECONOMIC IMPACT

In both country programs, evaluations have emphasized the major role played by women in co-management of primary health care facilities. Women are the principal actors in all aspects of health care, both as providers and as users. They are also the principal actors in raising and protecting the health of their children. When given the chance, women become energetically and untiringly involved in the details of running a health facility, in networking, communicating with authorities, meeting and discussing, and attending to the most minute matters that ensure quality. In all of these things, women are better than men, and furthermore, are more motivated. In the CLAS evaluated, where women were on the Committee, management and community outreach was more dynamic. The same was found in Venezuela.

Satisfaction of clients with services provided by co-managed health facilities was found in Venezuela to be significantly higher than in control facilities (Mascareño, 1997). Clients of FUNDASALUD facilities were more likely to report that the service functioned well, that it was able to resolve problems, and that there was high quality nursing care, medical care, and laboratory services. It is not surprising, therefore, that greater utilization is made of co-managed facilities.

Further impact on values of the community, seen in the Peru experience, is the renewed faith in government programs which was expressed by community leaders where CLAS exist. The fact that government has decided to turn over partial control of public services to the people is an, until now,

unheard of show of trust that empowers the community. It is a trust that the people take as a serious responsibility, since it is for the benefit of themselves and their children.

Economic impact in the community of co-management of health services has not been measured in either country experience. One could only surmise that, in the long-run, economic benefits would accrue due to the higher utilization and coverage of health services which results in healthier children with less school absenteeism, less work absenteeism by adults, and general improvements in health of beneficiaries.

VII. ISSUE OF EQUITY

Methods of ensuring more equitable coverage of health services have been put into practice in many primary health facilities with CLAS. First, sliding fee scales are established and enforced by all CLAS. Second, community members are the ones who best and most easily identify which are the most disadvantaged families in the community, so that complicated methods of income assessment by social workers are no longer needed. For example, the health center CLAS San Francisco in the Region of Tacna has developed a computerized data base with names of indigent families identified by leaders of community organizations. Validation of the information was provided through home visits by health center staff. The health center CLAS 9TH of October in Iquitos and the health center CLAS Consuelo Velasco in Piura, among others have also implemented this method. A benefit of this system is that it allows for quantitative measurement of equity through application of the concept of "surveillance for equity" (Taylor, 1992). Third, social marketing and home visits as programmed in the Local Health Plan seek to increase utilization of services by disadvantaged groups in most need of care. Many CLAS visited and evaluated around the country expressed the importance to them of making sure that care reaches the most needy people.

Further research is needed in both Venezuela and Peru to actually measure the degree to which civil society improves equity in health care delivery.

VIII. SUSTAINABILITY OF PROGRAMS WITH PARTICIPATION OF CIVIL SOCIETY

As long as the law remains in effect to allow public funds to be channeled directly to a private non-profit entity, there is no doubt that the civil societies currently participating in primary health care will reject a return to the traditional system of public administration. Everything points toward a consolidation of the co-management of civil society in health services, judging from comments made by members of civil society in both countries studied. We have not yet seen the full results of this new experience, this new mode of organizing and delivering health services to the public. All indicators of success in health care coverage, equity, efficiency, and quality in health facilities with civil participation are on a continual upward slope, and the point of plateau is still to be reached. The extreme changes in attitudes and behaviors that are reflected by such indicators would be very difficult to revert, since they are part and parcel of an irrevocable process of learning, maturation, and growth on the part of both health facility and community.

A prime example from Peru of what happens when you release the creativity of the population to solve its own problems, comes from the Health Post Chiclayito in Piura, Peru, a poor peri-urban town which began as a squatter settlement. At the behest of CLAS and the community, the health post provides training for school teachers, the school parents' association, schoolchildren, community volunteers (who identify and refer cases to the post), admission orientation for patients at the post, and continual training of health post personnel. The CLAS has strong leadership and a

powerful ability to convoke the community. Committees of community members have been organized for environmental sanitation, for family planning promoters, and others. There are frequent meetings of CLAS and the various committees. They report their activities periodically to representatives of other community organizations, and present trimester evaluations to the Community Assembly. These meetings are also utilized by the health post manager to sensitize social actors in other sectors to their roles in reaching the shared goal of "healthy community". The CLAS also receives complaints and suggestions, and finds solutions to them, which further allows a strong identification of the community with the health facility. An important aspect for the health post is marketing of their services, for which the primary strategy is quality of care and diffusion by satisfied customers. As another marketing strategy, the CLAS formed the CLUB-CLAS, promoting and equipping soccer teams ('Infantile' and 'Feminine' categories) to compete in local tournaments (Ocaña and Gonzales, 1997).

"An axiom that has been shown time and again in many years of development of the concept of community participation in primary health care, is that the less restrictions are placed on how the community can participate, the more creative the community becomes in identifying its own problems and coming up with highly unique and effective means to deal with the problems within their own context" (Taylor-Ide and Taylor, 1995).

To be certain, there are several issues to be resolved to assure more permanent sustainability of programs with participation of civil society. The first is related to the attitudes of health personnel themselves toward the new system of civil participation in health services management. Sustainability is related to the degree to which health facility personnel put faith in civil society to make decisions and provide creative direction to community health. This is a problem in several FUNDASALUD facilities, where health teams reject the concept that civil society administers the health facility. This is also seen in Peru, where an especially critical factor is the level of commitment to the concept of CLAS by the regional health authority and the chief physician of the health facility.

Another issue is the personalism that is found in some community representatives. The Director General of the Health Sector in the State of Lara, Venezuela expressed, "The community demands greater democracy of the leaders of civil associations in charge of ambulatory clinics, since there is a tendency towards personalism." In Peru, one finds also the same argument that representatives of community organizations personalize their participation in CLAS, and do not consult the community. There is, though, a built-in corrective mechanism to weed out CLAS members who do not truly represent community interests.

IX. CONDITIONS FOR SUCCESS

A. Economic Conditions

The main condition for success of public health facilities co-managed with civil society participation is continuing government financial support, since these facilities serve populations that have always and will continue to need subsidized health care. The idea that participation of civil society will lead to financial independence of health services is not born out by experience. As shown, the economic benefit of co-managed health services is the significantly increased efficiency of use of public resources resulting from increased utilization, increased quality and effectiveness of care, and increased equity. Mascareño's report indicates that the Venezuelan State is reducing its responsibility in health expenditures, producing the appearance of fees-for-services and voluntary payments requested of clinic users. He quoted Dr. Eleazar García, General Director of Health of the State of Lara, as saying that this situation "reduces equity and the universality of the services".

B. Political Conditions

In Venezuela, decentralization and the participation of civil society in social programs of the state are governmental policies. Dr. Eleazar García, General Director of the Health Sector for the State of Lara and the highest authority in that sector, has no doubt of the importance and need for civil participation in management of primary health facilities and, in general, in health services. Prior to being named to his present post, Dr. García was part of the FUNDASALUD team.

In Peru, there is an implicit, though not explicit, government policy regarding the role of civil society in the public sector. As the Peruvian government moves through the process of modernization and reform in the health and education sectors, the discourse is toward decentralization. Also, importantly, the written general policy document of the health sector, which sets forward the vision and mission of a reformed health sector, identifies among its principles the reformulation of the relationship between state and civil society, decentralization, and community participation (Ministry of Health, 1996). As the only embodiment of this policy to date, PAC with its Committees for Local Health Administration (CLAS) manifests the intent of this document to foment new and reformulated models of health service delivery which ensure equity, efficiency, and quality. The Minister of Health has been quoted in the press as supportive of CLAS:

> "Si, [la experiencia de CLAS ha sido] tremendamente positiva. Hay 500 CLAS. En ellos hay una identificación mucho mayor de la comunidad con su puesto o centro de salud. Lo siente como propio. ..." (Sr. Ministro de Salud, Marino Costa Bauer, March 14, 1997, Expreso)

Nevertheless, PAC national coordinating unit members assert that this new form of participation of civil society still lacks political viability in the intermediate levels of the health sector. The transition has been easier in some places than in others. In one region of Peru two years ago, printed posters appeared calling for a boycott of CLAS. In other areas, as noted by ex – Minister of Health Dr. Jaime Freundt, "health professionals employed directly by the government were the main opposition to CLAS, believing, rightly, that they would have to work harder and believing, incorrectly, that they would lose their jobs."

C. Conceptualization of community participation

There have always been problems in the conceptualization of community participation on the part of health authorities and health workers, which leads to a "low level of acceptance of people's participation in decision-making as a viable solution, on the part of some health sector functionaries in the center and periphery of countries" (Ganeva, 1990, 128). Some of this was noted in the evaluation report on CLAS, observing that "the people who were involved in service delivery under the PAC program have nearly universal enthusiasm for CLAS as compared to the people just talking about it" (Taylor, 1996). One reason for this has been noted in other parts of the world:

> "Community participation has rarely met the expectations of health planners/professionals around the world. The reason for this failure is that community participation has been conceived in a paradigm which views community participation as a magic bullet to solve problems rooted both in health and political power. For this reason, it is necessary to use a different paradigm which views community participation as an iterative learning process allowing for a more eclectic approach to be taken." (Rifkin, 1996)

In other words, there is a need for more realistic expectations of civil participation in public services management. At the same time, new methods to orient health workers and communities to the possibilities and instrumentation of their participation are needed.

D. Regulatory Framework

In the Venezuelan model, the lack of clear rules creates a problem from the side of health professionals to accept the management role played by the community. Dr. Ruy Medina, President of the Medical Association (*Colegio Médico)* of the State of Lara, stated that "the problem arises when the community overshoots its limits and feels to be "chief" of the physician; there, conflicts with the medical association appear. ...It is necessary, then, to establish norms on contracting, as much in the lines of command and their relationship with the community as in the structure of remunerations. It is better to attack the problem offering an incentive so that the physician, who is the fundamental point of the tripod, can incorporate into community work." (Mascareño, 1997). Despite the existence of "transparent rules of the game", there is evidently room for revision and further clarification of regulations governing the system in the State of Lara.

The CLAS system has strict legal guidelines as to the roles and responsibilities of CLAS on the one hand, and the public health sector on the other. Checks and balances in the system revolve around the development, approval, implementation, monitoring, and reporting on the Local Health Plan as the primary management instrument. The system works because the annual Plan provides the framework for each side to monitor and control the other.

Another issue is the distrust from the public sector regarding fiscal responsibility with public funds under private law, which needs correction with greater dissemination of the legal control mechanisms in place. As reported in the CLAS evaluation, "...since community members carefully monitor every expenditure with hours of discussion about the use of their own money, and with double signatures, there was no way that much corruption would occur. In fact, careful questioning revealed no instance in which significant suspicion was justified." (Taylor, 1996).

X. LESSONS LEARNED

The comparative analysis of two country programs of public health services co-managed with civil society participation leaves us with the following lessons:

1. There are different legal, regulatory, and organizational arrangements in the two countries studied that allow the participation of civil society in the direct administration and management of primary health facilities. Even though they are different in some ways, the alliance forged between the State and civil society results in better functioning of health services, with greater efficiency, better quality of care, and higher levels of satisfaction from users.

2. In the PAC-CLAS and FUNDASALUD experiences, the traditional system of "top-down" public administration is not being completely replaced by a new concept of "bottom-up" administration. Rather, both sides (public and private) have new roles, and it is important to clearly define these new roles. Problems occur when roles are not explicitly specified. A reassessment and determination of these new roles, especially on all administrative levels on the public side, is especially critical to the long-term viability of the participation of civil society in management of public services.

3. In both cases studied the presence of an intermediate public entity, FUNDASALUD for Venezuela and the Shared Administration Program national coordinating unit for Peru, to facilitate the interface between State and civil society is important and necessary.

4. The instrumentation of the technical and financial relationship between State and civil society, through a Local Health Plan (*Programa de Salud Local*) as used in the Peru experience, is highly recommended as an essential contractual guide to the transparent and effective delivery of primary health care services. Support should be provided for continual improvements in methods of participatory community assessment, and participatory local health planning, budgeting, monitoring, and evaluation.

5. Experience shows that economic sustainability (or independence) is not a tangible benefit of civil society participation in public health services management. Rather, the benefits lie in significantly improved use of public resources through improved productivity, wider population coverage, and more equitable delivery of services. The issue of improved equity is perhaps the greatest benefit, as improvements in the health of the entire society will only occur to the degree that health improves within the most disadvantaged sectors of the population.

6. Therefore, in order for co-managed facilities to function, there is a need for commitment and transparency on the part of the State in maintaining at least minimum funding levels, without which the contract between the State and the community organization cannot be fulfilled.

7. The only "losers" in these new management arrangements are the health personnel who, at the bidding of their ever-more demanding clientele, are motivated to work harder than before to provide more services with a higher level of quality. Incentives need to be built in to ensure the collaboration and positive attitudes of health workers, both contracted and permanent government employees, with their co-managers in the organized civil community.

8. Experience in the two countries studied, and in other countries, instructs us that civil associations or committees that co-manage public services should ensure membership of women, as well as representation of minorities and the poorest sectors of each community. The result will be greater dynamism and better development of strategies for improved equity.

9. There is need for a clarification of the concepts of "co-management with civil society" and "community participation", since differing and sometimes over expectations from politicians, health authorities, and health workers cause problems in their acceptance and support of this new administrative arrangement. "Co-management with civil society" is in fact an "iterative process" that involves time and the learning of management and other skills on the part of both health workers and community members. Expectations of an immediate mass convergence of the population in meetings and events only lead to disappointment and lack of support on the part of health workers and authorities.

10. The form of co-managed health services analyzed here may or may not be the best solution to providing health care to all communities, especially referring to the most dispersed and illiterate rural populations in mountains and jungles. IDB in Peru is currently supporting the development of alternative management models for these types of populations.

11. Based on this analysis, an area of future development is to find ways to better disseminate to community associations and their companion health facilities practical experiences that show how they can learn needed management skills, how to implement strategies to foment health care demand, promote healthier behaviors, and ensure equity, and strategies for working intersectorally for sustainable community development.

XI.. CONCLUSIONS: ROAD TO A NEW RELATIONSHIP BETWEEN STATE AND SOCIETY

If a general consensus could be described now, it would be that participation of civil society in the management of public health services has been successful in improving productivity, efficiency, quality of care, and use of methods to ensure equity. As a result, there is increased utilization of both preventive and curative health services, and improved health outcomes.

Why do some communities take off with incredibly creative means of organizing the people around health issues, involving them in a variety of educational activities for health promotion, generating increased demand and utilization of health services, etc.? The main question may be, **How can communities and community organizations best be oriented to needed management and other skills and the full potential of their participation ?** This is where resources and energies need to be directed.

The focus now should be on consolidating the concept and practice of co-management of public health care facilities by the State and organized civil society, especially on the side of community information gathering, prioritization of problems, planning, and monitoring.

How to achieve this? In recognition of the complex and multi-sectoral nature of human and community development, we will conclude with a methodology proposed for community-based sustainable human development that is applicable to the strengthening and diffusion of the CLAS and FUNDASALUD concept. This method was designed on the basis of experiences with participatory programs around the world that were successful in moving from local pilot projects to regional or national scale programs. The methodology follows three steps:

- **Selection of communities as learning examples** - Select one or more communities which already have a successful base of experience with participation of civil society in the co-management of health services.
- **Development of these communities as "Self-Help Centers for Action Learning and Experimentation"** – Provide technical assistance to further develop a local package of practical interventions that are appropriate to local social, cultural, economic, political, and environmental realities. A co-managed health service is a good place to start.
- **Expand the experience to other communities through "Sustainable Collaboration for Adaptive Learning and Extension"** - Begin by training people from surrounding area and local officials. They need to learn: a) how to gather and analyze data in their own situations using simplied methodologies; b) how to learn new patterns of working together; c) how to allocate resources according to priorities and for sustainable progress; and d) how to develop and implement their community's evolving package of interventions. (This methodology is proposed and further elaborated in: Taylor-Ide and Taylor, Community-Based Sustainable Human Development, 1995).

XII. INFORMATION SOURCES

A. Persons contacted for Peru study

- Shared Administration Program - National Coordinating Unit:
  Ing. Juan José Vera del Carpio, Coordinator
  Dr. Nicolas Velarde González, Consultant
  Econ. Zadith Soplín Vásquez, Financial Specialist
- Dr. Augusto Meloni Navarro, General Director of the Office of Financing, Investments, and External Cooperation of the Ministry of Health, and General Coordinator of Strengthening of Health Services Program/ Ministry of Health
- Lic. Carlos Bendezú, Strengthening of Health Services Program/Ministry of Health
- Lic. Julio Salcedo Ponce, Strengthening of Health Services Program/Ministry of Health
- Lic. Jaime Johnson, Strengthening of Health Services Program/Ministry of Health
- Dr. Danilo Fernández, General Coordinator, Program for Basic Health for All/Ministry of Health
- Ing. Hugo Almeida, Management and Systems Unit Coordinator, Program for Basic Health for All/Ministry of Health
- Dra. Mercedes Neves, General Director of Health Services, Health Region of Arequipa
- Dr. José Moisés Núñez Valdivia, Chief Physican, Health Center CLAS San Francisco, Health Sub Region of Tacna
- Dra. Katia LaPoint, ex – Chief Physician, Health Center CLAS San Martin de Porras, Health Sub Region III North Lima
- Dr. Rafael Cortez, Center for Research (CIUP), Universidad del Pacífico
- Dr. Carl E. Taylor, Founder and Professor Emeritus, Department of International Health, The Johns Hopkins University School of Hygiene and Public Health

B. Documents for Peru Study

- Supreme Decree N° 01-94-SA. Dispositions Destined to Improve the Delivery of Health Services in the Primary Level of Care (*Disposiciones destinadas a mejorar la prestación de los servicios de salud en el nivel básico de atención*).
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- Los Comités Locales de Administración de Salud (CLAS): Organización y Modelo de Gestión y el Programa de Salud Local. Program for Shared Administration, Ministry of Health. 1996.
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ANNEX I

COMPARISON OF HEALTH SERVICES ADMINSTRATION WITH PARTICIPATION OF CIVIL SOCIETY IN VENEZUELA AND PERU

	VENEZUELA FUNDASALUD	**PERU** SHARED ADMINISTRATION PROGRAM (PAC) - CLAS
LEGAL BASE	"Law of Planning and Participation of Civil Society in Public Administration in the State of Lara", Decree by the Legislative Assembly of the State of Lara, Barquisimeto, Venezuela, June 5, 1996.	Supreme Decree N° 001-94/SA, signed by the President of the Republic, President of the Ministers Council, and the Minister of Health, Lima, Peru, April 28, 1994.
ORGANIZATION OF CIVIL SOCIETY		
Type of organization	Civil Neighborhood Associations, Health Committees, and others legally constituted as non-profit non-governmental organizations. Except one, which is a foundation.	Committees for Local Health administration (CLAS) legally constituted as non-profit civil associations, under private law, with standardized statutes and conformation.
Lines of action	57% exclusively to health (including primary health care services, hospitals, ambulances, milk distribution prog., homes for elderly, and others). 43% include social programs, community or housing problems, social and/or religious activities, parent-teacher society.	100% co-administration of primary health care services.
Creation of organization	Pre-existing organizations created by local community members.	Formed at the initiative of local health authorities who convoke the community to decide on joining program and elect members of CLAS.
Entity to which it is legally responsible	FUNDASALUD	Regional Health Director, Ministry of Health
FINANCIAL REPORTING		
Entity responsible for setting norms and regulations	State level – FUNDASALUD, with approval by MState Government of Lara	National level – PAC national coordinating unit with approval by Minister of Health
Entity responsible for reporting from local level	Individual Association or NGO	Local Health Committee (CLAS)
Entity reported to	Internal control unit of FUNDASALUD, which reports to State Govenment of Lara	National coordinating unit of PAC, which reports to the Program for Basic Health for All and Minister of Health.
Frequency of reporting	Monthly, with annual closure	Monthly, with annual closure
Funding requires approval of prior financial report	Yes	Yes
Funding requires approval of prior technical report	No	Yes
Continuation of the project from one year to the next	Automatic	Contract renewal of individual CLAS depends on achievement of goals in Local Health Plan as well as financial

ANNEX II

PROPORTION OF HEALTH FACILITIES WHICH SATISFY SELECTED INDICATORS OF COMMUNITY PARTICIPATION, BASED ON SUBJECTIVE RATING BY HEALTH PERSONNEL IN EACH FACILITY, BY TYPE OF FACILITY AND PRESENCE OF CLAS

Low-Income Urban Health Facilities, Region of Arequipa - PERU

INDICATORS OF COMMUNITY PARTICIPATION	HEALTH CENTERS		HEALTH POSTS	
	With CLAS	Without CLAS	With CLAS	Without CLAS
	(N=5)	(N=15)	(N=14)	(N=32)
Quality of community participation:				
The community organization meets regularly	100%	67%	86%	72%
Meetings are led by a community member	100	60	93	88
Women participate in the community organization	100	80	93	88
Women participate in training and decision-making	100	67	86	72
Disadvantaged groups are adequately represented	60	33	29	41
Needs of socially and economically disadvantaged groups are addressed in the local health plan	100	87	86	66
The community organization implemented some of the following improvements:				
Needed services are newly available	80	47	86	53
Acceptability of services is improved (clinic hours, waiting time, personal availability)	100	73	86	75
A health promotor program was implemented	80	60	71	50
More extramural activities and home visits are done	100	80	86	91
Community projects have been successful	80	33	57	50
The community members help to implement activities in the following ways:				
Administration of funds	100	73	64	44
Acquisition and administration of medicines and supplies	40	13	57	22
The community organization plays a leadership role in health in the following ways:				
Establishing priorities with a community assessment	60	40	57	47
Planning activities	60	40	79	38
Participating in analysis of problems and solutions	60	33	71	44
Selecting or approving paid health personnel	60	7	43	22
Evaluating personnel or the local health program	40	13	57	28
Establishing financial management policies	40	13	43	9
Establishing logistics and supplies policies	40	13	43	6
Analyzing and interpreting health facility data	40	13	50	13

* The data base for this table was provided by the IDB-supported Program for Strengthening Health Services, Ministry of Health of Peru.

ANNEX III

FORMS OF COMMUNITY PARTICIPATION IN HEALTH FACILTIES CO-ADMINISTERED WITH CIVIL SOCIETY IN VENEZUELA AND PERU

Forms of Participation	BASELINE CASE VENEZUELA	COMPARISON CASE PERU
	Health facilities with community participation - FUNDASALUD Network	**Health facilities with community participation - CLAS**
Administration of resources	Civil society (mostly Health Committees) administers government funds from FUNDASALUD, the government (for minor construction), fees for services, donations from community, and other diverse sources.	Local Health Administration Committees (CLAS) administer funds from the government (vía PAC) and fees for services, and to a lesser extent, funds from other sources. Each CLAS has a commercial bank checking account from which to receive and disburse funds with two authorized signatures.
Supervision and control	Health Committees (or their equivalent) exercise supervision and control of the facility, managing information on functions, services delivered, monitoring personnel work schedules, and assignation of resources.	CLAS are contractually bound to supervise and control the implementation of the Local Health Plan (LHP) and accompanying Plan of Activities, including monitoring of personnel and work schedules, identification of subsidy beneficiaries, fee levels, and expenditures. CLAS meet at least every 15 days to monitor progress of the LHP.
Evaluation of management	In some cases, such as the “Ambulatorio Santos Luzardo”, the community has full control over facility management, carries out continual evaluations, and makes strategic decisions.	Monthly, the CLAS is required to submit to the Regional Health Director a legal disposition of activities completed that month, including administrative, financial, and health services reports.
Planning	Generally, the medical team in the facility does the planning. The community association discusses the plan and provides their opinion.	Generally, the medical team in the facility develops the Local Health Program based on a community diagnosis and prioritization of problems. The CLAS discusses the plan and provides their opinion to the medical team.
Contracting of personnel	Of 60 cases studied, 3 health facilities had direct contracting of personnel by Health Committees.	All facilities have the option to contract their own personnel, and most do. Other personnel working concurrently in the facility may be government employees or contracted by another government program*.
Mobilization of resources	The flexibility of Health Committees allows them to accede to a variety of governmental and private sector sources of financing.	CLAS are able to solicit funds directly from any governmental (FONCODES, municipal governments) or private (the Church, local NGO’s) funding source.
Participating in the design of policies	The interaction between the community and the health team leads to a mutual molding of health policies, for example, regarding type of medical specialists required and types of medicines.	Development of a Local Health Plan through collaboration between health team and CLAS allows setting of local priorities within the framework of national and regional health policies.

Maintenance and construction	All Health Committees participate in revamping and maintaining the physical plant. A good amount of resources go to building additions and repairs.	All CLAS orient resources management in large measure to improvement and maintenance of the physical facility, and to purchase of medical equipment and furniture. This occurs especially in the early stages of formation of the CLAS.
Security	Facilities are located in high crime areas. The community plays a role of safe-keeping the premises due to their permanent presence.	Facilities are located in high crime areas. The CLAS uses cash income to purchase window guards and other security devices, or to contract guards. In some cases, community members take turns guarding the facility in exchange for free services.

- In Peru*:* *Programa de Salud Básica Para Todos* (Program for Basic Health for All)

Annex IV

Comparison of Health Services Production Data* in Health Facilities With and Without CLAS[+] by Poverty Classification of Department [++] - Peru, 1997

	Very Poor		Poor		Regular		Acceptable	
	CLAS	**Non-CLAS**	**CLAS**	**Non-CLAS**	**CLAS**	**Non-CLAS**	**CLAS**	**Non-CLAS**
N° of Health Centers (HC)	31	216	75	196	55	187	3	276
N° of Health Posts (HP)	90	1,788	145	1,452	149	680	6	498
N° of inhabitants within jurisdictions (T)	429,999	4,028,554	1,160,991	3,808,318	959,754	2,779,787	101,698	7,228,113
N° of facilities per 10,000 inhabitants ((HC + HP)/T x 10,000)	2.8	5.0	1.9	4.3	2.1	3.1	0.9	1.1
Total n° of persons attended (A)	260,357	2,171,222	668,167	2,227,245	970,852	1,507,542	81,282	3,174,671
Coverage of services (A/T)	60.5%	53.9%	57.6%	58.5%	101%	54.2%	79.9%	43.9%
Intramural services delivered:								
Total n° of services (IN)	579,401	5,092,947	1,857,543	5,881,959	1,849,561	3,601,379	187,900	7,556,645
Rate of services per inhabitant (IN/T)	1.35	1.26	1.60	1.54	1.93	1.30	1.85	1.05
Extramural services delivered:								
Total n° of services delivered (EX)	13,180*	1,144,296	128,358	795,168	129,379	362,353	13,336	632,641
Rate of services per inhabitant (EX/T)	.03	.28	.11	.21	.13	.13	.13	.09
Preventive and promotional activities:								
Total n° of activities conducted (PP)	252,817	2,040,392	830,486	2,653,219	768,184	2,614,790	28,923	1,849,316
Rate of activities per inhabitant (PP/T)	.59	.51	.72	.70	.80	.94	.28	.26

* These data were obtained through the cooperation of the Program for Basic Health for All (PSBPT).

[+] CLAS: Health facilities which are in the Shared Administration Program with Committees for Local Administration of Health.
Non-CLAS: Comparison group of health facilities administered by the PSBPT program.

[++] Poverty classification is based on the percentage of population with Unsatisfied Basic Needs (NBI) (Instituto Nacional de Estadística y Informática, Peru).

Very Poor: Departments of Apurimac, Ayacucho, Amamarca, Cusco, Huancavelica, Pasco, Puno
Poor: Departments of Amazonas, Ancash, Huánuco, Junín, Loreto, Piura, San Martín
Regular: Departments of Arequipa, Ica, La Libertad, Lambayeque, Madre de Dios, Moquegua, Tacna, Tumbes, Ucayali
Acceptable: Department of Lima, Province of Callao

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