UNICEF / PERU

Report on

HEALTH REFORM, COMMUNITY PARTICIPATION, AND SOCIAL INCLUSION:

THE SHARED ADMINISTRATION PROGRAM

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Executive Summary

The experience of the Shared Administration Program (PAC – '*Programa de Administración Compartida*'), created in 1994, has been the most important expression of the health sector reform to this date, since it fosters the three major premises of the reform: quality, efficiency, and equity in health services. The PAC program is distinguished by the aspect of co-management of health services by the community through a committee of elected community members called CLAS ('*Comité Local de Administración de Salud*'). The CLAS receives and manages financial resources transferred from the public treasury for the purpose of providing health services to the community.

A CLAS is a private, non-profit entity that is legally registered, composed of three members elected by the community and three community members selected by the health facility manager. The seventh member is the health facility manager, usually the chief physician, who participates in all decisions of the CLAS and completes the scheme of co-management. By virtue of a legal contract between the CLAS and the Ministry of Health, CLAS are held responsible for ensuring the implementation of a Local Health Program that is developed annually on the basis of a community health diagnosis. This responsibility of CLAS translates into social control of the quality and efficiency of health services delivered. CLAS are given the power to contract health personnel and other workers for the health facility; therefore CLAS can and do require personnel to treat community members well. CLAS are given the power to make decisions on how funds (whether transferred public treasury funds or fees–paid-for-services) should be utilized. They therefore tend to use resources more efficiently, since they can better determine the needs and priorities of their own community and have an incentive to obtain more for less. CLAS are composed of community members who know best which families in the community are the most needy, therefore CLAS also have the capacity to improve equity in health care delivery, although some need orientation to this important aspect. As a local institution, CLAS helps to ensure the sustainability of health and other social development programs in the community.

CLAS alone does not represent community participation in health. Rather, CLAS is a component of community participation. Through its conferred authority and responsibilities, CLAS facilitates empowerment of the community. This empowerment, in turn, creates a more favorable environment for the community to act in a wider protagonist role in collective and individual health activities and behaviors.

PAC now covers over ten percent of peripheral health facilities in the country (611 of approximately 5000 health centers and health posts). Its administration at the central level of the Ministry of Health has recently progressed from being isolated and nearly independent, to being incorporated into the mainline administration of PAAG ('*Programa de Administración de Acuerdos de Gestión*') along with PSBPT ('*Programa de Salud Básica para Todos*'). PAC is now endowed with growing political support and good perspectives for future expansion.

The present document is a qualitative and quantitative analysis of PAC, which has been conducted in the framework of the mid-term review of the cooperation of Peru-UNICEF 1996-2000. The mid-term review provides UNICEF an opportunity to reinforce strategic alliances and achieve a

more effective collaboration with the country. Since the early design phases of program design, UNICEF has provided support to PAC: first, through provision of theoretical orientation via the Bamako Initiative; and later, through a variety of specific points of critical support for training, events, printing and dissemination of important program publications, and others.

The qualitative methodology utilized for this program analysis included: review of previous studies and evaluations of PAC; interviews with key officials in the Ministry of Health; and a review of the development of PAC in two Health Sub-Regions (Ayacucho and Chincha/Ica), including interviews with key officials and visits to CLAS utilizing interview guides. A quantitative analysis of national survey data from ENNIV 97 (National Survey of Living Standards, Instituto Cuánto, S.A.) was also conducted to compare sampling clusters with and without CLAS on a series of health care utilization and health expenditure variables.

CONCLUSIONS

1. Citizen participation in CLAS is an effective mechanism to improve the quality of care, production of services, and transparency in the utilization of public funds through community control of the health facility. This results in greater utilization of both preventive and curative health services, and by inference, improved health outcomes. Also, the administrative flexibility provided by the private, non-profit status of the CLAS allows a myriad of ways to potentiate the public sector investment in health services that is limited only by the level of creativity of the persons involved.
2. PAC is viewed by some within the Ministry of Health as only one of several possible means of achieving the goals of the health sector reform. The main point in question is the applicability of the PAC/CLAS model to rural areas of extreme poverty and illiteracy, where the capacity of the community to co-manage a health facility is doubted. A recent innovation in the new PAC directive to solve this issue is to allow one CLAS to administer a health center and the network of health posts within its jurisdiction. Operations research should be used to test this new model. It is clear that there are issues of training and program support that need to be resolved with any and all types of populations. Other types of adaptations to different types of populations could be considered. Following the principles of community participation, the most successful adaptations will be those that include the community and mid-level administrators in planning and designing the adaptations.
3. Mechanisms need to be developed to effectively orient each CLAS to the methods and activities that best promote health and equity in the community. 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 sides of community information gathering, prioritization of problems, local planning, and monitoring, and of personnel, logistic, and financial management under private law. Other important areas of orientation that are necessary now are general concepts and methods of individual and family health promotion and prevention, environmental health and safety, community empowerment, and equity in health.

4. It is important to recognize the confusion that exists in people's minds of the terms, "citizen participation" and "community participation". There is a need for more realistic expectations of civil participation in public services management. At the same time, new methods are needed to orient health workers and communities to the possibilities and instrumentation of their participation.
5. It is perhaps too great an expectation that the mere existence of a CLAS will improve community participation. However, we can infer that greater potential does exist in PAC/CLAS for stimulating community participation over time. This inference comes from the fact that the structure of PAC/CLAS contributes to community empowerment through the control that the community is allowed to exert on public services. The level of empowerment achieved in a community through PAC/CLAS depends on a constellation of factors. Factors of primary importance include: 1) the extent to which CLAS members are democratically elected so that true leaders are chosen, 2) the personal capability and leadership characteristics of the health facility manager, and 3) effectiveness of efforts to orient and/or motivate the community. Other factors of importance are: 4) permanence of health personnel in a particular community, and 5) consistency of supervisory and administrative support from UTES and Sub-regional health officials.
6. In summary, to the degree that the community participates in co-management of CLAS, which in turn supports community empowerment, the chances for community participation in health actions at the community and individual/family level will be improved.
7. Much work is still to be done to promote equity in health and health care. Whereas the community participation through CLAS offers increased opportunities to identify the indigent and provide them with services, the macro-financing arrangements of PAC need to be refined to offer increased budgets to poverty-area CLAS so that increased exoneration can be provided to needy patients. At the same time, all CLAS need better orientation as to the expectations of the health sector and specific methods they can use to improve equity within the community.
8. Renewed attention should be given to health promoter training programs, now linking them with CLAS. Where health promoters are utilized, more effective community extension by the health team and greater equity are facilitated.
9. The principal obstacles and needs for the development of CLAS have been --
   At the central level:
   - Need for on-going and systematic analysis of the development of CLAS to identify key problems that could be solved with central level support.
   - Need for lobbying to change legislation regarding non-exemption of taxes for CLAS.
   - The need to provide basic funding to sub-national health offices for costs of supervision and technical assistance for community development activities to establish and support CLAS.
   - Need to move toward standardization of information systems for CLAS and non-CLAS health facilities, without regressing on the advances made in CLAS in terms of community diagnosis and Local Health Programming, monitoring and evaluation.
   - Need for review of programming requirements designed at the central level for vertical health programs which are based on percentage goals with unknown denominators, to avoid confusion with requirements for Local Health Programs which are based on community-based population counts.

At the departmental level:

- Need for a strong mandate from the Central Level to support CLAS.
- Need for clear instructions as to the role of Sub-Regional level in relation to PAC/CLAS.
- Lack of funding support to commit personnel and vehicles to assist communities to organize for CLAS (thereby to ensure better representation in each community) and to supervise/train the health facility manager, health personnel and CLAS members on a continual basis.

In health facilities:

- Inadequate training/preparation of health facility managers regarding public health practice.
- Generally a lack of skills in basic personnel and financial management as they relate to private sector law.

RECOMMENDATIONS

Implications and Tasks for Future Development of PAC/CLAS

1. At all levels, establish an image of the permanence of PAC/CLAS as a viable form of health services organization that is beyond the stage of pilot project. Even though PAC may or may not be implemented in all health facilities of the Ministry of Health, it is necessary to provide consistent political and material support to the program so that it can continue to flourish and prosper in the facilities where it is already established.
2. Focus on health goals – It is of prime importance to maintain the vision of the final goals of the health sector in terms of reductions in the morbidity and mortality of the population. Avoid an over-emphasis on administrative procedures.
3. Focus on integrated health actions - Recognize that CLAS does not exist only to provide low cost or high quality health care. The development of healthy individuals and community depends on a variety of other factors such as environment, life-style behaviors (such as alcohol consumption, domestic violence, eating habits, exercise, hygiene), and self-care at home (including early recognition and home treatment of illnesses, and knowing when to seek care outside the home).
4. Health planning - Involve the community in more aspects of health planning to get their personal involvement in caring for their own health and that of their families. Also, planning to work together on solving problems of the entire community, such as improving the environment and other social services.
5. Specific health goals orientation - Orient CLAS to organize the community to emphasize principal health problems, and how the community can act in together and individually to confront those problems, for example (but not limited to):
   - Maternal mortality and maternal health emphasis – community analysis of maternal deaths; committees for maternal mortality prevention, etc.
   - Infant mortality and child health and nutrition emphasis - community committees for analysis and prevention of perinatal and infant deaths; etc.
   - Accident and injury prevention emphasis – community analysis of deaths due to accidents and injury; community awareness campaigns for prevention of accidents and injuries.

- Chronic morbidity emphasis – community analysis of adult deaths; blood-pressure screening campaigns; monitoring and education of adults with hypertension and other chronic morbidity; community orientation for preventive nutrition in adults.

6. Community epidemiology – Emphasize this as a community activity that serves as an effective educational tool which can contribute greatly to changes in individual health-related behaviors and improve health seeking behaviors on the part of the community in priority areas such as those suggested above.
7. Equity – While there can be efforts at the community level to identify and serve those families at greatest need (equity at a local level), it must be recognized that an equitable health system depends primarily on central and regional level decisions for allocation of funds. More support should be provided for more needy geographic areas according the proportion of the population with high levels of unsatisfied basis needs (equity of the health system). CLAS contributes to equity at a local level, but cannot be expected to contribute to equity of the health system merely by its nature of co-management with the community. The ability of each CLAS to exonerate fees when necessary, especially in areas of greater overall poverty, will depend on these central and regional-level decisions.
8. Social inclusion –
   - CLAS need to be oriented to specific measures to promote equity and social inclusion at the local level, including how to create an indigent list for each CLAS.
   - Improve the data reporting system for improved tracking of essential social inclusion indicators. For example, maintain a registry of indigent families, and monitor health care coverage and health status of those families.
9. Health promoter training – Support the renewal of health promoter work in communities in conjunction with CLAS to increase effectiveness of health programs.
10. Management training - In recognition of the complex nature of human and community development, a horizontal training methodology has been proposed for community-based sustainable human development that is applicable to the strengthening and diffusion of the CLAS concept. The methodology follows three steps:
    - Selection of communities as learning examples.
    - Development of these communities as "Self-help Centers for Action Learning and Experimentation".
    - Expand the experience to other communities through "Sustainable Collaboration for Adaptive Learning and Extension" (Taylor-Ide and Taylor, 1995).

Implications for Cooperation Peru-UNICEF

Potential areas of support by UNICEF to the Shared Administration Program could be:

1. Support for a pilot project in horizontal management and development training for CLAS.
2. Support for promotion of community participation, greater equity, health care delivery models, social marketing of services, effective health education methods, and other important issues. Share and disseminate information about successful methods and strategies used by other CLAS, utilizing a variety of communication channels, including events, meetings, newsletters, publications, computer networks, radio, and television. These issues would also be disseminated through horizontal training methods.
3. Support for pilot project or operations research on the CLAS model in areas of extreme

poverty and illiteracy, and other evaluative and operations studies that would serve to stimulate and support on-going policy dialogue on PAC.

4. Support for community organization activities to organize new CLAS to ensure adequate community orientation to CLAS and democratic elections of CLAS members.
5. Support for local health planning and evaluation, including additional financing for each facility to conduct local census and/or technical assistance to process census data, develop Local Health Programs ('*Programa de Salud Local*'), set up monitoring and evaluation systems, etc.
6. Support for health promoter training and retraining.
7. Support for development of human resources policies, including development of incentive systems for health facility managers and other personnel to ensure the hiring of professionals with proper skills to work with CLAS and to ensure continuity of care.
8. Support for improvements in information systems, including periodic evaluations of the validity of reported data in the new standardized information systems that will be implemented by the Ministry of Health for all CLAS and non-CLAS facilities.
9. Support for improved supervision of CLAS, including development of supervision checklists for medical and financial auditing, and an emergency fund for supervisory visits by central level program managers.

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"HEALTH REFORM, COMMUNITY PARTICIPATION, AND SOCIAL INCLUSION: THE CASE OF THE SHARED ADMINISTRATION PROGRAM"

I. BACKGROUND

A. INTRODUCTION

The participation of community organizations (especially those of women) in social programs designed to solve problems of poverty and survival, has been one of the most significant social phenomenon of Peruvian society in the past decades. The experience of CLAS, since 1994, has been the most important and possibly the only expression of the health sector reform. The co-management of health services in conjunction with the community through the CLAS permits the manifestation of the three major premises of the health sector reform: quality, efficiency, and equity. There is the potential for greater quality in health care with CLAS because the community is given social control of the health services and can demand better treatment from providers. There is the potential for greater efficiency because the population is more attracted to the health services, due to the improved quality of care, and the creativity of providers and the community has been freed to invent mechanisms for marketing the health services that are appropriate for their particular community. There is potential for greater equity with CLAS due to the mechanisms that can be implemented in conjunction with the community to identify the neediest families, attract them to the health facility, and/or take services to them.

The current review of the Shared Administration Program is being conducted in the framework of the mid-term review of the cooperation of PERU-UNICEF 1996-2000. This review provides an opportunity to reinforce strategic alliances and achieve a more effective collaboration with the country.

B. DESCRIPTION OF THE SHARED ADMINISTRATION PROGRAM

Brief History of Program Initiation and Development

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 grassroots organizations have been widespread throughout Peru to fill the vacuum of public support in helping to meet basic needs of the people.

Due to the ravages of hyperinflation, terrorism, and international isolation that rocked the country during the late 1980's and early 1990's, government social services were forced to reduce their funding to subsistence levels. Health services, especially non-hospital facilities such as health centers and health posts in peripheral areas, came to a state of collapse, being understaffed, under-equipped, and underutilized.

By the second half of 1993, some parts of the economy and government were beginning to recover. 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 then newly-instated Minister of Health, Dr. Jaime Freundt, and a team of advisors developed 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 to increase coverage of services, improve the quality of expenditure, improve the 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 in the first months of 1994 by a team of consultants[1] under the IDB-supported Program for Strengthening of Health Services, and an international expert on community participation and health[2]. In April, lobbying was done in the Inter-ministry Committee for Social Affairs. Supreme Decree N^{o} 01-94-SA, signed by the President of the Republic, Hon. Alberto Fujimori Fujimori, on May 2, 1994, put into law the Shared Administration Program. Between May and July, fieldwork was done to organize the first 13 CLAS in two areas. On July 25, 1994, four CLAS were instated in the Health Sub-region of Ayacucho, and on July 26, 1994, nine CLAS were inaugurated in the area of Chincha in the Health Sub-region of Ica. Between July and December of that year, approximately 250 additional CLAS were initiated in all parts of the country.

Process of Incorporation of Health Facilities into PAC

The incorporation of health facilities into PAC initially involved selection of communities with a strong history of community organizing. In the second half of 1994, PAC central-level managers provided orientation to health authorities in nearly all health regions and sub-regions, who in turn convoked meetings with local organizations, community leaders, and health personnel. Individual community meetings called 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.

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. In order to maximize the community empowerment effect of the program, it will be important to maintain the self-selection process as the program continues to develop. So far, communities are continuing to choose to enter the program. As news of the benefits of CLAS spreads to other communities, more request permission to join the program. Over 150 more CLAS are already organized and waiting to be recognized, while another 200 are in stages of formation.

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

How PAC/ CLAS Works

The Shared Administration Program (PAC – '*Programa de Administración Compartida*') has two principal strategies: 1) the formation of a Committee for Local Health Administration (CLAS – '*Comité Local de Administración de Salud*') composed of community members, and 2) the legal contract between the Ministry of Health and the CLAS based on a Local Health Program ("*Programa de Salud Local"*). PAC was designed on the basis of successful experiences with community participation in Peru and elsewhere, but with a new legal basis and specific 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.

Each CLAS is comprised of seven selected members. According to program guidelines, the community nominates candidates and votes on three members who represent local health-related or other community development organizations. The health facility manager appoints three other members from the community. The permanent seventh member is the health facility manager, usually the chief physician. The President of CLAS is elected within the members of CLAS, and serves for a period of one year, with the possibility of re-election for a second year. The CLAS also elects a secretary and treasurer from within the group. The three officers comprise the Board of Directors ("*Consejo Directivo*"), which meets approximately every one to two weeks, with full meetings of the CLAS once a month. CLAS members serve for a period of three years.

The CLAS is inscribed in the public registry as a private non-profit entity under private law. It is subject to taxes on income and purchases. A CLAS can also contract personnel under private sector law, which provides for deductions for taxes and social security, and allows for paid vacation time and other relevant personnel benefits.

The relationship between CLAS and the public sector is formalized through a legal contract between CLAS and the Regional Health Director. The contract is based an annual Local Health Program. Supreme Decree N^{o} 01-94-SA specifies by law the contractual responsibilities on both sides. The Local Health Program with budget guides financial and technical direction, monitoring, and evaluation. The tailoring of the plan to local needs, and the conferring of social control to CLAS, are the bases for efficacy, efficiency, and equity.

Parallel to the development of PAC, the government was creating other new programs in the health, education, and judicial sectors to reorient government social expenditures to areas of greatest poverty. In the health sector, the Program for Focalization of Basic Social Spending in Health ('*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. 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 to health professionals to work in isolated areas. Workers are hired under

personal service contracts with a three-month duration, renewable on the basis of performance evaluations. Contracts do not allow for any benefits and workers are responsible for their own taxes and insurance.

PAC/CLAS Program Objectives

The following intermediate objectives of PAC are being accomplished in a generally successful way in nearly all CLAS. This is 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 Program, CLAS prioritizes management results over procedures.
- **Contribute to administrative decentralization** - The 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 of Public Treasury funds.
- **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. Funds from other governmental sectors, non-governmental organizations, or other organizations can be received by CLAS. Some CLAS have created pre-payment systems and mutual funds to optimize the use of local resources, which potentiate public investment, and over time, improve the sustainability of both preventive and curative health services delivery (Vera, 1998).

A model of the functioning of PAC/CLAS is shown in Figure 1. This can be contrasted with the functional model existent in the traditional health system in Peru, as shown in Figure 2. It should be noted that in the Shared Administration program, there are many more formal linkages between the public health sector and the community, and there are more opportunities for social control of the health services by the community.

Figure 1
MODEL OF THE FUNCTIONING OF SHARED ADMINISTRATION PROGRAM (PAC)

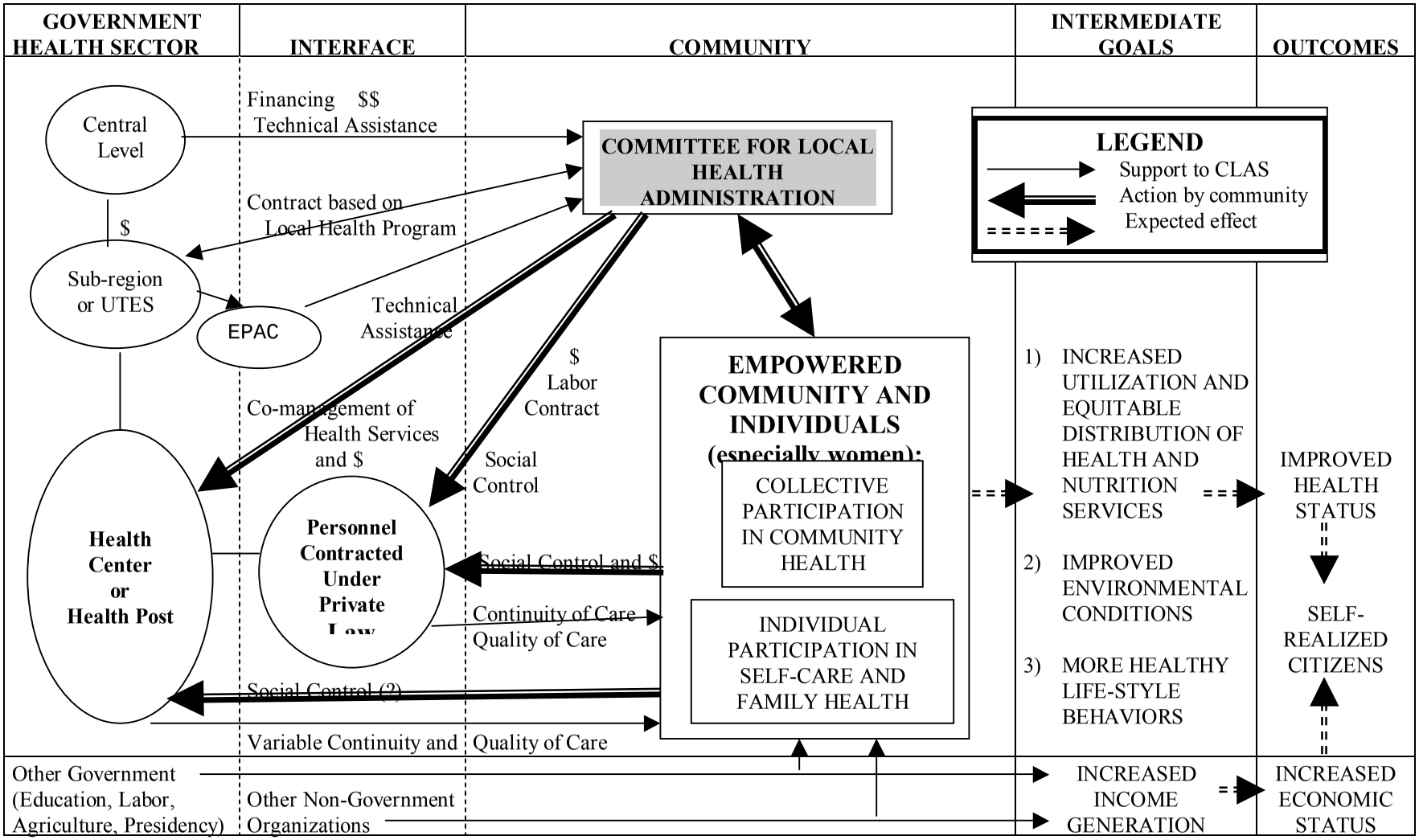
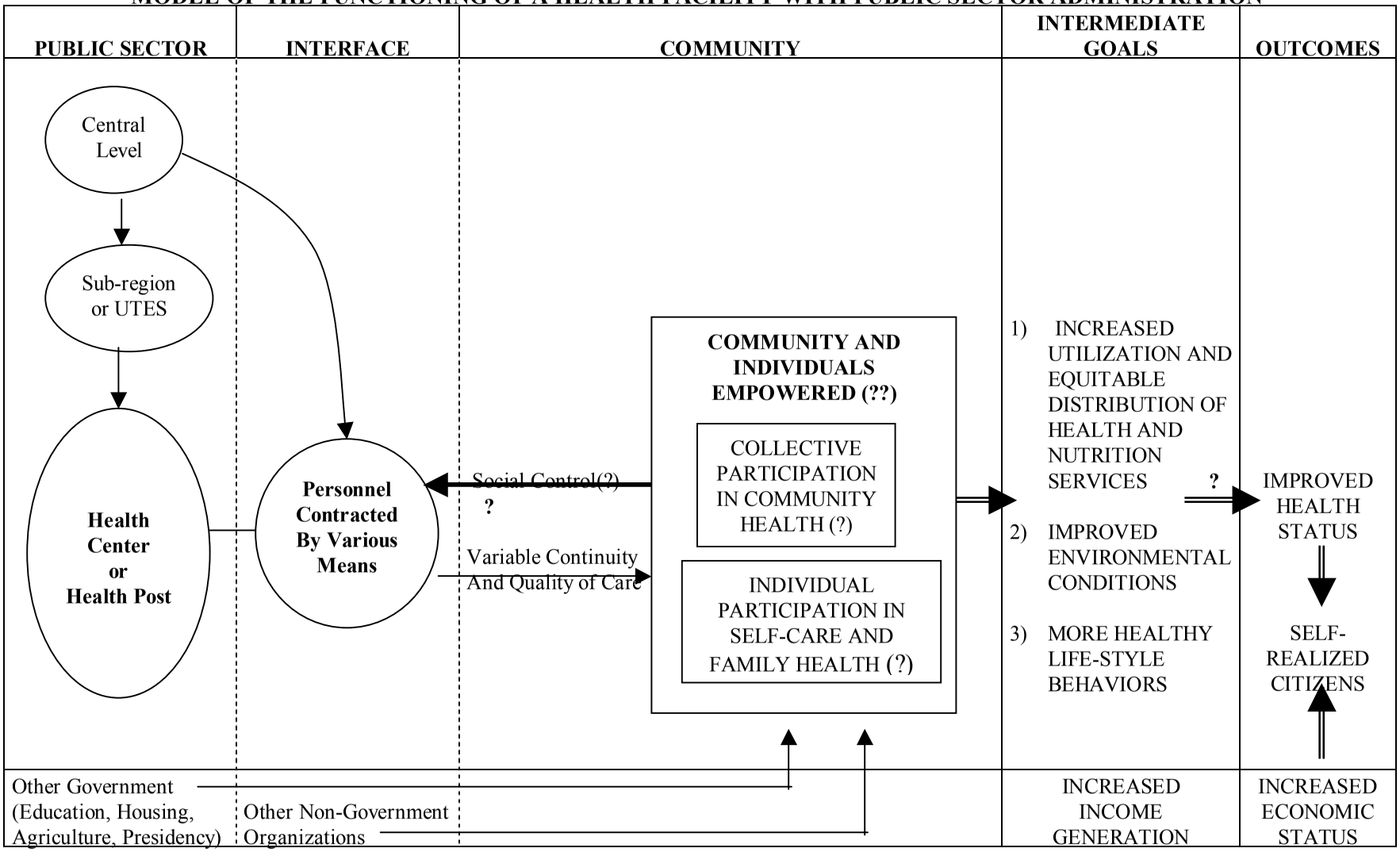


Figure 2

MODEL OF THE FUNCTIONING OF A HEALTH FACILITY WITH PUBLIC SECTOR ADMINISTRATION



C. SCOPE OF WORK FOR CURRENT REPORT

General and Specific Objectives

The general objective of the mid-term review is to formulate a vision of the program of cooperation and the role of UNICEF beyond the year 2000: to identify lessons learned from the program and its management, and to better orient it to the progressive achievement of CRC/CEDAW, in the framework of strengthening citizenship, democracy, and cultural diversity with equity.

Specific objectives of this review are:

a. To appreciate the PAC/CLAS experience as an alternative to the traditional system of administration of health services in the framework of health sector reform, in terms of whether its operational modality and strategy permit:
    (1) Greater access and satisfaction for users of health facilities with CLAS in comparison with those that do not have CLAS;
    (2) If the program permits empowerment of the population through participation in decision-making and greater equity and social inclusion of the population to the benefits of the health service.
b. Identify lessons learned for the Health Reform, identifying pending issues for the CLAS model, and for citizen participation in the management of health services. Identify the implication of these for PERU-UNICEF cooperation in the future.

Questions To Respond To

The review of PAC responds to the following questions:

a. Health sector reform: what are the tendencies, proposals and advances to date?
b. Description of PAC, its development and functioning:
    (1) Who are the actors that participate?
    (2) How was the program created?
    (3) What is the structure of the program?
    (4) How is PAC different from other existing programs?
    (5) How has PAC been inserted in the administration of other programs in the Health Sub-Regions and UTES ("*Unidades Territoriales de Salud*")?
    (6) What has been the role of EPAC ("*Equipo de Gestión del PAC*") in the development of CLAS, in regard to their formation, supervision, monitoring, evaluation, technical assistance, and others?
    (7) What has been the role of the Health Sub-Region/UTES and EPAC in the development of Local Health Programs ("*Programas de Salud Local*"), versus the participation of the community? What are the weaknesses?
    (8) How has the contract between the Sub-Regional Health Director and the CLAS from the point of view of the former? What have been the weaknesses?
    (9) What has been the opinion of personnel of the Sub-Regional or the UTES regarding:

- The system of personnel contracts under private law?
- The relations that have developed between personnel working in the same health facility but contracted under different regimens?
- The system of acquisitions?
- The system of financing CLAS?

c. What is the process of community participation?
   (1) To what degree does participation contribute to the achievement of the immediate goals of PAC?
   (2) What are the forms of community participation?
   (3) In what ways does the participation of community members contribute to improving the economic, social and political-institutional impact of PAC?
   (4) In what ways does participation contribute to a more equitable distribution of program benefits?
   (5) To what degree does participation contribute to the sustainability of the achievements of PAC; to transparency of management; to the increase in commitment and responsibility of the actors; and to the generation of new initiatives?
   (6) What are the factors for success in the experience of participation?
   (7) What conditions and processes were indispensable to achieve the success?

d. What is the opinion of users regarding the quality of care of CLAS facilities in comparison with non-CLAS facilities?
e. What is the productivity and efficacy of CLAS?
f. What are the mechanisms that contribute to greater equity of access of health services and social inclusion in CLAS facilities in comparison with non-CLAS facilities?
g. What is the sustainability and political conditions for the future within the framework of the health sector reform?
h. What is the agenda for CLAS within the framework of the health sector reform and the achievement of greater efficiency, citizen participation, and equity?
i. What has been the support provided to PAC/CLAS by UNICEF in Peru?
j. What have been the effects of previous experiences in health facilities with community-managed pharmacies in the functioning of CLAS? Has this experience with pharmacies facilitated the process of CLAS, hindered it, or had no effect?
k. What are the lessons learned, implications, and tasks for the cooperation of PERU-UNICEF in the future?

Methodology

a. Review of studies, evaluations, and relevant literature (see Bibliography).
b. Interviews with key persons in the Ministry of Health (see List of Persons Contacted).
c. Documentation of the development of the Shared Administration Program in two Health Sub-Regions (Ayacucho and Ica/Chincha) through key-informant interviews and visits to CLAS Health Centers utilizing interview guides (see Annex 1).
d. Secondary data analysis on health services utilization and costs in CLAS versus non-CLAS populations: National Survey of Living Standards (ENNIV '97), Instituto Cuánto, S.A.

e. Presentation of report findings for discussion and feedback in the Ministry of Health.

II. EVALUATION RESULTS - FINDINGS

A. HEALTH SECTOR REFORM

Within the past nine months, several major changes have been implemented in the Ministry of Health (MINSA) as part of modernization efforts within the on-going health sector reform. These changes directly affect PAC and strengthen its administrative base in MINSA. First, the Program for Administration of Management Agreements – PAAG ('*Programa de Administración de Acuerdos de Gestión*') was created by Ministerial Resolution N° 534-97-SA/DM in November 1997. Its purpose is to design strategies and actions for modernization of the health sector by means of institutional, financial, budgetary, and health services delivery changes, and to improve efficiency in use of public resources. Secondly, a Coordinating Unit for the Modernization of the Public Health Sub-sector was created within PAAG by Ministerial Resolution N° 052-98-SA/DM. The resolution named to the unit a General Coordinator, with representatives from MINSA: an advisor to the Minister, General Coordinator of the Office of Financing, Investments and External Cooperation, and General Coordinator of the Office of Planning; and from outside MINSA, a representative from the Program for Modernization of Public Administration of the Presidency of the Council of Ministers.

The formation of this new organizational structure was followed by Ministerial Resolution N° 143-98-SA/DM in April 1998 that incorporated the PAC and the Program for Basic Health for All (PSBPT) into PAAG. The purpose was to unify the administration of the two programs and thereby strengthen modernization efforts. In effect, this action pulled PAC into the mainstream of MINSA administration, and fortified the political commitment of MINSA to continue forward with PAC.

The most recent developments in the health sector reform have been a series of Ministerial Resolutions prepared by PAAG in June 1998, including one which approves a new directive (N° 03-PAAG-98) that provides norms regarding the functioning of PAC. This directive is important due to its explicit reaffirmation of PAC as part of the process of modernization and decentralization of the public health sector. The new directive also clarifies and strengthens the role of the regional health directorates in supervision of Local Health Programs and fiscal monitoring of financial resources of the State that are transferred to CLAS. It also describes more clearly the organization and conformation of each CLAS, and better defines mechanisms for managing and reporting finances, including tax issues, specifying functions of various actors in the health region directorate and in CLAS. It establishes the possibility that one CLAS can administer a network of health facilities based in a health center and including the health posts within its jurisdiction.

B. CASE STUDIES OF THE SHARED ADMINISTRATION PROGRAM: DEVELOPMENT AND FUNCTIONING

Two case studies on the development of CLAS at the Sub-regional level were conducted in order to illustrate how the structural design and guidelines for the Shared Administration

Program were actually implemented in the field, and what the respective results were in program operation and results. A series of data collection instruments were developed to aid in open-ended interviews with Departmental and UTES health officials and CLAS members (see Annex I). Data on personnel staffing, finances, production of services, etc. from nine health centers and posts with CLAS in the two Sub-regions studied are tabulated and shown in Annex II.

CASE STUDY I

DEVELOPMENT AND FUNCTIONING OF CLAS IN AYACUCHO

The Department of Ayacucho was one of the first three in the country to enter into the Shared Administration Program. This was for several reasons. Most importantly, the politics of health in the Department were converging on an interest and support for greater community participation in health services. Previously, there had been little community participation, poor performance of health personnel in health services, and little utilization of health services. During the 1980's, the Italian government and PAHO sponsored the "Programa de Salud Comunitaria del Trapecio Andino (PSCTA)" which introduced the concept of SILOS (Local Health Systems) in Ayacucho. The project did not involve the community directly in management of the health services, but it stimulated discussions as to who would represent the community. Would it be someone suggested by the government or someone who would be put forward by the community? It must also be mentioned that the Shining Path terrorist movement throughout the 1980's and into the 1990's originated and was in strongest force in Ayacucho, and undoubtedly was principally responsible for the collapse of health services during that time.

Secondly, it was to Ayacucho that a visit was made in January of 1994 by a team of consultants from Lima who were charged with the design of a health program that would transfer government resources to communities. The team members included Ing. Juan José Vera (Coordinator of PAC from 1994 to March 1998), Dr. Patricia Paredes, and Dr. Carl E. Taylor (expert on community health from The Johns Hopkins University). On that visit, the team interviewed people in communities in areas where the Shining Path had been active and government health services had been inoperative for a number of years. Services that had existed before were considered of poor quality and were little used. Through the years of terrorism, communities had learned to be self-reliant in self-protection and in basic services. People now said that they wanted to have government health services back, but that they would want to control them.

As a result, the Health Sub-Region of Ayacucho organized a meeting of major political figures from the Department, mayors from the principal cities of the Department and representatives of major community organizations such as the Federation of Mothers Clubs. The central level Ministry of Health supported the meeting, whose purpose was to inform and establish broad-based support for a new type of administrative arrangement for peripheral health services with community participation. At this event, the mayors of Luricocha (near Huanta), Quinua (across the valley from Ayacucho), and Santa Elena (in the city of Ayacucho) requested that their towns be included in the new program. These

became the first CLAS in Ayacucho. Facilitating factors present at the time were: 1) the fact that the Sub-Regional Health Director was running for national Congress, and 2) a high-ranking regional authority, President of the Regional Government of Ayacucho, was highly supportive of the proposed Shared Administration Program. The regional president, Mr. Carlos Bendezú, later became a long-term member of the three-person team of consultants in Lima who administered PAC in the Ministry of Health and oversaw its expansion on a national level.

The first to serve the role of CLAS coordinator in Ayacucho was Dr. Maxmilian Vega, a dynamic physician who was Director of the UTES Huanta. His interest led him to work closely with the newly-formed CLAS in the Health Center of Luricocha to develop a management model for that facility, providing suggestions for instrumentation of the PAC program that were not provided by the central Ministry. According to Dr. Vega, young physicians who were completing their required service in under-served areas following medical school graduation ("serumistas") had a key role in doing the necessary footwork and legal paperwork for establishing CLAS in Quinua, Luricocha, Santa Elena, and Carmen Alto. All of these "serumistas" stayed on as contracted or permanently assigned staff in the same health centers to carry on the work with CLAS once their required service time was completed. This factor allowed for continuity over a longer period of time to ensure consolidation of the CLAS in each place.

Another factor that helped to build and strengthen the first four CLAS in Ayacucho was support from FONCODES (Fund for Community Development) that provided S/ 22,000 in equipment and construction materials to each facility, arranged by the central level PAC Coordinating Unit. Communities provided the labor. Further support for equipment and building continues to come from a small allotment each year from PAC/Ministry of Health, and mostly from fees-for-service ("*ingresos propios*"), which are the source most CLAS in the country depend on. Other CLAS, such as those studied in Chincha, use creative means to obtain equipment or supplies from the Ministry of the Presidency, the Church, municipalities, FONCODES, and other national or international institutions.

In 1995, one year after initiation of CLAS in the Sub-Region, more funding became available to Ayacucho through PAC for new CLAS, and the Sub-Regional Director decided to establish three additional CLAS in the Health Centers of Belén and San Juan Bautista, and the Health Post of Nazarenas. Those facilities were chosen because there were 1) interest on the part of the chief physician and other health personnel, and 2) good organization of the community.

Although never formally appointed to the position of CLAS Coordinator, Dr. Vega served an important role in coordinating the newly founded CLAS between 1994 and 1995 while he was Director of the UTES Huanta. He was supported by a favorable attitude toward CLAS on the part of the then Sub-Regional Director, Dr. Antonio Surca, and most importantly by frequent telephone communication with his university classmate, Dr. Alfredo Sobrevilla, who was a member of the PAC coordinating unit in Lima. CLAS managers and members frequently sought out Dr. Vega to explain procedures or help them solve problems.

In 1995, Dr. Vega was named as Ayacucho Sub-Regional Coordinator of Basic Health for All (PSBPT), after which no one took full responsibility for CLAS, and there was no coordination between PSBPT and CLAS. Although the new Sub-Regional Director, Dr. Ruth Ochoa, was favorable towards CLAS, the direct responsibility for supporting all of them, except Luricocha, was held by the UTES Huamanga. That UTES viewed CLAS as private entities, and therefore provided them no supervision or support. The UTES was apparently not well-informed of PAC regulations and opposed certain actions of CLAS that were within their guidelines, such as the contracting of Ministry of Health permanent employees for additional hours over and above their required six hours of daily work. The UTES also wanted to do planning for their entire jurisdiction, and did not want the CLAS to do their Local Health Program.

This situation continued throughout 1996, but nevertheless, CLAS prospered with the support of Dr. Ochoa and a series of CLAS coordinators who were assigned to the job in addition to their normal responsibilities. In 1997, however, a new Sub-Regional Director did not support CLAS, a hold was placed on PAC/CLAS program at the central level so that supervision visits could not be made from Lima, and support further diminished for the CLAS in Ayacucho. Problems that came up in the CLAS were mostly left to fester chronically. Some problems turned into crises that also were not resolved. Reports of these problems reached Lima and began to make people question the program.

Processes Used for the Selection of CLAS Members in Ayacucho

In Luricocha, the original CLAS committee in 1994 was selected from three community groups: 1) the Church, 2) the 'ronderos' (a community organization designed to protect the community from terrorist attacks), and 3) the community council. In Quinua, the community council and ronderos were the driving forces in the community. In Carmen Alto, the mayor was selected to CLAS and played a strong role in leading the community involvement in CLAS. In Santa Elena, a local baker took a strong leadership role in CLAS.

CLAS in relation to other programs in the Sub-Region of Ayacucho

CLAS in Ayacucho has generally been treated as a private-sector administrative option capable of generating income and becoming self-supporting in many ways. Local health authorities have not valued the PAC program as an option for community participation in health, with Local Health Programming and monitoring to better meet the health needs of the population. Rather, once PSBPT was introduced shortly after PAC in early 1995, the two programs became competitive for administrative support, with the result that PSBPT received proportionately more.

The panorama has changed since March-April of this year for the CLAS in Ayacucho. First, there is a new Departmental Health Director, Dr. Roberto Aldoradín, who has a favorable position towards CLAS. Secondly, and more importantly, the structural changes in the PAC and PSBPT programs at the central level of the Ministry of Health have sent a message to Ayacucho that both programs are being treated with equal importance. Furthermore, it is now mandated that the two programs share supervision and monitoring functions. A new

CLAS coordinator has been named, Lic. Maura Arbayza, who shares supervisory responsibilities with PSBPT.

Role of EPAC in the formation and development of CLAS

There was never an EPAC ("*Equipo de Gestión del Programa de Administración Compartida*") in the Health Sub-Region of Ayacucho. After Dr. Vega joined PSBPT in 1995, a series of individuals from the Sub-Regional Office were assigned the job of CLAS Coordinator in addition to their normal jobs. These individuals supported CLAS to some degree during the next two and a half years, even when the Sub-Regional Director (from 1997 to 1998) was not favorable toward CLAS.

Development of Local Health Programs

Local Health Programs ("*Programa de Salud Local*" - PSL) have been completed every year by each CLAS in Ayacucho, following the "Green Book" guidelines published in 1996. The PSL is the heart and center of PAC, since it serves as the guide for health services delivery, monitoring, and evaluation. As well, the PSL is the instrument on which the legal contract between the Departmental Health Director and the CLAS is based. A key function of the health services in PAC is the community health assessment, which is achieved through a house-to-house community census. It is important to note that the purpose of community diagnosis and PSL is to make health planning and services delivery as relevant and appropriate as possible to community needs, realities, and resources. Local planning was meant to replace top-down planning which utilizes national or regional averages and priorities for assigning local goals and objectives. This consultant reviewed Local Health Programs of several health facilities visited. It was found that community diagnoses are being conducted according to the "Green Book", but when setting numerical goals, they utilize a template provided to them by central level programs as to what proportion of the population should be programmed for each specific health service. In many cases, that proportion is not relevant to the needs of the community. For example, the template could indicate that 25% of pregnant women are at high risk and that 90% of them should be programmed for prenatal care. However, that community could have a high-risk pregnancy rate of over 50%. So many needy women will not be considered in the programming. In another example, the template would indicate that 65% of all pregnant women should receive adequate prenatal care. However, the community could be small enough that 100% of pregnant women could easily be covered with adequate prenatal care. The health facility would have no incentive to keep working once they reach their 65% coverage figure, and they would report reaching 100% of their goal. On the other hand, if all 100% of pregnant women in that same community received adequate prenatal care, under the same system the facility would report reaching 158% of their goal (100/65), which gives a distorted view of the situation. It is more understandable to program and monitor straight coverage figures, utilizing the total population (or population sub-group) as the denominator.

Opinion of Sub-Regional and UTES personnel regarding PAC administrative systems

In general, the system of contracting of personnel under private law has not caused problems

in Ayacucho. There has been difficulty for health personnel themselves to get the proper paper work done regarding taxes and the like required with private contracts. The paper work takes time and advice is needed as to what has to be done, since health personnel are mostly unaccustomed to private sector regulations. It was recommended that someone be assigned from the Sub-Region to assist with the paper work. In regards to the relationships between health personnel employed by the Ministry of Health and those contracted by CLAS, there hasn't been as much a problem in Ayacucho as in other regions.

CASE STUDY II

DEVELOPMENT AND FUNCTIONING OF CLAS IN THE SUBREGION OF ICA – UTES CHINCHA

The PAC program began in Chincha on July 26, 1994 with the incorporation of nine facilities (five health centers and four health posts) into the program. The area of Chincha had been chosen at the initiative of the PAC Coordinating Unit in the central Ministry of Health. Ing. J.J. Vera and Lic. Carlos Bendezú made frequent visits to the area. Communities in Chincha showed great interest. Once the CLAS were established, continual technical assistance to Chincha was possible due to its close proximity to Lima. Even when there was no central level funding for supervision of CLAS in the provinces, the PAC coordinators from Lima could still travel to Chincha.

An important strength of the PAC program in Ica/Chincha was the longevity in his post of the Director of the Ica Health Sub-Region, Dr. Juan Felix Pun Jaramillo, who held his post from 1994 to June 1998. Dr. Pun oversaw the initiation of CLAS in his Sub-region, and continued to support the program in a consistent way throughout his term.

Despite the general assessment of Chincha as having a very successful CLAS program, unique problems have existed among the CLAS in Chincha since the beginning. In the early years, community members serving on the CLAS committee, or the communities themselves, took on the idea that they were going to be the owners of the health facilities. At the same time, the Sub-region of Ica had the impression that the CLAS were private entities that did not pertain directly to the Ministry of Health. Rather, the Sub-region considered itself to have only the responsibility to oversee fiscal aspects of CLAS through the intermediary of the health facility manager. This was the view of the then Chincha UTES Director, who did not see it as his responsibility to supervise or assist any other aspects of the CLAS. At the same time, however, the same director placed physicians of his own choosing as CLAS facility managers, which gave him control over the CLAS.

There were major problems in the relationships between health personnel who were Ministry of Health employees ("*nombrados*") and those who were contracted by CLAS. The labor union of health personnel did not want to allow personnel to be contracted, since they mistakenly thought they would lose their job stability. They also thought they would be forced to work harder. At one time there was a boycott of CLAS by health personnel who were Ministry employees.

CLAS in Relation to Other Programs in the Sug-Region of Ica/UTES Chincha

In Chincha, the PAC has been managed as a completely separate program, with its own coordinator in Ica who has been largely responsible for supervision and technical assistance to the 20 CLAS in the sub-region, 12 of which are in the UTES Chincha. Dr. Pun considered that the PAC program was less of an administrative burden to the Health Sub-Region because it is "self-administered". The UTES Director, Dr. Carvajal, also has this point of view.

Role of EPAC in the formation and development of CLAS

The Management Team for the Shared Administration Program ("*Equipo de Gestión del Programa de Administración Compartida*" – EPAC) has also been stable since the beginning of the program and has played an important role in supporting CLAS. The current CLAS Coordinator, Sr. Pedro Cordero García, is also Director of Community Participation for the Ica Sub-Region. He plays a dedicated role in providing constant technical assistance to all the CLAS in his area, visiting CLAS frequently, providing guidance by telephone, and holding technical meetings every six months to up-date CLAS members. Other EPAC members are Dr. Roland Aricama, a physician who was the EPAC Medical Auditor and Head of Epidemiology for the Ica Health Sub-Region, and Dr. Manual Carmona, Administrator of the Ica Health Sub-Region, who was EPAC Financial Auditor.

Development of Local Health Programs

Local Health Programs are developed exclusively by each health facility, in nearly all cases by the head physician and other health professionals. In most cases, the community members of CLAS assist in the organization and implementation, and sometimes in the analysis, of the community health survey, which serves as the basis for the community diagnosis necessary for developing the health plan. Community members do not participate in the actually writing of the Local Health Program. Once the plan is developed, CLAS members are frequently asked to review and approve it before it is finalized.

Opinion of Sub-Regional and UTES personnel regarding PAC administrative systems

One of the greatest strengths of PAC is the system of contracting personnel under private law. Personnel receive social benefits and vacation time, and contracts are of a longer duration so that they have less incentive to leave their post, even if it is in a more remote area. This benefits the local population that has time to build trust and confidence in their health care provider, factors that are strongly related to health service use. In contrast, PSBPT system of contracting personnel under personal services contracts has the effect of ensuring short periods of stay in a job site (recently extended from three-month to six-month contracts), since it does not provide for either job security, insurance, other social benefits, or paid vacation time.

The Director of Ica considers that each CLAS does a good job in the area of acquisitions.

At the same time, he stated that the system could be perhaps more efficient if certain items were purchased in bulk for various CLAS at the same time.

C. PROCESS OF COMMUNITY PARTICIPATION WITH CLAS

There is no room for doubt that participation of civil society in social development programs has a positive effect on program sustainability, transparency, efficacy, and efficiency. The Report of a Task Force on Portfolio Management for the Inter-American Development Bank (IDB) and the Report on the Eighth General Increase in the Resources of the IDB, published in 1993, concluded that participation of project or program beneficiaries is valuable not only from the viewpoint of development but also for the operational efficiency of the program. This was also the consensus conclusion by nearly all major development agencies (including UNICEF), academic institutions, and non-governmental organizations from Latin American who attended the IDB seminar on "Social Programs, Poverty, and Citizen Participation" in Cartagena in March 1998. There is a renewed and refined recognition of the importance of community participation within the new political structures of democracy in Latin America. This is no longer the same utopic and operationally ill-defined concept of community participation of the 1970's and 1980's. Rather, there are specific experiences now in Latin America, far from the rhetoric, of citizen groups who are administering public funds and programs in ways that reduce the possibilities of corruption and improve the quality and efficiency of public services. One of these experiences is PAC.

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 their formalization of solutions in the Local Health Program;
3) Decisions on use of funds for personnel, supplies, equipment, maintenance, and other aspects of running the health facility;
4) Monitoring and evaluation of the Local Health Program; and
5) Monitoring of health personnel, in terms of attendance and personal treatment of patients.

The degree to which each CLAS actually participates in each of these ways is subject to evaluation. In many cases, full participation in these aspects is dependent on orientation or training of CLAS members in the necessary management and negotiation skills. Most health personnel have never received training in basic health facility management, community surveys, or local health planning and evaluation. The extensive amount of training and orientation that PAC central level coordinators have been able to implement has focused on urgent issues of personnel contracts and financial management under private law, which are new to most workers in the health sector.

The IDB has identified some of the skills necessary for their own personnel to be trained in, as well as all other human resources working on participatory social development programs. These skills would be highly advisable for all personnel working with the PAC program, especially managers of health facilities in the Shared Administration Program, as well as sub-national level officials such as the regional CLAS Coordinator and field supervisors. The areas identified for training were:

- Skills for negotiation and conflict resolution
- Team formation
- Participatory management
- Analysis of target population
- Communication skills and methods

Forms of community participation in CLAS

Observational review of CLAS in various parts of the country, and especially in the two case studies conducted recently, revealed ways in which CLAS members are participating in co-management of the health facility:

- Making decisions on expenditure of government-transferred resources and income generated by charging patients fees-for-services ('*ingresos propios*').
- Making decisions on contracting of personnel – For example, the CLAS in Luricocha ensures that the person being contracted speaks Quechua adequately, treats people well, and identifies with their work. They do this to ensure the maintenance of a good image of the health facility in the community.
- Paying bills and wages for contracted personnel.
- Assisting health personnel staff with organization of health census in the community.
- Reviewing and approving Local Health Program.
- Monitoring implementation of Local Health Program.
- Assisting health personnel in promotional activities in the community, i.e. using the loudspeaker to make community announcements.
- Communicating directly with community members to orient them about services available in the health facility, and convincing them to go there (appealing to their feelings, for example, go there for my sake, to show you're my good friend"").

Illustrative data from the Health Region of Arequipa provides an initial level of evaluation of the process of participation through CLAS. 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 IV 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 were seen among health centers than among health posts. The data show the greater participation of women in CLAS, the greater role of CLAS in assessing

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

community needs, setting priorities, planning activities, policy making, and decision-making on financial and logistic management issues.

CLAS health centers had consistently better assessments than non-CLAS health centers. Nevertheless, there are areas that need improvement. For example, there is need for greater representation in CLAS of community members from the more disadvantaged sectors of the community. While there is a tendency for elected CLAS members to be natural leaders in the community, the health facility manager should ensure that at least one CLAS member comes from the more disadvantaged groups in that community.

Skills for the co-management of CLAS

One of the first concerns about CLAS is the issue of whether there are enough or any community members who are capable of co-administering an entity as complicated as a health center or health post. In fact, the CLAS system develops management skills on the part of health workers and CLAS members. In the January 1996 evaluation by Dr. Carl E. Taylor, nearly all CLAS evaluated had gone through difficult negotiations in the first year between community and health staff. Eventually, nearly all 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. He stated in his report:

"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).

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).

Contribution of participation to the achievement of immediate objectives of PAC/CLAS

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. This does not occur under public sector administration. Also, strict legal requirements for accountability on the part of CLAS for financial reporting and completion of the Local Health Program provide the framework for ensuring that PAC objectives are met.

Costs reduction with PAC

A major benefit of CLAS is the **improved efficiency in the utilization of public sector resources: more services for the same cost**. It is a fallacy to think that PAC/CLAS will eventually allow the government to reduce spending on health, assuming (wrongly) that PAC/CLAS can support itself with its own resources generated through fees-for-service and other means. Rather, 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.

Impact of the role of women in CLAS

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, as users, and now as members of CLAS. 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 more motivated than are men. In the CLAS evaluated, where women were on the CLAS committee, management and community outreach was more dynamic.

Contribution of community participation to a more equitable distribution of benefits

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 Program 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.

In all Chincha facilities visited, CLAS members identify zones where health personnel should do home visit campaigns. Chincha CLAS members identify community members who are indigent for exoneration of fees. In Ayacucho, health personnel who do home visits recognized indigent families who came to the health facility for care. Also, some Ayacucho health centers have such high levels of indigence that nearly anyone who claims such is exonerated from fees. On the other hand, health personnel in one health center scoffed at the many people who claimed they could not pay, and required nearly everyone to pay at least a token amount (about 1 sole).

Members of CLAS Quinua in rural Ayacucho serve as intermediaries and sometimes as translators between community leaders and health personnel when the latter go out to rural communities to provide integrated health care. This participation ensures the collaboration of communities and increases the likelihood that people who normally have no access to health care will come out to seek medical care or participate in preventive or promotional activities. Some of these Quinua CLAS members were previously trained as health promoters.

Contribution of community participation to the sustainability of the achievements of PAC, to the transparency of management, to the increase in commitment and responsibility of the actors, and the generation of new initiatives

A general conclusion that can be reached is that where the process for electing CLAS members has been more democratic, the CLAS has been more stable, there has been greater progress made in consolidating the relationship between CLAS and health facility. These issues contribute greatly to the sustainability of PAC at the level of the health facility, which in turn will contribute to the sustainability of the progress achieved by CLAS in development of the health services and other aspects of community development. The attainment of a democratically elected CLAS is dependent on several important factors. Chief among them is the prior orientation of the health facility manager to the best ways and means to convoke the community for orientation, nominations, and voting.

Increased transparency in CLAS as compared to non-CLAS has been clearly noted in the areas of financial management and information systems. In regards to financial management, the gathering, utilization, and reporting on fees-for-service ("*ingresos propios"*) is managed by the CLAS and contracted private accountants, while in non-CLAS these fees are still remitted to the UTES where the health facility loses control over the use of the funds. The information system is also subject to oversight by community members on the CLAS committee, and indications are that the information is more transparent under CLAS supervision. In non-CLAS health facilities, there is an incentive to report good figures on production of health services, an incentive that is not present in CLAS. Observers have commented that they have seen over-reporting of production data in non-CLAS facilities. Also, a review of production data reported by the UTES Huamanga (Ayacucho) suggests this to be true. See Annex III.

Success factors in the experience of participation: conditions and processes indispensable for success

Success in the experience of participation is taken to mean the proven ability of community members to have an effective voice in the co-management of a health facility. In such cases, the ideas, needs, and desires of the community are well represented in the delivery of health services. Several general factors can be identified that have contributed to success in the experience of participation:

1) Members of CLAS are democratically elected and represent different sectors of the community.
2) Women are included in the CLAS committee.
3) At least one member of CLAS has skills (from earlier experience and/or recent training) in administration and management.
4) The health facility manager is committed to working with the community to solve problems in the community.
5) The health facility manager has an orientation and dedication to community health, and not to just attending patients in a clinical setting.

Productivity and efficiency of CLAS

Efficiency in public sector services is measured by the relative cost of delivering the services that need to be provided to the beneficiary public. As services become more efficient, they are able to provide more units of service to more people for the same cost.

It was not possible to obtain for the current report reliable and comparable cost data regarding CLAS and non-CLAS health facilities due to the different financing sources and mechanisms of each type of facility. Personnel wages, the major cost of health services, has various paying schemes, even within the same health facility, and the information is not yet centralized. Without cost data, efficiency cannot be assessed. However, production data is available for purposes of comparing CLAS and non-CLAS facilities. The table in Annex V shows CLAS has a greater production of intramural health services, and a greater overall population coverage, than non-CLAS facilities within areas of comparable socio-economic status.

Sustainability and political conditions in the future in the framework of the health sector reform

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.

Given the recent change in the administrative organization of PAC within the Ministry of Health, it appears that the PAC strategy for health services delivery is gaining acceptance and support among a broader range of health officials. If the current staff of the MOH stays in place, there is a good chance that political support for PAC will tend to increase as more officials become well informed about PAC. This will correct a problem that has existed in the political viability of the PAC in the intermediate levels of the health sector. The transition to acceptance of PAC has been easier in some places than in others. Boycotts of CLAS have occurred in several regions, including Chincha, as mentioned previously, Cuzco, and others. 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." Now that much stronger political support is emanating from the central level for PAC, the sustainability of the program is more assured.

D. UTILIZATION OF HEALTH SERVICES IN POPULATION CENTERS WITH AND WITHOUT CLAS – EVIDENCE OF MEASURES OF EQUITY

In this section, tables are presented which were developed by the author utilizing data from the ENNIV 97 (*Encuesta Nacional de Niveles de Vida* 1997), Instituto Cúanto, S.A. to provide a measure of equity in the utilization of health services.

Methodology for this analysis

Data utilized for the following tables was the ENNIV '97 (*Encuesta Nacional de Niveles de Vida*) conducted by Instituto Cuánto, S.A. The survey utilized a representative random sample of 3843 households nationally, utilizing a multi-stage cluster sampling method within nine geographic domains of the country and urban-rural areas. In order to analyze utilization of CLAS health facilities, it was necessary to compare data on department-province-district-population center in the ENNIV '97 data set with a list of departments, districts, and population centers that have CLAS health facilities. Population centers, which entered as sampling clusters in the ENNIV '97 data set and that were found to match with names of CLAS health facilities, were coded as "CLAS" populations. All other population centers were coded as "NO-CLAS" populations. Quintile groups were created following the methodology of Cuánto to compare five levels of socio-economic strata on the basis of average per capita expenditure in each household. Data from Lima/Callao was excluded from the analysis since so few CLAS exist in that area. Analyses were carried out utilizing a sampling weight, so that "N's" shown on the tables represent the expanded sample. Most tables presented show separate data from urban and rural areas since there are such different situations of health care choice in the two as to make them incomparable. An analysis of the mean per capita expenditure of households in sampling clusters with and without CLAS by quintile groups showed that there were no significant differences within quintile groups, except in the highest expenditure group (V) in which "NO-CLAS" has a higher mean per capita expenditure.

Seeking of Health Care and Health Providers Utilized (CLAS vs. No-CLAS Areas)

Tables II-A and II-B show that there is little consistent difference between CLAS and NO-CLAS in the proportion of persons with reported illness who sought health care (see category "None"). The exception is found in Quintile V (the highest per capita expenditures) where significantly more ill persons living in CLAS population centers received care than NO-CLAS populations.

The tables also show very little difference in the type of health care provider seen by persons reporting illness, comparing persons living in areas with and without a CLAS. The exception again is the greater use of physicians in Quintile V of CLAS populations in both urban and rural areas.

Comparisons of CLAS and NO-CLAS aside, it is clear that lower Quintile groups utilize health providers less than higher Quintile groups, and that access to any health provider is 30-45% greater in urban than in rural areas. It is notable that physicians are the most highly

sought health care provider, followed at a long distance by pharmacists, then by nurses in urban areas and by health technicians and nurses in rural areas. It is also noteworthy that professional midwives provide so little of the health care (less than 1%) to this representative sample of the Peruvian population that lives outside of Lima/Callao, considering the importance of maternal and reproductive health.

Table II

PROPORTIONAL DISTRIBUTION OF HEALTH CARE PROVIDER FOR ALL PERSONS REPORTING ILLNESS IN PREVIOUS MONTH IN COMMUNITIES WITH AND WITHOUT *CLAS* BY QUINTILE OF PER CAPITA EXPENDITURE

II-A. URBAN AREAS OUTSIDE OF LIMA/CALLAO

	Quintile I		Quintile II		Quintile III		Quintile IV		Quintile V		TOTAL	
	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS
Physician	21.7	22.9	38.8	32.0	44.9	44.9	51.6	46.9	54.9	68.9	43.9	45.0
Dentist	1.3	0	0.3	2.9	2.1	2.1	2.0	3.7	2.2	0	1.5	1.6
Midwife	0	0	0.6	0	0.3	0.3	1.3	1.9	1.4	3.3	0.8	1.2
Nurse	1.2	1.7	2.0	0.8	0.7	0.7	1.8	1.9	0.8	0	1.3	2.0
Auxiliary	0.7	0	0	0	0.3	0.3	0	0	0.1	0	0.2	0
Promoter	0	0	0	0	0	0	0	0	0	0	0	0
Pharmacist	8.4	8.9	10.2	0	11.7	11.7	11.9	12.9	7.5	5.1	10.2	4.2
Trad.Midwife	0	0	0	0	0	0	0	0	0	0	0	0
Trad.Healer	0.2	1.7	0.6	0	0.4	0.4	0.3	0.7	0.6	0	0.5	0.8
Other	2.3	0	0.1	0	0.5	0.5	0	0	0	0	0.4	0.4
None	64.3	64.8	47.5	64.4	39.1	39.1	31.2	32.1	32.6	22.7	41.3	44.8
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
N=	243046	34316	562602	78178	619490	134684	591202	88637	407898	50132	2598108	416260

II-B. RURAL AREAS

	Quintile I		Quintile II		Quintile III		Quintile IV		Quintile V		TOTAL	
	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS
Physician	19.6	22.1	27.8	34.3	36.3	37.8	36.5	34.9	41.1	62.8	24.7	29.2
Dentist	1.1	0	1.2	3.6	0.5	0	1.1	0	0	0	1.0	1.0
Midwife	0.4	1.3	1.1	0	0.5	1.3	0	0	0	0	0.5	0.8
Nurse	5.3	1.9	3.3	2.6	2.7	1.3	3.3	3.7	0	9.3	4.5	2.2
Auxiliary	1.1	2.3	1.9	0	0.2	5.1	0	0	0	0	1.0	2.4
Promoter	1.5	2.2	0.9	2.7	1.6	0	0	0	0	0	1.2	1.6
Pharmacist	5.7	4.0	4.5	0	4.2	0	13.5	24.1	9.7	0	6.0	4.4
Trad.Midwife	0.1	0	0.5	0	0	0	0	0	0	0	0.2	0
Trad.Healer	1.3	1.3	1.3	0	2.3	0	1.1	0	2.8	0	1.4	0.6
Other	0.6	0.5	0.8	0	0.5	2.5	0	0	0	9.3	0.6	0.7
None	63.4	64.4	56.7	56.9	51.3	51.9	44.5	37.4	46.5	18.6	59.0	57.2
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

N=	1299367	173781	638586	88728	339807	61076	142409	44169	55339	8716		

Source: ENNIV 97, Instituto Cuánto, S.A.
Preparation: L. Altobelli

Place Where Health Care Is Obtained (CLAS vs. NO-CLAS Areas)

Tables III-A and III-B show the place where care was received for those who obtained care for a reported illness. The categories that concern us are those of Health Centers or Posts of the MOH and Health Centers or Posts with CLAS. A recent study has shown that an estimated 80% of clients who attend a health facility co-managed by a CLAS do not know it as such, or do not call it as such (Cortez, 1998). For this reason, therefore, the categories "Center MOH" and "Center CLAS" have been combined to interpret the information on Tables III, relying rather on the categorization of "NO-CLAS" and "CLAS" communities. Results show that in urban areas, all quintile groups, except Quintile II, show significantly greater use of health centers/posts in "CLAS" than in "NO-CLAS" communities. Also in rural areas, "CLAS" communities have somewhat greater overall use of health center/post than "NO-CLAS" communities (45.8% in all CLAS versus 43.2% in all NO-CLAS communities). "NO-CLAS" communities in both rural and urban areas were much more likely to use pharmacy for their health care needs.

Table III

WHERE HEALTH CARE WAS OBTAINED BY PERSONS SEEKING CARE IN COMMUNITIES WITH OR WITHOUT *CLAS* BY QUINTILE OF PERCAPITA EXPENDITURE

III-A. URBAN AREAS OUTSIDE OF LIMA/CALLAO

	Quintile I		Quintile II		Quintile III		Quintile IV		Quintile V		TOTAL	
	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS
Hosp. MOH	33.9	13.6	21.3	24.9	20.9	18.7	17.6	4.6	15.9	21.6	20.5	15.6
Hosp. IPSS	14.5	0	20.7	19.9	23.8	20.3	34.6	31.3	22.4	37.3	25.7	25.2
Hosp. FFAA.	0	0	1.6	4.2	1.2	3.5	3.4	0	2.2	0	1.9	1.8
Private Hosp.	0	0	0.2	5.9	0.8	6.4	1.5	1.0	4.9	0	1.5	3.4
Center* MOH	16.6	14.5	22.1	23.2	17.5	26.6	12.1	26.5	7.5	17.9	14.7	24.9
Center CLAS	0	14.5	2.1	2.1	1.3	0.7	0	2.3	0	1.5	0.9	2.1
Center Church	1.6	0	2.6	0	1.3	0	0	0	0.6	0	1.0	0
Private Office	1.6	13.6	7.0	19.9	9.3	18.6	11.9	14.2	28.7	15.1	12.3	16.4
Comm'ty Post	1.4	0	0	0	0	0	0	0	0	0	0.1	0
Pharmacy	23.4	25.2	19.5	0	19.6	0.7	19.0	19.0	11.7	6.6	17.4	7.7
Private home	0.7	4.8	1.8	0	3.4	4.5	1.0	1	5.0	0	2.5	2.2
Other	6.4	13.6	1.2	0	0.8	0	0	0	1.2	0	1.5	0.7
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
N=	86869	12089	295521	27842	377182	86168	406826	60216	274878	38737	1524046	229997

III-B. RURAL AREAS

	Quintile I		Quintile II		Quintile III		Quintile IV		Quintile V		TOTAL	
	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS
Hosp. MOH	12.2	16.2	18.9	18.3	21.4	7.9	12.9	5.5	5.5	32.9	14.8	13.5
Hosp. IPSS	2.1	3.5.	5.9	8.5	8.5	5.5	8.0	5.9	24.0	11.5	4.9	5.7
Hosp. FFAA.	0.3	0	0.3	0	0	5.2	0	0	0	0	0.4	0.9
Private Hosp.	0.3	0	1.2	0	0.5	0	3.1	0	0	0	0.7	0
Center* MOH	46.3	25.8	38.7	46.0	34.2	26.5	19.9	36.3	25.7	11.5	39.9	32.1
Center CLAS	4.7	26.5	1.4	4.2	1.9	2.8	1.0	0	0	11.4	3.3	13.7
Center Church	2.7	0	2.2	2.1	0	20.7	0	0	0	0	1.7	4.0
Private Office	3.8	2.5	7.7	2.1	12.6	15.9	17.1	2.9	21.6	21.4	8.0	5.4
Comm'ty Post	4.8	6.5	3.1	6.3	0.5	5.2	0	0	0	0	3.0	5.1
Pharmacy	15.6	11.1	10.4	2.1	8.6	0	24.4	38.5	18.1	0	14.6	10.6
Private home	6.0	7.5	7.0	2.1	7.5	10.4	8.0	11.0	5.1	11.4	6.4	7.2
Other	1.1	0	3.1	8.2	4.3	0	5.8	0	0	0	2.4	1.8
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
N=	475897	61916	276446	38289	165502	29374	79000	27659	29622	7095	1103165	172310

* Health Center or Health Post
Source: ENNIV 97, Instituto Cuánto, S.A.
Preparation: L. Altobelli

Satisfaction with Health Care Received (CLAS vs. NO-CLAS Areas)

Satisfaction is a variable frequently utilized to measure quality of care in health services. However, just as there are many dimensions of quality of care, there are many dimensions of satisfaction with that care. Therefore, one single question to measure satisfaction will not necessarily measure what you want it to measure, nor will you really ever know what it is that it is measuring. Also, patients' expectations about the quality of care will also influence levels of satisfaction.

Considering only persons with reported health care use who were attended in health centers or health posts, "CLAS" and "NO-CLAS" communities were compared on the level of satisfaction reported for the care received. For urban areas, Tables IV-A and IV-B show that satisfaction was higher for users of health centers or posts in "NO-CLAS" than in "CLAS" communities when looking at overall figures (83.1% in NO-CLAS versus 76.7% in CLAS satisfied). In rural areas, there was no difference overall in the level of satisfaction with care received by health center or post users in the two types of communities (72.9% in NO-CLAS versus 74.2% CLAS satisfied). There are differences in satisfaction by quintile group, with no consistent trend on which to make any conclusions about patient satisfaction.

Table IV

LEVEL OF SATISFACTION OF PERSONS ATTENDING A HEALTH CENTER/POST OF THE MINISTRY OF HEALTH OR CLAS IN COMMUNITIES WITH AND WITHOUT CLAS BY QUINTILE OF PER CAPITA EXPENDITURE

IV-A. URBAN AREAS OUTSIDE OF LIMA/CALLAO

	Quintile I		Quintile II		Quintile III		Quintile IV		Quintile V		TOTAL	
	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS
Satisfied	100	100	85.5	91.7	80.8	67.8	89.3	81.0	55.6	70.3	83.1	76.7
Somewhat Satisfied	0	0	9.9	8.3	19.2	29.8	7.9	19.0	24.0	29.7	13.0	22.3
Not satisfied	0	0	4.6	0	0	2.4	2.8	0	20.4	0	3.9	1.0
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
N=	14385	3514	71306	7036	71072	24102	49954	17378	20595	7513	227312	59543

IV-B. RURAL AREAS

	Quintile I		Quintile II		Quintile III		Quintile IV		Quintile V		TOTAL	
	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS
Satisfied	71.6	82.0	72.7	66.8	70.4	100	100	54.5	80	0	72.9	74.2
Somewhat Satisfied	21.7	15.4	27.3	29.0	28.2	0	0	45.5	20	100	23.2	23.5
Not satisfied	6.6	2.6	0	4.2	1.4	0	0	0	0	0	3.9	2.3
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
N=	242823	30839	110934	19229	59866	8602	16504	10027	7599	1621	437725	70317

Source: ENNIV 97, Instituto Cuánto, S.A.
Preparation: L. Altobelli

Cost Of Consultation (CLAS versus NO-CLAS Areas)

PAC has been noted by some as promoting a type of health facility management that sets a premium on collecting fees-for-service for use in improving the physical plant, purchasing supplies and equipment, and contracting additional needed personnel. Because the CLAS can make decisions on use of funds to improve services, they have an incentive to optimize cost recovery. On the other hand, non-CLAS facilities do not have this incentive to collect fees, and therefore would logically be more likely to exonerate patients from fees based on need. This is not what is shown by the data.

Tables V-A and V-B show the amount paid for services received at health centers or health posts, comparing "CLAS" and "NO-CLAS" communities. For the lowest quintile (I) in both urban and rural areas, considerably more "CLAS" than "NO_CLAS" were exonerated

from fees. For all quintiles combined, slightly more "CLAS" than "NO-CLAS" patients were exonerated from fees in both urban and rural areas. It is clear that significantly more "CLAS" health center/post users paid between S/ 0.1 and 2.0 soles as compared to "NO-CLAS" health center/post users, who were more likely to pay S/ 2.1 to 5.0 soles for health care in both urban and rural areas.

Table V

COST OF CONSULTATION FOR PERSONS ATTENDING A HEALTH CENTER/POST OF THE MINISTRY OF HEALTH OR *CLAS* FOR COMMUNITIES WITH AND WITHOUT *CLAS* BY QUINTILE OF PERCAPITA EXPENDITURE

V-A. URBAN AREAS OUTSIDE OF LIMA/CALLAO

	Quintile I		Quintile II		Quintile III		Quintile IV		Quintile V		TOTAL	
	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS
S/. 0 (No cost)	23.5	33.3	12.0	16.6	23.5	15.1	18.3	27.0	16.4	29.7	18.2	21.7
S/. 0.1 – 2.0	8.1	33.3	24.5	16.6	6.6	54.7	2.8	27.0	6.8	40.5	11.5	39.1
S/. 2.1 – 5.0	54.6	33.3	50.0	23.4	62.8	27.8	74.9	27.0	70.0	29.7	61.6	27.6
S/. 5.1 +	13.8	0	13.5	43.3	7.1	2.4	4.0	19.0	6.8	0	8.8	11.6
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
N=	14385	3514	71306	7036	71072	24102	49954	17378	20595	7513	227312	59543

V-B. RURAL AREAS

	Quintile I		Quintile II		Quintile III		Quintile IV		Quintile V		TOTAL	
	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS
S/. 0 (Gratis)	29.4	37.2	23.8	12.6	15.6	45.8	28.3	8.1	0	0	25.5	26.7
S/. 0.1 – 2.0	39.6	50.6	32.7	58.9	23.2	9.3	24.0	30.3	40	100	35.0	46.2
S/. 2.1 – 5.0	29.7	12.2	37.3	24.2	61.3	35.3	42.9	61.6	60	0	37.0	24.8
S/. 5.1 +	1.3	0	6.3	4.2	0	9.5	4.9	0	0	0	2.5	2.3
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
N=	242823	32359	110934	19229	59866	8602	16504	10027	7598	1620	437725	71837

Source: ENNIV 97, Instituto Cuánto, S.A.
Preparation: L. Altobelli

Cost Of Medicines (CLAS versus NO-CLAS Areas)

The purchase of medicines is usually by far the greatest health care expense, aside from laboratory analyses. The Ministry of Health has tried to alleviate the cost of medicine to the consumer by providing low-cost generic medicines through the PACFARM program (*'Programa de Administración Compartida de Farmacia'*). UNICEF has played a major role in introducing, field testing, developing, and disseminating the PACFARM program. In several CLAS visited, personnel complained of several limitations of the PACFARM

program. First, PACFARM frequently did not have the specific medicines requested by the health facility, and substitutes had to be used, or the patient had to be sent out to purchase the needed medicine at a commercial pharmacy. Secondly, there was a strong demand from many patients for name-brand medicines for specific illnesses, and they did not accept generic brands. Thirdly, some CLAS (for example, Chincha Baja in Ica) have discovered novel ways to obtain name-brand medicines at costs lower than the generic brands through PACFARM, such as purchasing through the PROVIDA program of the Catholic Church.

Equity in health care can be expressed by the proportion of persons in need who are exonerated from the purchase price of medicines, or who are able to obtain medicines at low cost. The limitations of the data available from ENNIV 97, as well as any other survey, is that the amount of medicine obtained by the patient may be only a portion of the treatment regimen prescribed by the health provider. For example, a child may have been prescribed three pills a day for five days (15 pills) but the mother bought only five pills.

Table VI shows that, for the lowest quintile group (I), there are significantly more health center/post patients in NO-CLAS areas who pay only 0-5 soles for medicines, as compared to those in CLAS areas. Only in Quintiles IV and V do CLAS-area patients pay less for medicines than in NO-CLAS areas. It should also be noted, however, that CLAS-area patients in most quintile groups are more likely to receive medicines.

Table VI

DISTRIBUTION OF COST OF MEDICINES OBTAINED IN A HEALTH CENTER/POST BY PERSONS ATTENDING A HEALTH CENTER/POST OF THE MINISTRY OF HEALTH OR *CLAS* IN COMMUNITIES WITH AND WITHOUT *CLAS* BY QUINTILE OF PER CAPITA EXPENDITURE

ALL AREAS OUTSIDE OF LIMA/CALLAO

	Quintile I		Quintile II		Quintile III		Quintile IV		Quintile V		TOTAL	
	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS	NO-CLAS	CLAS
S/. 0 (Gratis)	21.4	14.8	15.6	44.1	22.2	19.3	0	49.3	19.1	54.2	19.4	29.8
S/. 0.1 – 5.0	39.9	29.0	30.9	0	16.9	9.5	20.8	0	0	0	32.4	13.0
S/. 5.1 – 10.0	21.9	31.3	21.6	5.2	18.6	6.9	10.2	37.7	20.7	26.6	20.9	20.6
S/. 10.1-20.0	11.4	14.3	17.5	35.8	21.0	48.0	19.2	0	20.7	0	14.9	23.2
S/. 20.1 +	5.3	10.6	14.4	14.9	19.3	16.4	49.9	13.1	39.7	19.3	12.4	13.5
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
N=	114526	21920	54512	15583	28357	8543	7936	6180	7355	3041	212686	55268
% who received medicines	76.3	70.7	68.1	87.6	74.3	85.9	64.0	86.9	100.0	50.0		
N=	150.039	30981	80000	17783	38181	9941	12403	11124	7355	6086		

Source: ENNIV 97, Instituto Cuánto, S.A.
Preparation: L. Altobelli

Conclusions on equity from the ENNIV '97 data

In summary, there is little difference between CLAS and NO-CLAS communities in terms of the proportion of persons needing care who seek health care, in the type of health personnel who provides their care, or in the level of satisfaction with care received. The differences are seen in type of health facility utilized (in urban areas), in cost of consultation, and in the obtaining of medicines. CLAS communities in urban areas much more likely to seek health care in a health center or health post (while NO-CLAS communities were more likely to use a Ministry of Health hospital or commercial pharmacy). This difference is not seen in rural areas, where there is much less choice in the type of health facility available.

The issue of equity is most apparent in the cost of consultation and medicines, comparing costs in health centers and posts. Although the proportion of persons with total cost exoneration is similar in CLAS and NO-CLAS communities, it is clear that CLAS users pay less for a consultation. Also, CLAS patients have a higher rate of total cost exoneration for the purchase of medicines than do NO-CLAS patients. At the same time, CLAS patients pay more on average for medicines, but are also more likely to obtain a medicine in the same health center or post where they had the consultation.

E. SUMMARY OF THE SUPPORT PROVIDED TO CLAS BY UNICEF

UNICEF has supported PAC/CLAS in various phases of its development. During the initial phase of design of the Shared Administration Program, the methods of working with communities to organize and legally constitute their participation in the program were inspired by literature on the UNICEF Bamako Initiative. This literature illustrated ways in which the community could have access to public resources for health services in the community. Secondly, UNICEF had promoted a project in Lima and Chimbote called PRORESER ("*Programa de Revitalización de Servicios Periféricos con Participación Comunitaria*") which later inspired the development of rotating drug funds ("*Fondos Rotatorios de Medicamentos*") through the Program for Shared Administration of Pharmacies (PACFARM).

During the process of development and expansion of CLAS, UNICEF played a role at key points along the way that provided important strength to the program at strategic moments of its development. Several of the points of UNICEF support included:

- Training of community leaders involved with CLAS. UNICEF provided support to working meetings and events in different parts of the country. In one example, training and orientation were provided to district mayors and "*ronderos*" of the San Marcos Province in the Department of Cajamarca (in the northern sierra of Peru). It was planned to establish a network of 14 health centers and health posts as CLAS. "*Ronderos*" are local citizens who volunteer to serve on armed committees for community protection against subversives. In another example, UNICEF supported an encounter to explain the PAC/CLAS program to 130 chiefs of small jungle

communities on the northern border of Peru with Ecuador called the "*Cordillera del Condor - Condorcaqui*" in the Department of Amazonas. The chiefs sent a letter to the Minister of Health requesting their incorporation as CLAS.

- Production and printing of diverse educational materials for CLAS, especially materials oriented toward providing simplified information to health workers and community leaders. A very important publication funded by UNICEF is the manual known as the "Green Book" that summarizes all the legal aspects of CLAS and includes a guide to implementing a simplified community survey and developing a Local Health Program. Every CLAS has its copy. UNICEF is currently funding the printing and dissemination of the new PAC/CLAS directive and norms.
- Training in cost analysis and how to develop Local Health Programs, including the presence of international experts.
- Support for the implementation of evaluations and follow-up of the CLAS experience.
- Serving as interlocutor between CLAS and other concurrent experiences or programs, such as PACFARM.
- Since January, 1997, UNICEF has supported the development of the four CLAS in North Lima, assisting them with activities of promotion and dissemination of information in their communities, including support for a periodic bulletin, communication workshops, megaphones, health promoter training, and other support. One of the four CLAS, elected from among them, receives and administers UNICEF funds for the benefit of them all.

F. EFFECTS OF THE PACFARM PROGRAM ON THE FUNCTIONING OF CLAS

PACFARM ("*Programa de Administración Compartida de Farmacias*") was created in 1994 within the same *Directive 01-SA/DM-94* that established PAC. PACFARM is a program of generic medicine distribution and sales with a rotating fund for purchase of new supplies of medicine. UNICEF played a major role in the design, local testing, and implementation of PACFARM, which is based on the rotating drug fund strategy developed in the BAMAKO Initiative.

The program began with the donation to each health facility of an initial supply of medicines which was administered by a group of citizens elected from the community, in coordination with health personnel under the leadership of the health facility manager (usually the head physician). Medicines were and continue to be sold with a 10-15% mark-up in price. Earnings are used to purchase replacement medicines with an excess left over to invest in development of the pharmacy. In this way, health facilities can purchase shelving, computers, and other supplies for the pharmacy, or can maintain and/or improve the physical plant. According to program requirements, 10% of all medicines are to be provided free-of-charge to indigent patients. This level, however, is below the necessary proportion of exonerations required for populations of extreme poverty.

New supplies are generally purchased from DIGEMID, which does bulk purchasing of generic medicines. DIGEMID ("*Dirección General de Medicinas, Insumos y Drogas*", a

dependency of the Ministry of Health) has developed a system of sub-regional warehouses that purchase medicines from DIGEMID and resell them to individual pharmacies in health facilities. Sub-regional warehouses, under the responsibility of the Regional or Sub-regional Health Director, generally resell the medicines at a 10-20% mark-up. This mark-up was originally authorized to allow warehouses to build up their physical facility and improve their capability to provide service. Once these investments were made, the excess income created by the mark-up becomes a fund that is utilized in ways that are likely to be undocumented. This is a problem for health facilities in poverty areas, which have trouble maintaining their rotating drug fund due to high levels of exonerations that are required of them. The unexpected outcome for them is that they are unable to afford the drugs at the mark-up price set by the sub-regional warehouses, they become depleted of stock, and are unable to obtain more drugs for the needs of their patients.

PACFARM has been a remarkably successful program for improving the supply of medicines to Ministry of Health facilities. The program is now so widespread and accepted that it has become the standard way of operation. In health facilities that are not CLAS, the "shared administration" aspect of the rotating fund has taken on less importance as time goes on. If the community is involved, it is on a very limited basis with the pharmacy. In general, frequent complaints about the program are that certain medicines run out at the sub-regional warehouse, and there are no alternative medicines available. In these cases, health center or health post patients are forced to go to a commercial pharmacy to obtain the medicines they need, usually at a considerably higher cost. Non-CLAS health facilities are required to buy their medicine stocks from PACFARM, whether or not there is stock available to purchase. It is forbidden for them to purchase drugs from third parties.

On the other hand, CLAS are very involved with the PACFARM program in their facilities, and they take care to monitor the financing and purchasing of medicines. The same skills they have developed with co-managing the health facility are utilized with PACFARM. As PAC/CLAS has not been bound by the requirement to purchase from PACFARM, some have become very creative and acquire medicines from different sources to obtain lower prices or acquire specific name-brand medicines that are demanded by their patients. Not everyone has been fully convinced of the value of generic medicines. The Catholic Church has a program called PROVIDA, which purchases in bulk and/or receives donations of name-brand medicines from pharmaceutical laboratories and resells them to CLAS at a price lower than that of the equivalent generic medicines from PACFARM. Recently, the pharmacist in charge of PACFARM for the Sub-region of Ayacucho announced that DIGEMID was requiring that all health facilities, including CLAS, purchase their medicines from PACFARM. This could signify increased costs to the consumer and/or more frequent unavailability of medicines in the PACFARM pharmacy.

III. EVALUATION RESULTS - CONCLUSIONS

A. Agenda for PAC/CLAS in the Framework of Health Care Reform, And the Goals of Greater Efficiency, Citizen Participation, And Equity

1. 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 by inference, improved health outcomes.

2. The major goals of health sector reform are to improve efficiency, quality, and equity in the delivery of health services. The Shared Administration Program with its strategy of citizen participation, is the primary manifestation of the health care reform at the current time. Citizen participation in the Committees for Local Health Administration (CLAS) is an effective mechanism to improve the quality of care, productivity of health personnel, and transparency in the utilization of public funds through community control of the health facility. The administrative flexibility provided by the private, non-profit status of the CLAS allows a myriad of ways to potentiate the public sector investment in health services that is limited only by the level of creativity of the persons involved.

3. The Shared Administration Program is viewed within the Ministry of Health as only one of several possible means of achieving the goals of the health sector reform. The main point in question is the applicability of the PAC/CLAS model to rural areas of extreme poverty and illiteracy, where the capacity of the community to co-manage a health facility is doubted. The best answer to that question could be found in operations research to test the model in those types of populations. It is clear that the PAC/CLAS model is effective in many types of populations, but there are issues of training and program support that need to be resolved with any and all types of populations. Adaptations of the program to different types of populations also need to be considered. Following the principles of community participation, the most successful adaptations will be those that include the community in planning and designing the adaptations.

4. PAC/CLAS provides the legal and organizational framework for promoting greater citizen participation and equity in health care. There is still so far to go in achieving full citizen participation in collective and individual efforts for community and family health that there is no end of need for work and support to each CLAS. Mechanisms need to be developed to effectively orient each CLAS to the methods and activities that best promote health in the community. 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, local planning, and monitoring. Other important areas of orientation that are necessary now are general concepts and methods of individual and family health promotion and prevention, environmental health and safety, community empowerment, and equity in health.

5. It is important to recognize the confusion that exists in people's minds of the terms, "citizen participation" and "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). In other words, there is a need for more realistic expectations of civil participation in public services management. At the same time, new methods are needed to orient health workers and communities to the possibilities and instrumentation of their participation.

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)

6. "Community participation" could be defined as: 1) co-management of publicly-funded services; 2) collective efforts to improve community services, such as water and environmental sanitation projects, or projects for construction of buildings to be utilized by the community; or 3) individual decisions for self-care or early home-care of oneself or one's family. Within those definitions, it is not as clear that the communities are "participating" in health any more than they do in other forms of health care administration. It is perhaps too great an expectation that the existence of PAC/CLAS will improve community participation in those terms. However, we can infer that greater potential does exist in PAC/CLAS for stimulating that type of community participation over time. This inference comes from the fact that the structure of PAC/CLAS contributes to community empowerment through the control that the community is allowed to exert on public services. The level of empowerment achieved in a community through PAC/CLAS depends on a constellation of factors. Factors of primary importance include: 1) the personal capability and leadership characteristics of the health facility manager, 2) the extent to which CLAS members are democratically elected so that true leaders are chosen, and 3) effectiveness of efforts to orient and/or motivate the community. Other factors of importance are: 4) permanence of health personnel in a particular community, and 5) consistency of supervisory and administrative support from UTES and Sub-regional health officials. It is possible to achieve community empowerment without PAC/CLAS. However, the improved efficiency, quality of care, and permanence of health personnel that are strengthened by CLAS are extremely important outcomes of PAC that are likely to improve the outlook for community empowerment over time.

7. In summary, PAC/CLAS is an effective means of citizen co-participation in health services management. It is also a necessary but not sufficient ingredient in achieving community participation. Community empowerment itself is a necessary and sufficient means to achieve community participation in collective community health, individual self-care, and family health. To the degree that the community participates in co-management of CLAS, which in turn supports community empowerment, the chances for community participation in health actions at the community and individual/family level will be improved. See Figure 1.

8. Much work is still to be done to promote equity in health and health care. Whereas the community participation through CLAS offers increased opportunities to identify the indigent and provide them with services, the macro-financing arrangements of CLAS need to be refined to offer increased budgets to poverty-area CLAS so that increased exonerations can be provided to needy patients. At the same time, all CLAS need better orientation as to the expectations of the health sector and specific methods they can use to improve equity.

B. Obstacles and Needs for Further Development of PAC/CLAS

The principal obstacles and needs for the development of CLAS have been and continue to be:

1. At the central level:

- Need for on-going and systematic analysis of the development of CLAS to identify key problems that could be solved with central level support.
- Need for lobbying to change legislation regarding non-exemption of taxes for CLAS.
- The need to provide basic funding to sub-national health offices for costs of supervision and technical assistance for community development activities (gasoline and per-diems).
- Need to move toward standardization of information systems for PAC/CLAS and non-CLAS health facilities, without regressing on the advances made in CLAS in terms of community diagnosis and local health programming, monitoring and evaluation.
- Need for review of programming requirements for vertical health programs, so that both the programming and delivery of health services can be integrated at the point of patient contact.

2. At the departmental level:

- Need for a strong mandate from the Central Level to support CLAS.
- Need for clear instructions as to the role of Sub-Regional level in relation to PAC/CLAS.
- Lack of funding support to commit personnel and vehicles to assist communities to organize for CLAS (thereby to ensure better representation in each community) and to supervise/train the health center manager and health personnel on a continual basis.

3. In health facilities:

- Inadequate training/preparation of health facility managers regarding public health practice.
- Generally a lack of skills in basic personnel and financial management as they relate to private sector law. Contracting of personnel with private-sector contracts brings a host of requirements for paying various taxes and insurance fees (income tax, FONAVI, IPSS). Financial management usually requires that each CLAS hire a part-time accountant to balance its books every month.

IV. RECOMMENDATIONS

A. Implications and Tasks for Future Development of PAC/CLAS

- At all levels, establish an image of the permanence of PAC/CLAS as a viable form of health service organization that is beyond the stage of pilot project, even though the program may still be modified. Even though PAC may or may not be implemented in all health facilities of the Ministry of Health, it is necessary to provide consistent political and material support to the program so that it can continue to flourish and prosper in the facilities where it is already established.

- Focus on goals – Provide more emphasis than is currently given on the goals of the health sector, rather than on the specific processes for administering funds to get there. In the development of improved or alternative administrative or organizational schemes for CLAS, it is of prime importance to maintain the vision of the final goals of the health sector in terms of reductions in the morbidity and mortality of the population.

- Focus on integrated health actions - Recognize that CLAS does not exist only to provide low cost or high quality health care, but that the development of healthy individuals and community depends on a variety of other factors such as environment, life style behaviors (such as alcohol consumption, domestic violence, eating habits, exercise, hygiene), and self-care at home (including early recognition and home treatment of illnesses, and knowing when to seek care outside the home).

- Health planning - Involve the community in more aspects of health planning to get their personal involvement as individuals caring for their own health and that of their families and community, as well as their involvement with other individuals to work together on solving problems of the entire community, such as improving the environment and other social services.

- Specific health goals orientation - Orient CLAS to organize the community to emphasize specific health goals, for example:

    - Infant mortality and child health emphasis - community analysis of

perinatal and infant deaths; committees for perinatal and infant mortality; programs for early detection of malnutrition and nutritional orientation of mothers/families; renewed orientation to early home detection and treatment and referral of infant and child illness; implementation of environmental and hygienic measures to prevent infant/child infections.

- Emphasis on protection of children with special needs – community committees to plan assistance for children with special illnesses and disabilities; orphaned, abandoned, or run-away children; victims of child abuse; and others.
- Maternal mortality and maternal health emphasis – community analysis of maternal deaths; committees for maternal mortality; development of improved maternity education and services at the community level (micronutrient supplementation [especially iron and vitamin A], prenatal care, birth attendance, postnatal and newborn care); community solutions for attending complicated births; campaigns for screening and early treatment of cervical and breast cancer and sexually transmitted diseases; high quality voluntary family planning education and services
- Accident and injury prevention emphasis – community analysis of deaths due to accidents and injury; community awareness campaigns for prevention of accidents and injuries.
- Chronic morbidity emphasis – community analysis of adult deaths; blood-pressure screening campaigns; monitoring and education of adults with hypertension and other chronic morbidity; community orientation for preventive nutrition in adults.

- Community epidemiology – Emphasize this as a community activity that serves as an effective educational tool which can contribute greatly to changes in health behaviors in priority areas as suggested above.

- Equity – While there can be efforts at the community level to identify and serve those families at greatest need (equity at a local level), it must be recognized that an equitable health system depends primarily on central and regional level decisions for allocation of funds – providing more support for more needy geographic areas according the proportion of the population with high levels of unsatisfied basis needs (equity of the health system). CLAS contributes to equity at a local level, but cannot be expected to contribute to equity of the health system merely by its nature of co-management with the community. The ability of each CLAS to exonerate fees when necessary, especially in areas of greater overall poverty, will depend on these central and regional-level decisions. The Ministry of Health is currently working on a system to distribute funds on an equity basis on the national level. This should allow the Ministry of Health to assign a minimum proportion of exonerations per health facility, and modify the financing system to provide more funds to poorer populations to finance the exonerations.

- Social inclusion –

- CLAS need to be oriented to specific measures to promote equity and social inclusion at the local level, including how to create an indigent list for each CLAS.
- Improve the data reporting system for improved tracking of essential social inclusion indicators. For example, maintain a registry of indigent families, and monitor health care coverage and health status of those families. Also, ensure that all extramural visits are documented as well as are intramural visits. CLAS have not been reporting extramural visits, which generally are half-day or full-day excursions of a multidisciplinary health team to outlying communities.

- Management training - In recognition of the complex nature of human and community development, a methodology has been proposed for community-based sustainable human development that is applicable to the strengthening and diffusion of the CLAS 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 simplified 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 (Taylor-Ide and Taylor, 1995).

B. Implications for Cooperation Peru-UNICEF

The general feeling among those responsible for the PAC/CLAS program in the Ministry of Health is that major financial support for on-going activities of PAC will continue to be available from the public treasury. There are, however, a good number of points of program support that will be needed along the way, to be coordinated on an on-going basis with Ministry of Health officials. Potential areas of support by UNICEF to the Shared Administration Program could be:

1. Support for a pilot project in management training for CLAS

Select one or more departments where there exists a strong and successful CLAS. Provide orientation and training materials to that CLAS to develop it into a demonstration center. Provide funding support for members of CLAS from other health facilities to spend time in observational training ("*pasantia*").

2. Support for pilot project or operations research on the CLAS model in areas of extreme poverty and illiteracy

UNICEF could support technical assistance or operational costs to the Ministry of Health for the design and/or careful monitoring and evaluation of a CLAS in poverty areas where CLAS has been weak due to characteristics of the population, or where CLAS has not yet been attempted.

3. Support for promotion of community participation and greater equity

UNICEF can support training or local/regional events with participation of health center or health post managers and CLAS members to exchange information about: methods to empower the community, methods to involve the community in collective activities for community health as well as individual participation in self-care and family health, and methods to improve equity.

4. Support for community organization activities to organize new CLAS

The organization of a new CLAS, if done properly, is a labor-intensive activity that requires promotional work in the community as well as assistance for completion of legal requirements for the formation of a CLAS. Leaving this work to a briefly oriented head physician of the health facility does not ensure that the critically important process of electing/selecting CLAS members will be done adequately. UNICEF could potentially support this work, which could include support for gasoline and personnel costs.

5. Support for local health programming, monitoring, and evaluation

This year only S/ 300 soles for each CLAS was available to support the "updating" of local health surveys to begin the annual planning process for development of the all-important Local Health Program ("*Programa de Salud Local*"). In 1997, each CLAS had received S/ 1,300 soles to carry out their community health survey. The amount provided this year falls very short of what is needed, since the health conditions or priorities in the community can change from year to year. Also, many communities have frequent changes in population through either immigration or emigration. Birth rates may increase or decrease, the economic situation of families can change rapidly so that families move into (or out of) indigent status, etc.

UNICEF can support annual community surveys through a variety of means: financing (for

printing of questionnaire and interviewer support), technical assistance and/or training in organization and implementation of the survey, TA to improve survey instrument, TA to develop manual and computerized methods of analysis.

6. Support for training and re-training of community health promoters/volunteers

It may be time to return to the strategy of utilizing health promoters to extend primary health care into the community and improve access of services to everyone who needs them. Prior to recent improvements in the staffing and equipment of peripheral health facilities, promoters worked with a health center or post which frequently had a health technician or minimal professional staff who were too busy, or not motivated, to properly train or supervise them. There was always the problem of the poor quality of back-up services, which reduced the effectiveness of patient referrals by health promoters. The existence of CLAS in a community provides an opportunity for building stronger links to community volunteers such as health promoters, and utilizing them more effectively than has ever been possible before. Training a critical mass of health promoters in a community would also provide a constant pool of candidates to serve on the CLAS committee, which is rotated at least every three years. UNICEF funds could provide support for training materials, technical assistance, and other training costs.

7. Support for development of human resources policies

It will be necessary to develop human resources policies to ensure that qualified individuals are contracted as managers of CLAS. The profile of a CLAS manager requires a good foundation in public health and many aspects of management as applied to primary health care planning- monitoring- and evaluation, health services organization, personnel, logistics, financing, working with communities, and others. These skills can be obtained by on-the-job training, but would be better considered as requirements for the job. With the proper incentives, the job as CLAS manager would be attractive to physicians (or other professionals) who already have these skills, and the job could become competitive with other sources of employment for well-qualified individuals.

Another problem in the area of human resources policies is the situation of frequent turnover and lack of continuity in relations with CLAS and management of the health center, which may eventually cause the program to suffer. Currently, CLAS managers are generally physicians who are young, enthusiastic, and consider CLAS as an important experience in their formation. Once the experience is gained, many move on to hospitals in urban areas, or to post-graduate programs for further specialization. Policies to provide incentives to stay longer may help to solve the problem. On the other hand, it may be a situation that the health sector will have to live with in regards to peripheral health facilities, especially in under-served areas. This issue needs to be further studied to determine what solutions are feasible and most effective.

8. Support for improvements in information systems

The information system has recently been improved in Ayacucho so that both CLAS and

Basic Health for All (PSBPT) utilize the same monthly reporting forms on production of services. This is an important advance in unifying health information. All other Departments should make the change from separate information systems to a unified one. At the same time, it is recommended that the Office of Statistics and Informatics (OEI) of the Ministry of Health seriously review the numerical codes assigned to each health facility for reporting in the Health Information System (HIS) and in all project information systems (including PAC, PBSPT, and others). The HIS codes were designed before the National Institute of Statistics and Informatics (INEI) designed codes for the national census. The INEI codes are currently utilized in national surveys such as the five-year national Demographic and Health Survey (DHS), known as the "Encuesta National de Demografía y Salud Familiar (ENDES)", and the "Encuesta Nacional de Niveles de Vida (ENNIV)", which was financed in 1997 by UNICEF. A unified coding system will facilitate data analysis for evaluation and monitoring of health service utilization and health status of the population with cross-referencing of the various databases available.

9. Support for improved supervision of CLAS

Provide assistance to PAC to design supervision guidelines for CLAS, such as a checklist of items to observe or ask about, and a series of open-ended questions to obtain information on more qualitative aspects of the interactions between the community and the health service.

V. LIST OF PERSONS CONTACTED

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VI. DISSEMINATION OF FINDINGS

Presentation by author and discussion of report findings in the Ministry of Health: July 31, 1998, with participation of representatives from:

- Öffice of Financing , Investments, and External Cooperation, Ministry of Health
- PSBPT ("*Programa de Salud Básicia para Todos*")
- PAC ("*Programa de Administración Compartida*")
- PFSS ("*Programa de Fortalecimiento de Servicios de Salud*")
- PSNB ("*Programa de Salud y Nutrición Básica*")
- Team contracted by the Ministry of Health to evaluate PAC
- Health Sub-region of North Lima
- Universidad del Pacífico
- UNICEF, Dr. Mario Tavera

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ANNEX 1

Questionnaires Utilized for Case Studies In Two Sub-Regions

UNICEF / PERU

SISTEMATIZACION :

"REFORMA DE SALUD, PARTICIPACION COMUNITARIA E INCLUSION SOCIAL: EL CASO DEL PROGRAMA DE ADMINISTRACION COMPARTIDA"

DEPARTAMENTO:_____ Fecha:_____

Nombre y Cargo de la persona entrevistada:_____

PREGUNTAS PARA PERSONAL DEL DEPARTAMENTO

(a) Descripción del PAC, su desarrollo y funcionamiento (Temas para las entrevistas cualitativas para los estudios de caso en provincias):

(10) ¿Quienes son los actores que participaron en la creación del CLAS?

(11) ¿Como se gestó el proceso? Historia de la creación de los CLAS en el Departamento.

(12) ¿Como se desarrolló el proceso?

(13) ¿Cual es la estructura del programa?

(14) ¿Quién es el coordinador de CLAS dl Departamento?

(15) ¿Cuales son sus responsabilidades?

(16) ¿Hay un EPAC en la Sub-Región?

(17) ¿Quienes lo conforma?

(18) ¿Cada cuanto tiempo cambia los integrantes del EPAC?

(19) ¿Que funciones desempeñan los integrantes del EPAC?

(20) ¿Como se distingue el PAC de otros programas existentes en cuanto al manejo desde la Sub-Región?

(21) ¿Como se ha insertado el PAC entre la administración de otros programas en el Departamento?

(22) ¿Cuál ha sido el rol de la EPAC (Equipo de Gestión del PAC) en la formación y desarrollo de los CLAS (fortalezas y debilidades) (p.e. en cuanto a la formación inicial de los CLAS, su supervisión, monitoreo, evaluación, asistencia técnica, y otros)?

(23) ¿Cual ha sido el rol del Departamento el desarrollo de los Programas de Salud Local, versus la participación de la misma comunidad? ¿Cuáles son las debilidades?

(24) ¿Como ha funcionado el contrato entre el Director del Departamento y el CLAS de punto de vista del primero? ¿Cuales son las debilidades?

(25) ¿Cual ha sido la opinión del personal del Departamento sobre el PAC en cuanto a: (Incluye análisis de las debilidades en cada punto)

- El sistema de los contratos con personal bajo la ley privada?

- Las relaciones que han desarrollado entre personel de salud contratado bajo diferentes regimenes que trabajan en el mismo establecimiento?

- El sistema de adquisición de bienes?

- El sistema de financiamiento de los CLAS?

- La producción de servicios en los CLAS versus los establecimientos no-CLAS?

- La calidad de atención en los CLAS versus los establecimientos no-CLAS? ¿Cuales son las debilidades?

- ¿Cuales son las diferencias entre los CLAS urbanos y rurales?

- Cual es la condición laboral del personal de CLAS vs. No-CLAS en el Departamento (UTES) (Nombrado, Contratado, Serumista)?

NO-CLAS	Nombrado	Contratado Salud Básica	Contratado CLAS	Serumista	TOTAL
Medicos					
Enfermeras					
Obstetrices					
Aux. Enf.					
Dentista					
Tec. Laboratorio					

CLAS	Nombrado	Contratado Salud Básica	Contratado CLAS	Serumista	TOTAL
Medicos					
Enfermeras					
Obstetrices					
Aux. Enf.					
Dentista					
Tec. Laboratorio					

Financiamiento según nivel de pobreza para el año 1997:

	CLAS					NO-CLAS				
	A	**B**	**C**	**D**	**Total**	**A**	**B**	**C**	**D**	**Total**
Personal										
Bienes										
Servicios										
Insumos/Med.										
Infraest.										
Equipos										
Capaci.										
Número de establecimientos										

Quien toma decisiones sobre la distribución de fondos que provienen del Gobierno Regional para el sector salud?

Cual es la política sobre el uso de recursos propios para los establecimientos No-CLAS?

Cual es la política sobre el uso de recursos propios para los CLAS?

Cual es la cantidad de ingresos propios que se han reportado para el año 1997?

	CLAS	**NO-CLAS**
Monto total de ingresos propios		
Monto enviado a la UTES		
Numero de establecimientos		

UNICEF / PERU

SISTEMATIZACION :

"REFORMA DE SALUD, PARTICIPACION COMUNITARIA E INCLUSION SOCIAL: EL CASO DEL PROGRAMA DE ADMINISTRACION COMPARTIDA"

Departamento:_____
Fecha:_____
Establecimiento:_____**Urbano / Rural:**_____

PREGUNTAS PARA EL ESTABLECIMIENTO

1. ¿Cual es el tamaño de la población en su área de influencia?_____

CREACION Y DESARROLLO DEL CLAS

2. ¿En que fecha fundó el CLAS?_____
3. ¿Bajo que condiciones decidieron establecer el CLAS?

4 .¿Cómo se hizo la convocatoria a la comunidad? Quienes asistieron a la convocatoria?

Conformación del CLAS

Cargo	Sexo	Edad	Educación	Profesión	Experiencia previa en salud	Capacita-ción en la gestión?
5. Médico Gerente	M F		PI – PC – SI – SC – T - U			
6. Presidente	M F		PI – PC – SI – SC – T - U			
7. Secretaria	M F		PI – PC – SI – SC – T - U			
8. Tesorero	M F		PI – PC – SI – SC – T - U			
9. Miembro	M F		PI – PC – SI – SC – T - U			
10. Miembro	M F		PI – PC – SI – SC – T - U			
11. Miembro	M F		PI – PC – SI – SC – T - U			

12. ¿Con que frecuencia se reune la Junta Directiva del CLAS?
13. ¿Las decisiones estan anotadas en una acta de cada reunión?
14. ¿Las decisiones estan llevados a cabo en la práctica?

15. ¿Cuantas horas semanales se dedican los miembros de la Junta Directiva al manejo del

CLAS?

16. ¿Con que frecuencia se reune la Junta Directiva con la Asamblea General?

17. ¿Cómo estan las relaciones entre la Junta Directiva y el médico/gerente?

18. ¿Cómo estan las relaciones entre la Junta Directiva y el personal de salud?

19. ¿Cuántas personas trabajan en el establecimiento y su condición laboral?

	Nombrado	**Contratado Salud Básica**	**Contratado CLAS**	**Serumista**	**TOTAL**
Medicos					
Enfermeras					
Obstetrices					
Aux. Enf.					
Dentista					
Tec. Laboratorio					

RELACIONES CON LA UTES O EL DEPARTAMENTO

20. ¿Quien es el Coordinador de CLAS del Departamento?

21. ¿Cada cuanto tiempo viene a visitar o supervisar el establecimiento?

22. ¿Que aspectos del establecimientos supervisa el coordinador?

ASPECTOS DEL ESTAB. SUPERVISADOS	SI	NO
Finances Producción Coberturas Asuntos de personal Adquisiciones Rendiciones Utilización de ingresos propios Otros		

23. ¿Que aspectos del establecimiento se deberían supervisar?

24. ¿Qué les parecen el estilo de los supervisores de la Región en relación a los CLAS?
Tipo capacitador
Tipo fiscalizador
Tipo no interesado

INGRESOS PROPIOS

25. ¿Cual es el promedio mensual que reciben del MINSA?

26. ¿Cual es el promedio mensual que reciben del Gobierno Regional?

27. ¿Cual es el promedio mensual de ingresos propios (i.p.)?

28. Como ha sido el total de i.p. para los últimos años?
1995_____
1996_____
1997_____

29. ¿Que han comprado con los ingresos propios? En que más han gastado los i.p.?

30. ¿En que medida los recursos propios contribuyen al éxito del CLAS (comparandolo con la situación en el establecimiento pre-CLAS y con otros establecimientos cercanos no-CLAS)?

PRODUCCION DE SERVICIOS

31. ¿Cual es la producción de servicios para el 1997?

INDICADOR	Numero en 1997
# atendidos	
# atenciones intramurales	
# atenciones extramurales	
# actividades de prevención y promoción	
# habitantes en el área de influencia del establecimiento	

32. ¿Tienen metas de salud? ¿Cómo se han fijado las metas? ¿Existen resultados de alguna evaluación del logro de las metas?

EQUIDAD

33. ¿Que porcentaje de pacientes están exonerados?

34. ¿Por qué se han establecido ese porcentaje?

35. ¿Como se identifican las personas que deben ser exoneradas?

36. ¿Piensan que es importante que se de especial atención a buscar las personas más indigentes de la comunidad?

37. ¿Cuales son los factores claves para poder acceder a los servicios de salud?

38. ¿Hay mecanismos de mercadeo social para promocionar el establecimiento en la comunidad? ¿Los mecanismos tienen el objetivo de identificar y atraer la gente normalmente excluida de los servicios de salud?

39. ¿Como pueden asegurar que las personas que no pueden pagar esten exoneradas de las tarífas?

ABASTECIMIENTO DE INSUMOS Y MEDICINAS

40. /?Como se hace la adjudicación de bienes para el establecimiento?
41. ¿Tiene PACFARM? Fecha de inicio de PACFARM:_____
Fecha de inicio de CLAS:_____
42. ¿ De quienes compran las medicinas, y en que porcentaje?

% de PACFARM_____
% de laboratorios_____

43. ¿Si es que compran de laboratorios, porque?

44. ¿Que opinan sobre el funcionamiento de PACFARM en el establecimiento?

PARTICIPACIÓN DE LA COMUNIDAD EN LA GESTIÓN (Para cada punto, incluye un análisis de las debilidades)

45. ¿En diagnóstico de la comunidad?

46. ¿En priorización de problemas?

47. ¿En preparar el Programa de Salud Local (PSL)?

48. ¿En supervisar el PSL?

49. ¿El decisiones para adquisición de bienes?

50. ¿El manejo de fondos y rendición de cuentas?

51. ¿En otras decisiones?

52. ¿Cual ha sido el rol del CLAS en la generación de nuevas iniciativas?

53. ¿Cuales son los factores de éxito de la experiencia de participación?

54. ¿Que condiciones y procesos fueron indispensables para alcanzar el éxito?

UNICEF / PERU

SISTEMATIZACION :

"REFORMA DE SALUD, PARTICIPACION COMUNITARIA E INCLUSION SOCIAL: EL CASO DEL PROGRAMA DE ADMINISTRACION COMPARTIDA"

ESTABLECIMIENTO:_____

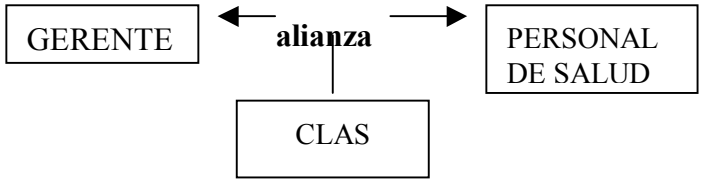
DEPARTAMENTO:_____ **Fecha:**_____

Nombre y cargo de la persona entrevistada:_____

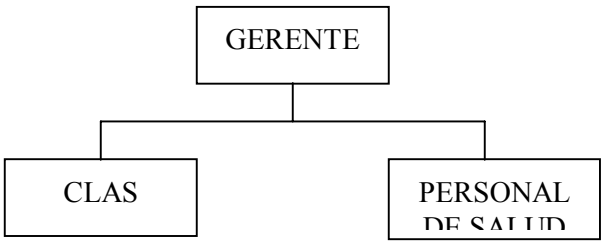
Por favor, indicar el tipo de organización que existe en este establecimiento (Marque el tipo que existía anteriormente, lo que existe ahora):

TIPO I
CONTROL
COMUNITARIO

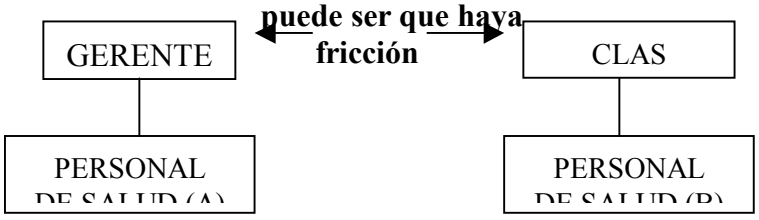
TIPO II
CONTROL
MEDICO-TECNICO



TIPO III
CONTROL
GERENCIAL-VERTICAL



TIPO IV
CONTROL
DIFUSO



Ref.: R. Cortez, 1998.

ANNEX II

Data from CLAS in Ayacucho and Ica/Chincha

Annex II

Data on Human and Financial Resources for Health Facilities with CLAS In Ica/Chincha and Ayacucho

NAME OF FACILITY		ICA/CHINCHA					AYACUCHO			
		Centro Chincha Baja	**Centro Sunampe**	**Centro Alto Larán**	**Puesto Condorillo Alto**	**Puesto Santa Rosa**	**Centro Carmen Alto**	**Centro Belén**	**Centro Quinua**	**Centro Luri-cocha**
Total Population		12,000	19,720	4,675	2,432	3,176	5,077	7,662	4,162	3,739
Date of Foundation			1994	1994	1995	1994	1995	1995	1994	1994
Area: Urban/Rural		rural	urban (40% IPSS)	rural	rural	rural	urban	urban	rural	rural
CONFORMATION OF CLAS										
Females	Manager	no	no	yes	yes	yes	yes	no	no	no
	President	no	si	no	no	no	no	no	no	yes
	Others	3 of 5	3 of 5	3 of 5	2 of 5	2 of 5	0 of 5	1 of 5	0 of 5	1 of 5
Education of	University	4	3	0	0	0	2	4	0	0
6 members	Superior Technical	1	1	1	4	6	1	1	1	3
	Secondary Complete	1	2	5	0	0			2	1
	Secondary Incomplete	0	0	0	2	0			1	2
	Primary Complete	0	0	0	0	0	1		1	0
	Primary Incompletea	0	0	0	0	0			0	0
PERSONNEL										
Permanent Staff	Physician	0	1	0	0	0	0	0	0	0
('Nombrado')	Nurse		1	0	0	0	2	1	0	0
	Obstetriz (midwife)	1	1	0	0	0	2	2	0	0
	Auxilary turse/Technician	2	1	1	0	0	7	2	5	3
	Dentist	1	1	1	0	0	0	0	1	0
	Laboratory technician	0	1	0	0	0	0	1	0	1
	Statistics technician	1	1	0	0	0	0	1	0	0
	Driver	0	1	0	0	0	0	0	1	0
	Social worker	0	0	0	0	0	0	1	0	0
	Sanitary inspector	0	0	0	0	0	0	0	1	0
	TOTAL	**6**	**8**	**2**	**0**	**0**	**11**	**8**	**8**	**4**

Name of Facility		Centro Chincha Baja	Centro Sunampe	Centro Alto Larán	Puesto Condorillo Alto	Puesto Santa Rosa	Centro Carmen Alto	Centro Belén	Centro Quinua	Centro Luri-cocha
Contracted by CLAS	Physician	3	2	1	2	1	1	1	1	1
(12 hours)	Nurse	2	2	1	2	1	1	1	1	1
	Obstetriz (midwife)	0.5	1	1	1	0	2	0.5	1	1
	Auxilary nurse/technician	2	3	1	2	1	1	1.5	3	2
	Dentist	1	1	0	1	0	1	0.5	0	0.5
	Laboratory technician	2	1	1	0	0	1	0.5	1	0
	Statistics technician	1*	0.5	1	0	0	2	0.5	1	1*
	Pharmacy technician		1	0	0	0	1	1	0	0
	Cash registrar	0	0	0	0	0	0	1	0	0
	Accountant	1*	0	0	1*	1*	1	1	0	0
	Cleaning	1	0	0.5	0.5	.5*	1	0.5	0	1
	Guard	1*	0	0.5	0.5	0	0	0.5	0	0
	Driver	1	0	1	0	.5*	1	0	0.5	0
*=With own income	**TOTAL**	**15.5**	**11.5**	**8**	**10**	**6**	**12**	**9.5**	**8.5**	**7.5**
Monthly Transference from Ministry of Health (in soles)		11,500	10,784	8,377	6,027	5,069	11,700	10,034	10,513	9,615
Monthly Income from	1998	6,000	5,500	700	400	450	2,800	2,650	900	1,100
Fees for Service (average)	1997	6,000	3,500	300-400	350	450	2,600	2,000	800	680
	1996	3,500		600	200	200				
	1995	2,000			150	90				
Ratio Transference / Fees-for-Service		1.92	1.96	4.82	15.1	11.3	4.2	3.8	11.7	8.7
Fees	Medical consultation	3	2.5	2	2	2	2	2	1.5	1
	Prenatal care	0	0	2	2	2	0	2*	0	0
	Birth attendance	15	20	15	20	No	30	25	10	8
	Postnatal care	0	0	2	0	2	0	0	0	0
	Immununization	0	0	0	0	0	0	0	0	0
	Diarrhea/ARI	0	0	0	2	0	2	0	0	0
	Wound treatment	0	2	2	3	3				
Exonerations (%)	Intramural	5-6%*	7.00%	5%	30%	10%	65%	variable	2%	2%
	Extramural	100%	100.00%	100%	100%	100%	100%	100%	100%	100%

*plus 7-8% under contract with the municipality

Name of Facility		Centro Chincha Baja	Centro Sunampe	Centro Alto Larán	Puesto Condorillo Alto	Puesto Santa Rosa	Centro Carmen Alto	Centro Belén	Centro Quinua	Centro Luri-cocha
Production of Servicios in 1997	a. Persons attended	ns	9,307	ns	3,183	2,249	7,086	7,454	3,665	2,240
	b. Visits	11,912	23,479	5,720	5,200	3,936	16,967	14,179	11,273	10,400
	c. Preventive/promocional activities	ns	3,088	ns	ns	ns	ns	ns	ns	ns
	d. Number of inhabitants	12,187	11,832	4,675	2,232	3,176	5,071	7,643	4,162	3,739
	e. Coverage (a/d)		79%		131%	71%	140%	97%	88%	60%
	f. Concentration (b/a)		2.52		1.63	1.75	2.39	1.9	3.1	4.6
	g. Conc. PPA (c/d)		0.26							
	h. Births per month		30				22		8	5
PACFARM	% of medicines	20	90	60	90		50	100	100	100
	Margin of gain PACFARM	0.1	0.1	0.1	0.15				0.1	0.1
	Marginn of gain - commercial medicines	0.1	0.15	0.15						

ANNEX III

Production Data from UTES Huamanga Ayacucho - 1997

Annex III

COVERAGE AND CONCENTRATION OF HEALTH SERVICES

HEALTH SUB-REGION OF AYACUCHO
UTES HUAMANGA

Health Centers and Posts - 1997

	PersonsAttended A	Number of Visits B	Total Population C	COVERAGE RATE A/C	VISITS PER PATIENT (Concentration) B/A
HEALTH FACILITIES WITH CLAS					
CS Belen	7454	14179	7662	0.972853041	1.902200
CS Carmen Alto	7086	16967	5077	1.395706126	2.394439
CS Santa Elena	4239	9370	3627	1.168734491	2.210426
CS San Juan Bautista	14471	28267	19766	0.732115754	1.953354
PS Nazarenas	8057	13528	11111	0.725137251	1.679036
TOTAL	**41307**	**82311**	**47243**	**0.874351756**	**1.992664**
HEALTH FACILITIES WITHOUT CLAS					
CS Acos Vinchos	2566	7379	2381	1.077698446	2.875681
PS Urpay	1883	3718	992	1.898185484	1.974508
PS Huaychao	881	2339	1087	0.81048758	2.654937
PS Suso	733	2426	606	1.209570957	3.309686
CS Ochros	5304	10017	2854	1.858444289	1.888574
PS Cceraocro	686	2317	685	1.001459854	3.377551
PS Ccaccamarca	1484	3393	1371	1.08242159	2.286388
PS Chumbes	684	3141	1474	0.464043419	4.592105
PS Simpapata	1930	4183	1170	1.64957265	2.167357
PS Laramate	388	2316	454	0.854625551	5.969072
PS Santiago de Pischa	221	1257	416	0.53125	5.687782
PS Pacaycasa	644	4842	1599	0.40275172	7.518633
PS Muyurina	1216	3991	941	1.292242295	3.282072
PS Compañía	1083	3091	871	1.243398393	2.854108
PS Socos	5610	9890	5163	1.086577571	1.762923
PS San Pedro de Cachi	699	2016	575	1.215652174	2.884120
PS Rumihuasi	644	2760	460	1.4	4.285714
PS San Jose de Ticllas	760	3721	1068	0.711610487	4.896052
PS Santa Rosa de Cochabamba	1289	2647	1182	1.090524535	2.053529
PS Rancha	317	1516	858	0.369463869	4.782334
PS Naupallaccta	64	74	872	0.073394495	1.15625

PS Chiara	1040	5414	2409	0.431714404	5.205769
PS Allpachaca	729	1608	692	1.053468208	2.205761
PS Llachoccayo	524	1937	516	1.015503876	3.696564
PS Quiñasi	1138	3451	1285	0.885603113	3.032513
PS Cocas	219	2530	1030	0.212621359	11.55251
PS Vilcanchos	894	2454	857	1.043173862	2.744966
PS Paccha	1801	3418	2313	0.778642456	1.897834
PS San Juan Culluhuanca	561	3245	754	0.74403183	5.784313
PS Occollo	544	1363	1638	0.332112332	2.505514
TOTAL	**36536**	**102454**	**38573**	**0.94719104**	**2.804193**

ANNEX IV

Indicators of Community Participation
Management Self-Evaluation
Arequipa

Annex IV

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 - Arequipa 1997

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

- Data base provided by J. Salcedo, Training and Management Support Area, Program for Strengthening Health Services, Ministry of Health of Peru.

ANNEX V

Production of Health Services
by Poverty Classification – Peru 1997
CLAS versus No-CLAS

Annex V

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, Cajamarca, Cuzco, 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

Prepared by :