PRAES ANNUAL PROGRESS REPORT: YEAR 1

October 2005- September 2006

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PRAES - Promoviendo alianzas y estrategias is a project financed by the United States Agency for International Development (USAID) and administered by Abt Associates Inc.

PRAES – Promoviendo Alianzas y Estrategias está orientado apoyar el proceso de descentralización y reforma del sector salud. Así, dedica esfuerzos a la profundización del proceso de transferencias de competencias funciones en salud entre los niveles de gobierno nacional, regional y local y asiste técnicamente la implementación, monitoreo y vigilancia ciudadana de los planes participativos regionales de salud. El proyecto brinda asistencia técnica para el diseño del modelo e instrumentos técnicos de aseguramiento que permita ampliar la cobertura de un plan de seguro de salud con garantías explícitas. PRAES se concentrará en los siguientes resultados:

- *Promoción y diseminación de una agenda consensuada de reforma de salud en el periodo de transición gubernamental*
- *Transferencias de competencias y funciones de salud a los Gobiernos regionales y Locales*
- *Implementación, monitoreo y vigilancia ciudadana de Planes Participativos Regionales de Salud*
- *Fortalecimiento del rol rector del Ministerio de Salud*
- *Reforma del financiamiento y aseguramiento en salud.*

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Fecha (mes, año)

Cita recomendada

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Acronyms

AECI	Spanish Agency of International Cooperation
CDC	Center for the Development of Competencies
DALY	Disability Adjusted Years of Life
DGSP	General Directorate of Human Health - MoH
IDB	Inter American Development Bank
GalenHos	Hospital management information system
HIA	Health Impact Assessment
HPI	Health Policy Initiatives
NDI	Nacional Democratic Institute
MIMDES	Ministry of Women Affaires and Social Development
MN	Micro network
MoF	Ministry of Finance
MoH	Ministry of Health
MSH	Management Sciences for Health
OEI	General Office of Information - MoH
PAHO	Pan American Health Organization
PAMAFRO	Project for the Control of Malaria in the Border Zones of the Andean Region
PRHP	Participatory Regional Health Plan
PRODES	Pro Decentralization project
RDD	Regional Development Division
RHC	Regional Health Councils
RHD	Regional Health Directorate
SEUUS	User Survey Assessment Package
SIS	Integrated Health Insurance
SISFOH	Household Targeting System
SNIP	National Public Investment System
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Executive Summary

Nacional level

In political terms, this year has been characterized by the national election of the country's President and members of Congress. During the pre-campaign period political parties worked towards the definition of their governmental plans and this proved to be favorable to the project's objective to provide technical health information to political actors. Thus, technical teams of 18 political parties continued to participate in consensus building workshops and meetings organized by PRAES in association with CARE, Health Policy Initiatives (HPI), National Democratic Institute (NDI) and the United Nations Population Fund (UNFPA) in order to identify key common issues of a health reform agenda. This process led to the endorsement by 16 political parties of the Political Parties Agreement in Health ("*Acuerdo de Partidos Políticos en Salud")* and its wide dissemination through mass media and direct distribution by the partners and social society organizations.

The new administration of the Ministry of Health (MoH) has incorporated the Political Parties Agreement in Health and particularly the proposal for its implementation elaborated by PRAES and the above mentioned partners, as an important input of the MoH's medium term plan. Furthermore, members of Congress, particularly of the Health Committee and the Social Security Committee, have started a dialogue on the legislative agenda that derives from the agreement. These deliberations have been supported by PRAES, especially regarding the decentralization of health functions to the local governments and the universal health insurance reform.

During the first semester of the year –October 2005- March 2006- the health decentralization process continued the phase of accreditation of the Regional Governments' capabilities to receive the health competencies established in the 2005 Annual Transfer Plan. In general terms, this process has been successful as a majority of regions have had an adequate performance regarding the accreditation indicators. In terms of the continuity of the decentralization process, the Peruvian Government officially approved the functions and competencies of the 2006 Annual Transference Plan.

The new government has issued decentralization guidelines that will accelerate the transfer of functions, particularly in the cases of health and education. It is expected that the totality of programmed health functions will be transferred to Regional Governments by the end of 2007, while the transfers to Local Governments will start by the implementation of pilot experiences during 2007. The Northern Macro Region, supported by PRAES, played an important role in the consensus building process with the MoH and the constructive relationship between the national and regional levels which has characterized this process. In the recent debate regarding the role of the Local Governments in health, PRAES has promoted the constitution of a working group with eight important partners to provide continuous technical input and advice to the MoH for the definition of the models of local decentralization. A key factor for the success of the decentralization process is the strengthening of the regional and local capabilities to exercise the transferred health functions. In this area PRAES is contributing to develop institutional skills for sustainable managerial training programs by two local universities.

Regarding the health insurance reform, PRAES provided technical assistance to MoH for the development of a National Burden of Disease Study, which lays the foundation for the design of the Guaranteed National Health Insurance Plan that will be elaborated with PRAES' support in the coming months. The consensus between the MoH authorities and Congress members of the different represented parties creates a favorable condition for the advancement of this major health reform, which is included in the Political Parties Agreement in Health. PRAES has been working towards creating an environment for constructive deliberation on this issue with key actors.

Regional level

During the year the most important challenge in the regions has been the implementation of the Participatory Regional Health Plans (PRHP). This has entailed focusing on communicating the plans, strengthening leadership capabilities of Regional Governments, elaborating action plans for 2006-2007 and formulating operational and investment plans and budgets for 2007. Implementing these critical areas and particularly allocating resources and efforts towards poor geographical areas, has proven to be complex as inertia to follow traditional paths has to be gradually minimized. A key factor is the political will from high level authorities of the Regional Governments to align efforts towards the citizen mandated health priorities. PRAES provided continuous support, through its Regional Advisors in La Libertad, Lambayeque and Ucayali, and by the end of the year, operational plans, budgets and investment profiles for 2007 linked to the PRHP have been approved in each region. These are necessary technical conditions to guarantee the implementation of the PRHP during the coming year.

In the case of San Martin, an adverse political context has impeded a similar performance. The Regional Government was unsuccessful to accredit more than 50% of the faculties of the 2005 Transfer Plan and failed to approve the PRHP. This has implied that this region is lagging behind and special efforts will need to be developed in the next year to revert the current situation.

Political support to the sustainability of the PRHP has been promoted through a series of meetings with the regional political candidates to the up coming regional and local elections. Local Promoter Groups, assisted by PRAES, organized consensus building processes in La Libertad. Lambayeque, San Martin and Ucayali that have led to the endorsement of Political Health Agreements. A particular focus of these agreements is the commitment of all the parties to continue and strengthen the implementation process of the PRHP and in the case of San Martin, an agreement has been reached for the immediate approval of the PRHP. In all the cases, social society organizations have been involved as observers and have expressed their will to oversee the fulfillment of the political agreements.

Overall project performance has been satisfactory during the year according to expected results as shown in Table I.

Table I: PRAES Performance Indicators – Year 1

Type of indicator	Indicator	Level	Timeframe	Target	Actual	Cumulative
Program output 1/	Document containing consensus on health reform agenda endorsed by political parties at the national level.	Central	Oct.- Dec. 2005	1	1	100%
Program output 1/	Document containing consensus on health reform agenda endorsed by political parties at the regional level.	Regional	May.-Nov. 2006	3	3 (*) La Libertad San Martin Ucayali	100%
Program output 1/	A clearing house and critical review of key health policy documents produced in Peru during 1995-2005	Central	Jun-Set. 2006	1	1 First stage	100%
Performance indicator 1/	Number of national political parties that include health reform issues in their governmental plans	Central	Jan.-Mar. 2006	5 major parties	16	100%
Program output 1/	Number of technical report/policy briefs/ submitted to newly elected authorities at the national level	Central	Ago. -Dec. 2006	5	5	100%
Program Output	Number of Northern Macro Region Executive meetings	Regional	Jan. -Sep. 2006	5	5	100%
Performance indicator	Number of Regional Governments that have accredited over 75% of health functions of the Annual Transference Plan	Regional	Jan. -Mar. 2006	3	20	100%
Performance indicator	Number of Regional Governments that have completed their annual estimation of Regional Health Accounts	Regional	Abr.- Sep. 2006	3	1 (**)	33%
Program Output	Number of public events to present the Participatory Regional Health Plans	Regional	Jan.- Jun 2006	3	3	100%
Program Output	Document of global strategy and action plans for Participatory Regional Health Plan implementation	Regional	Jan.- Jun 2006	3	3	100%
Performance Indicator	Number of Regional Governments that have prioritized public health strategy implementation	Regional	Jan.-Jun. 2006	3	3	100%
Performance indicator	Number of Regional Governments that have aligned prioritized strategies with Regional annual operational plan and budget	Regional	Jun. –Set.. 2006	3	3	100%
Program Output 1/	National Burden of Disease Study	Central	Oct 2005-Sep. 2006	Yes	Yes	100%
Program Output	SISFOH's operational guidelines completed	Central	Jun.-Sep. 2006	Yes	Yes	100%
Performance indicator	Hospital Belen has implemented the Management Information System (GalenHos)	Regional	Mar. -Sep. 2006	Yes	Yes	100%

1/ Expected results in year 1 according to Contract GHS-I-00-03-00039-00 333
(*) Ongoing. The document approved by Lambayeque's political parties representatives is expected by November, 2006
(**) Ongoing. The estimation in two additional regions is expected by December, 2006.

1. Summary of progress

1.1 Component 1: Advocacy for Health Sector Agenda during Government Transition

1.1.1 Purpose

During the first year of the project, Peru has been engaged in electoral campaigns for the Presidency, Congress, Regional Governments and Local Governments. In the past, government transitions have frequently led to a lack of continuity in health policies and progress; a prolonged period of inactivity on the part of new authorities; and, owing to lack of institutional memory, frequent repetition of previous studies, program designs, and initiatives. With the purpose to contribute to diminish these risks at the national level and in 4 regions, this component has been aimed at:

- Improving the quality of the public debate with respect to health sector during the electoral campaigns.
- Building consensus among political parties regarding to a medium term heath agenda.
- Promoting continuity of health policies and programs by the new health authorities.

1.1.2 Results

Health sector issues are debated publicly in the 2006-2007 political transition

In close consultation with USAID/Peru, PRAES has led advocacy work to keep health reform on the national agenda during the pre-election periods at the national level and in four regions. The project has strengthened its relationships with political leaders and has partnered with other USAID and non–USAID projects to facilitate a multiparty agreement on a consensually defined agenda for health reform.

From October to December 2005 PRAES, in association with CARE, NDI, HPI and UNFPA, continued the facilitation of a consensus building process among political parties that had begun during the PHR*plus* project. In this period, following a program that started in March, representatives of 18 political parties attended four final workshops and meetings and issued and approved a document containing an agreed upon Health Reform Agenda. This agenda includes agreements on the following topics: maternal and child health, HIV-AIDS, tuberculosis, malaria, health sector decentralization, health insurance, health sector financing, pharmaceuticals and social participation.

During January and February 2006 the partners promoted the endorsement of the *Political Parties Agreement on Health* by 16 political leaders and in March a public event was organized to present the document to key national actors and to submit the agreement to oversight organizations such as the Ombudsman's Office, the National Agreement (Acuerdo Nacional) and Foro Salud. It was also submitted to the MoH, being the main institution that is responsible for its implementation. Additionally, meetings were held with main newspapers, TV and radio to provide them with information about the *Political Parties Agreement on Health.* A majority of them informed the

general public about the agreement. The document was disseminated nation wide through (i) an "encarte" in the newspaper Peru 21 (60,000 units distributed) and (ii) dissemination of a printed document (3700 units distributed), effort that was supported by the partners of this initiative.

At the regional level, a proposal to promote a consensus building process to define regional health agendas with regional political parties was developed. Regional partners were identified to constitute the Promoter Groups in Lambayeque, La Libertad, San Martín and Ucayali. These Promoter Groups conducted, with technical assistance from PRAES, approximately 6 meetings with an average of 10 political organizations in each region, which led to the Political Agreements to sustain and continue implementation of the PRHP. Social society organizations and oversight institutions such as the Regional Ombudsman Offices participated as observers and also committed efforts to supervise the achievement of the agreements (See Annex B).

Newly elected government as well as its appointed health authorities and officials receive key information and policy advice in a timely fashion

Under USAID/Peru guidance, PRAES has established a close working relationship with the new MoH authorities and members of the Health, Social Security and Decentralization Congressional Committees. It has continued to partner with other USAID and non–USAID projects to promote the implementation of the multiparty agreement on the health reform agenda.

On the basis of the Political Parties Agreement on Health, PRAES, with the collaboration of CARE, NDI, HPI and UNFPA, developed a technical report that contained an implementation proposal including indicators, base lines, goals and interventions for each of the topics contained in the multiparty agreement. This document was submitted to the new MoH authorities and has been adopted by the MoH as a basis for its medium term national health plan.

A systematization of the consensus building process that led to the agreement has been developed with the purpose of providing lessons learned and recommendations for: (i) the implementation and monitoring of the agreement; and (ii) the processes of political consensus building in the 4 regions, in the context of the regional elections.

The project has continued to disseminate health policy information through "aide memoirs", monthly project bulletins and the project web site. It has organized several events (breakfast meetings) in close coordination with Congress members to facilitate a dialogue on the decentralization process and universal health insurance. With collaboration from PAHO, the project has set up a clearinghouse which contains a critical review of 50 health policy documents produced about Peru from 1995 through 2006 and project team members have actively participated in public fora on health reform.

1.1.3 Performance

This component has reached all the expected performance indicators as shown in the table below.

Table 1: Component 1 Performance Indicators

Type of indicator	Indicator	Level	Timeframe	Target	Actual	Cumulative
Program output	Document containing consensus on health reform agenda endorsed by political parties at the national level.	Central	Oct.- Dec. 2005	1	1	100%
Program output	Document containing consensus on health reform agenda endorsed by political parties at the regional level.	Regional	May.-Nov. 2006	3	3 (*) La Libertad San Martin Ucayali	100%
Program output	A clearing house and critical review of key health policy documents produced in Peru during 1995-2005	Central	Jun-Set. 2006	1	1 First stage	100%
Performance indicator	Number of national political parties that include health reform issues in their governmental plans	Central	Jan.-Mar. 2006	5 major parties	16	100%

(*) Ongoing. The document approved by Lambayeque's political parties representatives is expected by November, 2006

1.1.4 Lessons learned

Regarding the consensus building process with political parties at the national level:

- The main political parties in Peru have among their members, professionals with ample public health experience and knowledge. An initial recognition of their own capabilities is key to generate a favourable context to build a respectful deliberation environment.
- The facilitation strategy should be aimed at providing unbiased information, stimulate dialogue, and allow participants to harmonize their own ideas. It is of the utmost importance that the facilitators maintain a strictly neutral "honest broker" position, which generates trust between the political parties' representatives and the facilitators, as well as among themselves.
- Even among initially opposed political positions, there are a number of health issues on which a common interest is shared among party representatives. A consensus building process must focus on promoting that these issues surface though dialogue, putting contentious points aside for later consideration. Sufficient time must be allowed build momentum into this process.
- The will of the government party to apply the agreements, as well as of the parties represented in Congress to include them in their legislative agenda is demonstrating that these agreements have great possibilities of being implemented. Further efforts to stimulate multi party deliberation are necessary in this stage to align the executive and legislative, for successful implementation.

At the regional level:

- The consensus building processes at the regional level have had an advantage regarding the national process, as regional health priorities have been previously identified in their respective PRHP. This has been a favourable condition to generate a deliberation environment which has led to the achievement of consensus.
- In all the regions the promoters of the dialogue have been prestigious local organizations. This has been very important, as a tendency to resist initiatives that come from Lima is quite common as they are seen as attempts to impose an external centralized agenda.

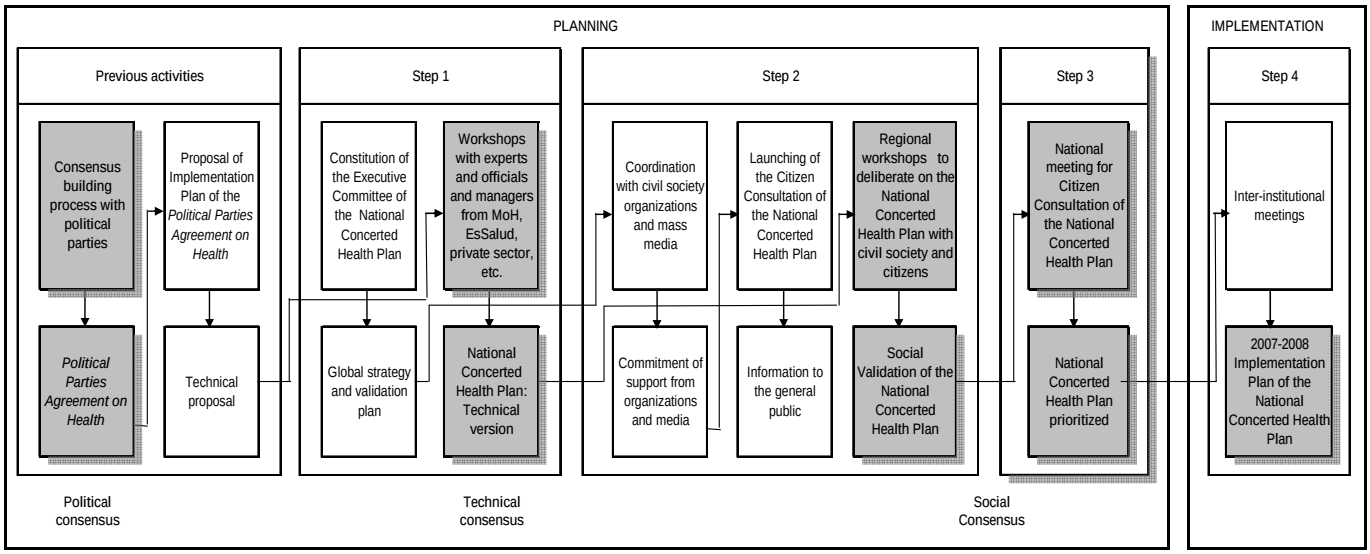
- The promoter groups need technical assistance to organize and carry out the process, particularly to help them set up the "rules of the game" and maintain a neutral position. This fosters trust of the political parties towards the promoter groups.

- In contrast to the national level, generally the regional political parties do not have specialized technical teams. Special attention must be placed in the capacity building aspect of the process providing access to qualified experts.

1.1.5 Perspectives

- The favourable disposition of MoH to implement the Political Parties Agreement on Health, taking into account the implementation proposal developed by PRAES and its partners, opens a unique opportunity to advance towards a Participatory National Health Plan. Initial coordination has been made regarding a work plan towards this end, that includes a stage of consensus building within the National Health Council and MoH officials; a next step would entail coordination with the new Regional and Local authorities to promote a consultation process with social society organizations an citizens in the regions, led by the Regional Health Councils. Finally a national consultation event would take place so as to prioritize interventions and policies for implementation of the national health plan. In the near future, MoH should define if this process will move forward and the support that is needed for this important task.

Figure 1: Proposal of Citizen Consultation of the National Concerted Health Plan



- Diverse congress members (Unidad Nacional, APRA, Alianza por el Futuro y UPP) have initiated a multi party dialogue about universal health insurance, which is one of the main themes of the Political Parties Agreement on Health. This constitutes an important opportunity to define by consensus the basis legal framework that is needed for this major health reform. Initial coordination has taken place to facilitate a dialogue to determine the basic guidelines for the design of the Essential Health Plan and the National Health Oversight Agency.

- The dialogue processes with regional political parties in Lambayeque, La Libertad, San Martin y Ucayali, has also allowed progress towards political agreements that ratify the health priorities and the PRHP. It is expected that this will contribute substantially to the sustainability and continuation of the approved health policies, strategies and interventions by the new regional and local authorities in the coming years.

1.2 Component 2.a: Health Sector Decentralization – Transfer of Health Functions

1.2.1 Purpose

During year 1 of the project, the health decentralization process was characterized by the accreditation of Regional Governments for the transfer of health functions corresponding to the 2005 Transfer Plan and the approval of the 2006 Transfer Plan. Under the new government, the main decentralization agenda is the transfer of health functions to Local Governments, particularly those associated to the production of health services. With the aim of providing support to these processes, this component has been oriented towards:

- Advancing the transfer process of health functions to the Regional Governments and providing assistance for the accreditation process.
- Clarifying the role of Local Government and the coordination mechanisms with the regional level regarding health functions, which can be categorized in three main areas: (i) environmental health, (ii) health promotion and prevention and (iii) health services production
- Building consensus between the national, regional and local governments regarding the transfer of functions to the local levels, particularly related to health service provision and production, which entails new institutional arrangements for health service stewardship, organization and management, financing, human resources management and social participation, among the most important.

1.2.2 Results

Regional Governments have revised and updated the Medium Term Plan of Transfers of Health Competencies and Functions on the basis of a consensus building process in 4 regions

Continuing the Concerted Map of Competencies methodology developed under PHRplus, the project provided technical assistance to MoH and Regional Governments for the 2005 accreditation process for the transfer of health functions to the Regional Governments. Additionally, support was provided to facilitate the agreement and approval of the 2006 Transfer Plan, on the basis of the Medium Term Plan of Transfers.

Regarding the accreditation of the 2005 transfer plan, 92% of the faculties have been accredited by 23 Regional Governments, as shown in the table below.

Table 2: Results of the 2005 Accreditation Process

23 Regional Governments	37 Faculties
Average percentage of health faculties accredited by Regional Governments included in the 2005 Annual Transfer Plan	91.7%
Percentage of Regional Governments that have accredited 75% or more health faculties included in the 2005 Annual Transfer Plan	82.6%
Description:	
17 Regional Governments (including Lambayeque y Ucayali)	37 faculties accredited
3 Regional Governments (including La Libertad)	27 faculties accredited
1 Regional Government	22 faculties accredited
1 Regional Government	21 faculties accredited
1 Regional Government (San Martin)	17 faculties accredited

Source: MoH report to the Decentralization Committee of Congress (20.09.06)

Considering the additional faculties included in the 2006 Transfer Plan, up to date 60% of all regional health faculties have been officially approved so as to be subject to the accreditation process. According to the guidelines of the new government, the remaining 40% are expected to be transferred in 2007.

Table 3: Distribution of Regional Health Functions Transfers

Regional Health Functions	Faculties				
	Total	2005	2006	2007	2008-9
a. Approve regional health policies	3	2	1		
b. Formulate and execute Regional Health Plan	13	7	5	1	
c. Coordinate actions of integrated health	11	3	3	3	2
d. Participate in the National Coordinated and Decentralized System	1	1			
e. Promote and execute activities of health promotion and prevention	5	1	1	3	
f. Organize the level of health care of the public sector in coordination with local governments	5	3	0	2	
g. Organize and maintain health services in coordination with local governments	9	2	6	1	
h. Supervise public and private health services	3	1	0	2	
i. Conduct the prevention and risk control of emergencies and disasters	6	0	5	1	
j. Supervise and control the production, commerce and consumption of pharmaceuticals	11	3	6	2	
k. Promote and preserve regional environmental health	14	3	1	10	
l. Plan, finance and execute infrastructure and equipment investment projects	8	0	8		
m. Provide information on health management, supply and services	9	6	0	3	
n. Promote the formation, training and development of human resources	21	4	2	13	2
o. Evaluate the achievements in health	4	1	0	3	
p. Execute actions to increase nutritional levels in coordination with local governments	1	0	0	1	
Total	124	37	38	45	4

Source: MoH and National Council of Decentralization

During the first semester the *Methodological Guidelines for the Elaboration of the Map of Concerted Competencies* were developed on the basis of the systematisation of the experience. This document contains the methodology to elaborate a map of health competencies that distributes health functions among the national, regional and local levels, as well as to the health providers and civil society organizations, and has been used by other USAID projects –AprenDes and PRODES- for its application to the Education Sector and the Social Sector (MIMDES), respectively. Another associated product is the update of the *APTO software* that will be used to facilitate the elaboration of the Medium Term Transference Plans to Local Governments on the basis of the analysis of the distribution of health functions to local levels.

Selected Local Governments have formulated an Annual Plan of Transfers of Health Competencies and Functions in 4 regions

In order to advance technical inputs regarding the decentralization process to local governments and highlight its main issues, the project has elaborated a technical report for the discussion of the role of local governments in health and has adapted and applied the Map of Concerted Competencies in several workshops with local governments of La Libertad under the leadership of the Provincial Municipality of Trujillo. Furthermore, in order to enhance the consensus building process about the decentralization process to local governments, PRAES has organized a work group (Mesa de Descentralización Local) with the participation of AMARES, CARE, Foro Salud, HPI, Management Sciences for Health (MSH), MuniRed, Pathfinder and PRODES, which has become an important technical counterpart to the MoH on this issue.

Regional Health Directorates permanently produce and analyse Regional Health Accounts in 4 regions

Building of the progress made by the regional governments with the support of PHR*plus,* the Regional Health Directorates of Ucayali updated the estimation of Regional Health Accounts for 2004, showing an advanced degree of institutionalization of this tool. PRAES provided technical assistance to the Planning Office of the Regional Government and the Regional Health Directorate to conduct the estimation process, including organizational and methodological issues.

In the case of the Regional Health Directorates of La Libertad and Lambayeque, they have finished with the data collection process for the annual estimation. The delay in the estimation of Regional Health Accounts is due to time constraints faced by the team responsible of the measurement. In these cases, the team in charge of the estimation of the Regional Health Accounts was involved in parallel activities related with budgeting, planning formulation and investment. However, this process is expected to be concluded by the end of 2006.

To facilitate the continuous periodical estimation and the extension of the methodology to other regions, the project undertook the development of ACRES, software to facilitate a standardized estimation and analysis by the regions.

Local Universities in 2 regions provide health management training and consulting services, as well as health systems research as required by the Regional Governments

The second PROGRESA Diplomas for (1) teachers – PROGRESA Docentes- and (2) top level managers – PROGRESA Gerentes 1- in charge of the Universidad del Pacífico in Lima concluded successfully. In the first case, the 30 trainees were: representatives of Ayacucho, Ucayali and San Martin's Human Resources Offices; fourteen professors of the San Cristobal of Huamanga University in Ayacucho; and four professors from each one of the following universities: Pedro Ruiz Gallo of Lambayeque, National University of Trujillo of La Libertad and the National University of the Center in Junin. In the second case, the 30 trainees were Regional Health Directorate officials of Ayacucho, Ucayali, San Martín, Amazonas, Piura, Tumbes and Loreto.

Additionally, in Lambayeque the PROGRESA Diplomas for middle level managers –PROGRESA Gerentes 2- and operational level managers –PROGRESA Gerentes 3- in charge of the Pedro Ruiz Gallo University also concluded. In each case 30 health officials at intermediate and operational management levels have been trained.

In San Martin and Ucayali the PROGRESA Diplomas for middle level managers – PROGRESA Gerentes 2 – and operational level managers – PROGRESA Gerentes 3 – in charge of the National University of Trujillo and the University Pedro Ruiz Gallo of Lambeyeque have concluded. The participants of these Diplomas were selected: 30 health officials at intermediate management level and 30 at the operational management level.

In order to make PROGRESA sustainable without USAID funding, the project provided support to both local universities to identify new market opportunities. Workshops were organized and facilitated in La Libertad and Lambayeque in order to identify the current gap between the regional supply and demand of training services and to develop capacities to undertake a market analysis of PROGRESA, so as to provide the program under conditions of financial sustainability. Additionally, support has been provided to the University Pedro Ruiz Gallo of Lambayeque to develop a proposal for the extension of PROGRESA II and III to Amazonas, Cajamarca and Piura. The Regional Health Directorate of Lambayeque has asked the University Pedro Ruiz Gallo to organize PROGRESA Diplomas for middle level managers – PROGRESA Gerentes 2 – and operational level managers – PROGRESA Gerentes 3.

Regional Governments and Regional Health Directorates of the Macro Northern Region continuously exchange experiences and coordinate activities

Five Northern Macro Region Executive Meetings have taken place during the year, with the collaboration of AECI, CARE, Pathfinder, PDI, PAMAFRO and Vigia (See Annex C). The main topics that have been discussed and agreed upon have been:

- Assessment of the Northern Macro Region, definition of priorities and the 2006 agenda
- Health Decentralization: 2006 Transfer Plan and revision of accreditation criteria
- Pharmaceuticals and Free Trade Agreement
- Program for Malaria Control of the Andean Community
- Prevention and control of malaria and other metaxenic diseases in the Northern Macro Region
- Participatory health planning
- Health service users satisfaction monitoring and evaluation
- Increase in the supply of health services in the Northern Macro Region

During the period a proposal of a Plan of Prevention and Control of Metaxenic Diseases as elaborated and approved by the Northern Macro Regions, which includes 6 basic strategies:

- Implementation of a multi-sector and multi-governmental program of prevention and control of metaxenic diseases.
- Decentralization of the diagnostic and control services of metaxenic diseases
- Reorganization of the health services netwroks in areas of risk of metaxenic diseases
- Implementation of a surveillance system of migrations
- Implementation of permanent education of providers and strengthening of the Regional Center for the Development of Competencies (CDC) in the control of metaxenic diseases.
- Implementation of Management agreements and accountability mechanisms to improve regional performance in the prevention and control of metaxenic diseases.

The scope of these meetings was broadened to include the Social Division Managers of the 9 regions. The common topic which has been developed is the transference of social functions from the national to the regional level, under the assistance of MIMDES and with support by PRODES and PRAES. In a workshop with the participation of selected local governments, the Social Division Managers discussed the decentralization of MIMDES and validated the Concerted Map of Competencies of this sector, which had been developed with support from PRODES, following PRAES' methodology.

1.2.3 Performance

This sub-component has reached the majority of the expected performance indicators as shown in the table below.

Table 4: Component 2.a Performance Indicators

Type of indicator	Indicator	Level	Timeframe	Target	Actual	Cumulative
Program output	Number of technical report/policy briefs/ submitted to newly elected authorities at the national level	Central	Ago. -Dec. 2006	5	5	100%
Program Output	Number of Northern Macro Region Executive meetings	Regional	Jan. -Sep. 2006	5	5	100%
Performance indicator	Number of Regional Governments that have accredited over 75% of health functions of the Annual Transference Plan	Regional	Jan. -Mar. 2006	3	20	100%
Performance indicator	Number of Regional Governments that have completed their annual estimation of Regional Health Accounts	Regional	Abr.- Sep. 2006	3	1 (*)	33%

(*) Ongoing. The estimation in two additional regions is expected by December, 2006.

1.2.4 Lessons learned

- The first necessary condition for the decentralization process is a strong political will. This has been a fundamental factor in the health decentralization experience, which has been demonstrated by the alignment of the political demand of the Regional Governments and the political leadership of the Minister of Health.
- The decentralization process requires a clear definition of the roles and functions of the three levels of government. In the case of the health sector this was possible due to the formulation of the map of concerted competencies and functions between MoH and the Regional Governments.
- On the basis of a consensus on the functions to transfer from one level to another, it is also necessary to agree upon the methodology of the transfer process. In the case of the health sector, a medium term plan was concerted; indicating which functions and faculties will be transferred in each year as well as the accreditation criteria for the faculties in each year.
- Both the identification of the health functions to be transferred to Regional Governments as well as the specification of the transference process required a previous process of homogenisation of criteria among the regional authorities, indispensable for a successful negotiation with the national level. A decisive contribution to this end was the coordination of the Regional Health Directors of the Northern Macro Region (Tumbes, Piura, Lambayeque, La Libertad, Cajamarca, Amazonas, San Martín, Loreto y Ucayali), as well as the coordination with the rest of the Regional Health Directors of the country.
- The accreditation for the transfer of functions and particularly the exercise of the transferred functions require intensive capacity building which should be planned from the beginning of the process of decentralization. This requires a joint effort from the national, regional and local levels and the development of training capabilities in the local universities.
- Projects of technical cooperation and other social society organizations can play a significant technical role in support of the development and strengthening of decentralized capabilities as well as in promoting consensus building processes between key actors. This requires an alignment between cooperation agencies and the governmental institutions in charge of decentralization.

1.2.5 Perspectives

- The new government has issued guidelines for accelerating the decentralization process, particularly in health and education to the local governments. This is a positive factor as it will maintain the decentralization momentum over the next years.

- However, it is necessary to take into account that decentralization is not only a matter of transferring functions from one level to another. The decentralization process demands a global organizational redesign of the State. Therefore, decentralization is necessarily part of a broader process of modernization and reform of the State, which must include, among other issues, additional resources to make decentralization feasible as well as a new financing scheme to balance regional inequities.

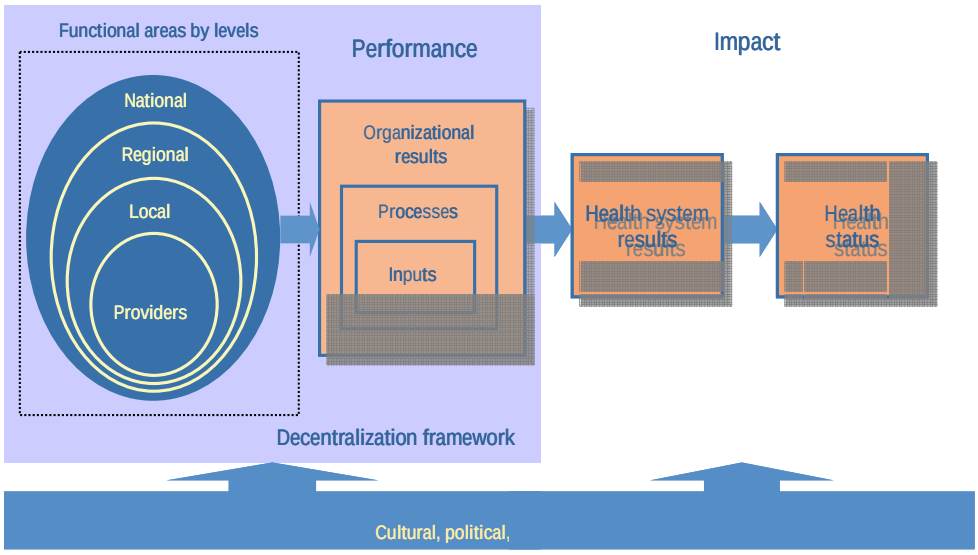
- Health decentralization will necessarily touch upon the need to resolve the fragmentation of the health sector if increase in efficiency is to be achieved. In the 2005 and 2006 processes of transfer to Regional Governments overall health functions have been included, such as health markets regulation, health policy making and planning, organization and management of health services, among other. An effective exercise of these functions needs that the Regional Government develops the role of a health authority over the public and private sectors in the region.

- It is necessary to recognize that the decentralization process will have diverse rhythms in different regions and in the different levels of government, and as such will require strategies that take into account specific conditions. Particularly regarding local decentralization, there is a vast heterogeneity between local governments, as well as in their existing capabilities. Gradual implementation needs to be considered in the context of a consensus building process between the regional and local levels to take into account the specific conditions of the region and the heterogeneity of the local levels within each region. This will demand the promotion of deliberations between regional and local levels to negotiate and approve a medium plan of decentralization in each region.

- In the short term, an important effort will be to contribute to the design of pilot experiences of health decentralization to selected local governments, particularly under a model of joint management between provincial and district municipalities, in order to preserve the health services networks and take advantage of economies of scale and of the existing capabilities.

- Finally, the development of the Monitoring and Evaluation (M&E) System of Decentralization and the elaboration of a base line should be a priority in the coming months. This system should be based consider the health functional areas and their distribution by levels identified in the Map of Concerted Competencies. For each of the functional areas, the M&E system should consider: (i) performance indicators and (ii) overall impact indicators, corresponding to: health system results (increase in equity in access, efficiency, service quality, democratization, participation and accountability) and health status (level and distribution) corresponding to health priorities at the national and regional levels.

Figure 2: Health Decentralization Monitoring and Evaluation System



1.3 Component 2.b: Health Sector Decentralization – Implementation of Participatory Regional Health Plans

1.3.1 Purpose

Under PHR*plus* PRHP were developed in four regions with direct citizen participation in the definition of health priorities. It is well documented that a majority of strategic plans fail to be implemented, both in the public and private sectors. In order to avoid this, during this year PRAES has dedicated substantial efforts to support the implementation of these plans. The component has been aimed at:

- Developing global implementation strategies, action plans and investment profiles to foster PRHP implementation
- Facilitating effective multi-institutional and intergovernmental coordination for PRHP implementation under Regional Government leadership
- Development of participatory evaluation mechanisms to assess PRHP implementation progress.

1.3.2 Results

Regional Governments, in coordination with Local Governments, have implemented their Participatory Regional Health Plans in 4 regions

A strategy for PRHP implementation was developed including a six-component approach:

- Communicating the plan
- Strengthening leadership capabilities of Regional Government
- Elaborating action plans for 2006-2007
- Formulating operational and investment plans and budgets for 2006-2007
- Strengthening monitoring capabilities of the Regional Health Council
- Designing and implementing participatory evaluation

In each step, proposed activities and sub activities were identified as well as roles and responsibilities of the different key regional actors. In three regions (Lambayeque, La Libertad and Ucayali) leadership teams for PHRP implementation were constituted. In the cases of Ucayali and Lambayeque this team is comprised by the regional health, education and sanitation directors under the leadership of the Social Division Managers; in La Libertad, this team is conducted by the General Manager and additionally includes the Manager of the Planning Division of the Regional Government; and in Lambayeque by the Vice President, the Social Division Manager, the Planning Manager and the regional Health and Housing Directors. Workshops were organized and facilitated in the three regions with Regional Government and Local Governments' authorities, health authorities and technical officials, health providers (hospital and primary level facilities) and social organizations representatives to increase their in-depth knowledge of the PRHP and discuss and approve the global implementation strategy. In all the cases, the focus was placed in the first four components steps, while the last two components were programmed for the next year.

Subsequent technical team work was assisted by the project to elaborate proposals for the 2006-2007 action plans: definition of intermediate and final results, prioritisation of intermediate results for 2006-2007, derivation of activities and investment projects to be developed in this period in each region (See Annex D). These proposals were revised and approved in an additional workshop in each region. The action plans have a pro-poor approach as they include a prioritisation of geographical areas according to poverty levels, as shown below.

Table 5: Prioritized PRHP geographical areas

Region	Province	District	Poverty index 1/	Population
La Libertad	Bolívar	Bambamarca	100%	3,408
	Gran Chimú	Sayapullo	98%	7,593
	Julcán	Huaso	100%	6,347
	Otuzco	Agallpampa	95%	9,631
	Otuzco	Sinsicap	99%	8,308
	Otuzco	Usquil	93%	26,053
	Pataz	Chillia	100%	10,341
	Pataz	Huancaspata	97%	6,527
	Pataz	Huayo	100%	3,027
	Pataz	Ongón	100%	1,574
	Sanchez Carrión	Chugay	99%	18,296
	Sanchez Carrión	Cochorco	99%	9,058
	Sanchez Carrión	Curgos	98%	8,086
	Sanchez Carrión	Marcabal	99%	12,459
	Sanchez Carrión	Sanagorán	100%	12,559
	Sanchez Carrión	Sarín	99%	9,009
	Sanchez Carrión	Sartimbamba	97%	13,167
	Santiago de Chuco	Angasmarca	96%	5,042
	Santiago de Chuco	Santa Cruz de Chuca	99%	3,478
	Santiago de Chuco	Sitabamba	100%	3,610
Lambayeque	Ferreñafe	Cañaris	100%	12,691
	Ferreñafe	Incahuasi	99%	14,884
	Lambayeque	Salas	96%	14,035
Ucayali	Atalaya	Raymondi	86%	24,982
	Atalaya	Sepahua	81%	6,696
	Atalaya	Tahuanía	91%	5,171

1/ Percentage of people with at least 1 unsatisfied vital need

Source: 2005 Population Census

On the basis of these action plans, support was provided to the Regional Health and Housing Directorates of La Libertad; Lambayeque and Ucayali to formulate the following investment profiles according to the National Public Investment System (SNIP) standards (See Annex E)

Finally, technical assistance was provided to the three regions for the development of the Regional Health Directorates Institutional Plans and budgets for 2007, aligning these with the activities of the action plans. It is expected that this will contribute to a seamless transition of PRHP implementation in 2007 with new regional government authorities.

Regional Health Councils will develop the capability for continuous monitoring of the progress of Participatory Regional Health Plans in 4 regions

PRAES has formulated a proposal for a Participatory Evaluation of PRHP in the regions, which is based on the Health Impact Assessment (HIA) methodology that combines technical analysis and citizen participation. HIA is commonly defined as "a combination of procedures, methods, and tools by which a policy, program, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population"[1]. The HIA methodology will be used to evaluate objectively the health effects PRHP implementation. It will provide recommendations to increase positive health outcomes and minimize adverse health outcomes through a process of consensus building between the Government and citizens to derive recommendations and commitments for performance improvement. The major steps in conducting an HIA include:

- Screening (identification of the main PRHP interventions and policies under assessment),
- Scoping (identification of the health effects to consider)
- Assessing results and impacts (identification of which people have been affected and how they have been affected)
- Reporting (presentation of the results to decision-makers and social society organizations)
- Evaluating (public deliberation to determine measures to improve performance)

This proposal has been validated with the Regional Health Councils of La Libertad and Lambayeque, and in the coming months the proposal will be presented to the new regional government authorities for approval.

Increased familiarity with the goals and processes of decentralization in the health sector among public officials, private sector leaders and the public.

Three PRHP (La Libertad, Lambayeque and Ucayali) were approved by the respective Regional Governments and published with PRAES' support. Public events for the presentation of the PRHP of La Libertad, Lambayeque and Ucayali have taken place. They have been organized by the Regional Health Directorates and the Regional Health Councils and were attended by representatives of the provinces, authorities of the different sectors, representatives of civil society organizations and public sector officials. In these events, the Presidents of the Regional Governments confirmed the binding nature of the PRHP and set forth the commitments for 2006 and 2007. On the basis of the systematisation of the process, a *Methodological Guidelines for the Formulation of Participatory Health Plans* has been elaborated and disseminated for the extension to other regions. In La Libertad, these guidelines are being utilized for the development of the Social Regional Plan, under the leadership of the Social Division Manager. Finally, a systematisation of the Citizen Consultation to define health priorities in Lambayeque has been published and widely disseminated.

[1] 1999 Gothenburg consensus statement, www.who.dk/document/PAE/Gothenburgpaper.pdf

1.3.3 Performance

The proposed objectives have been achieved in three regions: La Libertad, Lambayeque and Ucayali. In the case of San Martin the progress has been very slow, as the PRHP, although approved by the Regional Health Council, has not been approved by the Regional Government. Only recently in the context of the support of the political parties to the PRHP and their commitment for its implementation, has the Regional Government showed signs of interest in approving the PRHP.

Table 6: Component 2.b Performance Indicators

Type of indicator	Indicator	Level	Timeframe	Target	Actual	Cumulative
Program Output	Number of public events to present the Participatory Regional Health Plans	Regional	Jan.- Jun 2006	3	3	100%
Program Output	Document of global strategy and action plans for Participatory Regional Health Plan implementation	Regional	Jan.- Jun 2006	3	3	100%
Performance Indicator	Number of Regional Governments that have prioritized public health strategy implementation	Regional	Jan.-Jun. 2006	3	3	100%
Performance indicator	Number of Regional Governments that have aligned prioritized strategies with Regional annual operational plan and budget	Regional	Jun. –Set.. 2006	3	3	100%

1.3.4 Lessons learned

- An indispensable condition for the implementation of strategic health plans is the leadership of high level authorities, communicating the vision to the rest of the organization. The leadership of the PRHP was achieved due to the citizen involvement that generated a mandate to the Regional Governments. In the context of the appointment of new regional government authorities and officials, this element needs to be reinforced by bringing together these new governmental actors with social society organizations and citizens to assess progress and renovate the government's commitment. Additionally, an external and internal communication strategy must be developed.

- The implementation of the PRHP has involved other social sectors such as housing and sanitation, nutrition and education. This initial inter sector coordination needs to be strengthened by clarifying the role of the Social Development Divisions and their relationship with the Regional Directorates.

- Public institutions, such as the Regional Health Directorates (RHD) have a strong inertia to conduct their affairs in a traditional manner. Implementing strategic plans that reorient objectives and beneficiaries is a major challenge, which requires a new set of incentives and accountability mechanisms, a new organization structure and revised work processes. These changes will take time and will need continued technical support.

- It has been necessary to dedicate efforts to articulate operational plans, investment plans and budgets, as traditionally these management tools are not aligned to achieve strategic objectives. The progress made to date needs to be reinforced in the following years by redefining the planning and budgeting cycle.

- The elaboration of tools, such as investment profiles templates has facilitated the process of formulating investment projects. However, it is necessary to centralize the investment decisions in the Regional Government so as to set clear priorities in line with Regional Development Plans. Additionally, a specialized team of professionals needs to be constituted, instead of having the scarce human resources scattered in the different offices and Regional Directorates.

1.3.5 Perspectives

- The political agreements that have been reached in the regions are a key element that will contribute to the sustainability of the PRHP implementation by the new authorities. Building on this commitment, the Regional Health Councils will play an important role in the governmental transition to the new authorities, informing them on the progress made and recommending the approval of the participative evaluation process.

- During 2007 the implementation process in the prioritized areas will take place according to the action plans, through a joint Regional and Local Government intervention, particularly regarding:

  - Provision of water and sanitation servicies
  - Reorganization of health networks and micro networks
  - Alignment of the Local Health Plans of ACLAS facilities to regional health priorites
  - Equipment of emergency services of referral health centers and hospitals
  - Equipment of basic health services in micro networks
  - Stregthening of outreach health interventions, through sectorization of the catchment population of the micro networks
  - Improvement of the distribution of pharmaceuticals and vaccines
  - Extention of Integrated Health Insurance (SIS) affiliation in rural areas

- The RHC will organize the participatory evaluation process as a mechanism of effective feedback from citizens to the Regional and Local Governments to guide the implementation process. This process will involve social society organizations, existing surveillance groups and citizens.

1.4 Component 4: Health Sector Financing and Insurance

1.4.1 Purpose

Recent evidence seems to confirm that the Integrated Health Insurance (SIS) has partially reduced economic barriers to maternal and child health services and produced a initial shift from historic budgets to production-related payment mechanisms. However, progress toward universal coverage of health insurance is considered limited as only 40% of the population has health insurance coverage and 37% of total health financing is out-of-pocket expenditure by households.

During this year this component's purpose has been oriented to:

- Promoting the inclusion of health insurance in the national health policy agenda

- Developing a National Burden of Disease Study, as a basis for the design of a Guaranteed National Health Insurance Plan

- Providing technical assistance to the Ministry of Finance (MoF) for the implementation of SISFOH in accordance to the national targeting strategy

1.4.2 Results

MoH has developed a National Burden of Disease study

The project developed the report *"Burden of Disease Study: a review of international experiences"* on the basis of the review of the experiences of Mexico, Ecuador and Chile and the results from the Global Burden Disease Study[2]. This report includes an analysis of the methodological approach used in each country, which is based on the Disability Adjusted Year Life (DALY) indicator to measure the burden of disease. Even though this methodology is widely accepted, the results are biased due to the secondary source of information used, reflecting the burden of disease of the population that have access to health services. In general, in these countries the results reflect demographic and epidemiological transitions towards to non-infectious diseases.

Although initial steps were taken for the constitution of a multi-institutional National Burden of Disease Committee, resistance on the part of EsSalud to share data made it impossible to develop a joint work. In this context, PRAES provided direct technical assistance to MoH for the estimation of the National Burden of Disease Study based on mortality data and epidemiological parameters from Latin American countries. The technical assistance also included the adjustment of the 2004 mortality data base in order to avoid the misspecification bias of the cause of death.

On this basis MoH developed a first estimation, with the collaboration of the Carlos III Institute of Spain and the technical assistance of PRAES. The project revised MoH's Burden of Disease Study and included a new classification of the diagnosis group according to the epidemiological profile of the Peruvian population. The next step will be to adjust previous DALY estimations with national morbidity data and the validation of local experts, to avoid biases due to the epidemiological parameters used, which reflect the burden of disease of a sample of Latin American countries.

In the post election period, the project has organized events for policy dialogue with newly elected health authorities and Congress members on health finance and universal health insurance in order to reach consensus on the design and implementation of the Guaranteed National Health Insurance Plan.

Ministry of Finance has implemented the Household Targeting System (SISFOH)

During the year MoF agreed with International Development Bank (IDB) on three indicators regarding targeting of social programs which were included in the Conditionality Matrix for October 2006:

- Record of socio-economic classification of households ("padrón de beneficiarios SISFOH") in 20 cities.
- Use of the record by 3 social programs, including SIS.
- Decrease of leakages in these programs by 10%

In this context, MoF requested technical assistance from PRAES regarding (i) update of the targeting tools to be used by the Household Targeting System (SISFOH) and (ii) design of the SISFOH's operational manual. Regarding the first issue, the current official targeting tool was developed by PHR*plus* to help assist social programs to allocate subsidies among poor population in urban areas. MoF requested PRAES to adapt these tools to target subsidies in rural areas,

2 Murray C, López A. *Global mortality, disability, and the contribution of risk factors: Global Burden of Disease Study*. The Lancet 1997; 349:1436-1442

specifically by the Conditional Cash Transfer Program "Juntos". The project updated the SISFOH algorithm considering the agreements between the MoF and the Juntos Program. This study proved the robustness of the methodology as well as validated the scores and the socio-economic questionnaire (Ficha Socioeconómica) for urban and rural areas. Thus, is expected that the MoF will continue supporting the utilization of this tool by the Household Targeting System and recommend its utilization to the Juntos Program.

Regarding the design of the SISFOH's operational manual, PRAES has provided technical assistance to the MoF, including issues related to the definition of the "padrón de beneficiarios", verification mechanism, coordination mechanism among SISFOH, social programs and local government, among others. The project has also provided additional technical assistance from an international consultant from Colombia to revise technical documents elaborated by the MoF

MoH has developed information systems for health service management improvement

PRAES has worked closely with the General Office of Information (OEI) of MoH with the aim of transferring GalenHos, the hospital information system to MoH. OEI has ratified the interest of MoH in the implementation of GalenHos in public hospitals and in order to do so, asked for the following adjustments:

- New validation rules for diagnosis and procedures, gender and age.
- Development of a new reporting module based on a MoH proposal.
- Inclusion of the new MoH standards which were approved by Supreme Decree
  - International Clasiffication of Diseases, 10th revision, for the registration of medical diagnoses
  - Current Procedural Terminology / MoH Catalogue of services, for the registration of medical and other health procedures
  - National Identification document for the identification of users
  - MoH health facilities identification code, for the registration of facilities catalogued as destination / origin
  - International Classification of Neoplasms, for the registration of the histology of a neoplasm
  - List of districts, villages and minor towns, for the definition of the residence or non-residential origin of healthcare facilities users.

These adjustments were made and the billing module developed tested and implemented in the Belen Hospital of Trujillo.

GalenHos has been successfully presented to private and public hospital managers. Additionally, the MoH and several Lima hospitals have visited the Belen Hospital in Trujillo to see the development and functioning of GalenHos. Up to date, several hospitals have requested the implementation of GalenHos, such as Loayza Hospital, Noguchi Mental Health Hospital, Cayetano Heredia Hospital, La Banda Hospital (San Martín), the Regional Health Hospital of Ayacucho, Abancay Hospital, among others. Specifically, Cayetano Heredia, Huamanga, Hipólito Unanue, Casimiro Ulloa and Noguchi hospitals have received advice from the project for the implementation of GalenHos.

Initially, the project developed the User Survey Assessment Package (SEEUS) to assist the Regional Health Directorate of La Libertad in the measurement of the user dissatisfaction index, which is a quality performance indicator included in the Management Agreement between the Regional Health Directorate and the Integrated Health Network in Trujillo. The project successfully implemented this system in the Regional Health Directorate and in the main hospitals of Trujillo and trained to the members of the Quality Division of these institutions.

However, the Quality Division of the MoH adopted SEEUS as a managerial tool to asses the effectiveness of quality improvements plan in public health facilities and has made efforts to implement it nationwide. A pilot experience was developed in the Hospital of Huamanga, with the support of the project. Additionally, MoH sent the software to all the Regional Health Directorates for their use. MoH compiled all the features to be adjusted as result of the validation stage. Technical assistance was provided by the project to complete these requirements. In support of the implementation efforts of MoH the project organized 4 courses and up to date personnel of more that 80 public institutions have been trained (See Annex F).

1.4.3 Performance

Table 7: Component 4 Performance Indicators

Type of indicator	Indicator	Level	Timeframe	Target	Actual	Cumulative
Program Output	National Burden of Disease Study	Central	Oct 2005-Sep. 2006	Yes	Yes	100%
Program Output	SISFOH's operational guidelines completed	Central	Jun.-Sep. 2006	Yes	Yes	100%
Performance indicator	Hospital Belen has implemented the Management Information System (GalenHos)	Regional	Mar. -Sep. 2006	Yes	Yes	100%

1.4.4 Lessons learned

Burden of Disease Study

- It has been proven that is possible to estimate the national burden of disease combining local mortality data with Latin American epidemiological parameters. However, diseases with high years of life lived with disability (YLDs) require adjustment with local morbidity data due to evidence of bias on DALY`s estimation.
- Both, morbidity and mortality databases have several constraints due to problems regarding misclassification and underreporting. Hence, is required to enhance DALY`s estimation making adjustment through systematic review and internal consistency.
- Although the Epidemiological Unit of the MoH was interested to carry out the estimation of the National Burden of Disease, this division has no incentive to use these results in a broad sense (i.e as an input to design a Guaranteed National Health Insurance Plan). In this context, it is required that other divisions (General Directorate of Human Health –DGSP-, Vice-Ministry's Office) within the MoH get involved with this study.
- The main results shows the non-infectious diseases, particularly those related with mental health are high-priority. In the future MoH will need to define a specific policy and allocated resources to face this kind of disease.

GalenHos

- The integrated hospital information system was developed following an incremental development approach gradually including critical functions, in a flexible manner so as to leave open new possibilities for growth options. This approach was adopted in order to avoid a potential sense of frustration based on the long time required for the appropriate software analysis, design, programming and adjustments.

- An effective and visible leadership is needed from the managerial staff that has the highest level of decision-making in the hospitals, to guarantee that the necessary resources (human and equipment) for the implementation of the information system will be allocated.

- Any information system development is necessarily accompanied by a critical review of workflows; as such it is important that all staff involved in the execution of optimization efforts is also present in the phases of the information system design, development, trials, and implementation.

- Clinical data registration standards definition by MoH is a important condition to facilitate the sustainability of the application, to avoid the sudden obsolescence of the application and to permit the extension of the system to other health facilities.

- The implementation of GalenHos is less expensive than the alternative of updating the information systems that are currently being used in public hospitals in approximately 40%, as estimated on the basis of the analysis of the situation of six public hospitals.

SEEUS

- The design of the exit survey should be validated not only with the MOH, but also with representatives of health services. This strategy will allow designing a more representative survey, including hospital information as well specific issues regarding health centers and posts.

- The MoH must conduct a multi-stage implementation process nationwide. To this end, the MoH should start providing information to Health authorities, Hospital Directors, Regional Health Directorates, among others, regarding the advantage of using SEEUS as a management tool. The support of these key actors is required to provide sustainability to this process. The distribution of the software without any information or training sessions generates unnecessary resistance.

- The Regional Health Directorate must be in charge of the implementation process within the regions. These responsibilities should include the training of health facilities team on how to operate SEEUS and how to analyze the main results. The latter is a key issue due to the new methodological framework based on the estimation of a dissatisfaction index. It is important that in the training session participate members of the quality and statistical units of health facilities. Furthermore, the Regional Health Directorates must provide guidelines regarding sampling design, data collection frequency and procedures. In the past, health facilities has estimated non-representative sample due to inappropriate method used.

1.4.5 Perspectives

Burden of Disease Study

- The Burden of Disease Study's results can be used by the MoH as a baseline to assess health interventions and PRAES will actively disseminate the results of the study within the decision makers and academic community to analyze the implications of the study for public health priority setting.

- The Burden of Disease Study is a relevant input to define a Guaranteed National Insurance Plan for the implementation of the universal coverage policy established by the current administration. This information will be used to prioritize the diseases with the greatest contribution to disability and death in the country which from a public health perspective must be covered by the national insurance plan. Many of these diseases are currently excluded from traditional insurance plans.

GalenHos

- Although GalenHos has reached an essential (but considerable) size of software development, it is important to prepare additional modules. Suitable candidates for future development are:

Pharmacy, Operating Room, Imaging services, Clinical Pathology and Blood Bank. This can be feasible if financing is channeled from hospitals interested to have these developments -as additional to the essential modules already developed.

- GalenHos' extension should be related to the demand from public hospitals. In a first phase Lima public hospitals will be targeted as potential partners, although in a second phase regional public hospitals will be approached as such.

- GalenHos should be complemented by MoH with an application oriented to the basic health level, in such a way that the referral and counter-referral process is facilitated. In the medium term, a unified medical file can be envisioned for each user, including every contact, diagnosis and procedure made in the public health facilities network.

SEEUS

- SEEUS allows health facilities to identify critical areas and to set quality management priorities. However, in order to enhance quality management performance, health facilities require developing skills to define improvement plans. To this end, the project will recommend MoH to develop a data base with cost- effective improvement plans or to promote the organization of a network to share experience with health facilities.

- It is required to complement SEEUS analysis with internal client dissatisfaction analysis. This will provide additional information and will allow the identification sources of dissatisfaction. In this sense, MoH has requested the project to provide technical assistance to develop additional features to SEEUS, including external client module.

2. Limitations and Recommendations

2.1 Limitations

2.1.1 Situation in San Martin

The political instability of the region, with several changes of the President of the region, led to a continued replacement of officials in the Regional Government and the Regional Health Directorate. This has delayed the project's activities in the region, particularly because of the failure of the Regional Government to approve the PRHP and to fully accredit the 37 faculties of the 2005 Transfer Plan. In order to overcome this situation, the project made multiple efforts, including the decision to move its office from Tarapoto to Moyobamba, for a better coordination with the Regional Government. Notwithstanding the direct intervention of the MoH, to support the region in the accreditation process and to provide support for the approval of the PRHP, the situation has not been solved during the year.

In this situation, and in agreement with the project's CTO, during year 1 project decreased its efforts in the region until a more stable solution is reached, limiting temporarily its intervention to the promotion of the consensus building process with civil society representatives.

2.1.2 EsSalud

Although the repeated reaffirmation of the MoH regarding the development of the Burden of Disease Study, no real progress was made by the Ministry to move forward the constitution of the multi institutional technical committee, as well as of the memorandum of understanding with EsSalud for data sharing. EsSalud continued to refuse to share information with MoH for the Burden of Disease Study.

2.1.3 SISFOH

The MoF constituted the Central Unit of Targeting; however the progress in setting up the system has been very slow. Several attempts have been made by the project to motivate the MoF to develop a strategy to disseminate the purpose and advantages of SISFOH to political actors, so as to promote the sustainability of this key policy and instrument.

2.2 Recommendations

A significant limitation of the governmental policies in the country has been the lack of continuity through different governmental periods. In the health sector, sustainability of health policies is essential as many of the desired results are not attainable in the short run or during the period of one administration. The possibility that a participatory process will be launched by MoH to formulate the National Concerted Health Plan opens a very important opportunity to lay the foundation for medium and long term health policies with political and social support. It is highly recommended that USAID and other donors promote and support this major effort.

2.2.1 Component 1

- The process of capacity and consensus building with political parties has demonstrated that this kind of intervention is highly cost-effective. In this sense, it is convenient that this work continues with members of Congress in coordination with MoH, particularly regarding health decentralization, health insurance, health financing and subsidy targeting, human resources, among the most important.

- In the regions, where capacities are scarcer a continued involvement of party members in consensus building processes should be actively promoted, particularly those appointed to the Regional and Local Councils of Coordination (*Consejos de Coordinacion Regional y Local*).

- It is also important to prepare new generations of political leaders with a better understanding of public health policies. A specific program to inform young party members about public health and health system agenda would be highly recommended.

2.2.2 Component 2

- It would be very convenient if some of the selected pilot sites for local decentralization coincide with the prioritized intervention areas of the PRHP: networks of Santiago de Chuco in La Libertad, Ferreñafe in Lambayeque and Atalaya in Ucayali. This would allow to concentrate efforts in specific geographical areas and to allocate resources to zones that have the greatest needs.

- The adaptation of the PROGRESA modules, particularly Gerentes 3, to a distance learning format could greatly contribute to capacity building in Local Governments that will receive health functions in the coming years. This distance learning diplomas would also contribute to the sustainability of PROGRESA in the two local universities in La Libertad and Lambayeque.

- The involvement of the Social Development Managers of the Regional Governments in the Macro Region Executive Meetings in year 2 opens an opportunity to include the implementation of the national policy of malnutrition reduction and the role of the Regional Governments as major points in the agenda. Coordination and active participation of MIMDES would be required.

- During year 2 an effort should be made to improve the process of participatory budgeting at the regional and local levels. The most significant drawback up to date has been that these processes are not usually within the framework of regional development plans. In this sense, it would be desirable to carry out experiences of participatory budgeting fundamentally as a prioritization exercise of pre-defined investment projects aligned with the PRHP, allowing for a relatively minor proportion of the investment budget to be assigned to other objectives. This would contribute to a joint Regional and Local Government financing of the most relevant projects and thus to strengthening the relationship among these levels of government. To enhance the capabilities of the regions to formulate investment profiles, it would be cost effective to develop software modules on the basis of the investment templates that have been elaborated with PRAES support. This would permit to extend this tool to other regions.

2.2.3 Component 4

- In the coming months two legislative initiatives should be promoted among key Congress members. On one hand, a law to set the general parameters for the design of the Guaranteed Nacional Insurance Plan and a definite time frame for its development. This should include an explicit mandate to EsSalud to provide information and participate in the design. On the other hand, a law to mandate the design of the institutional arrangements for the constitution of a National Health Oversight Agency (Superintendencia Nacional de Salud). If funds are available, study tours to Chile (FONASA) and Colombia (Superintendencia de Salud) would be convenient for Congress members and MoH.

- As has been mentioned, progress to implement SISFOH has been very slow. Coordination between USAID and IDB would be advisable to assess the situation and define technical assistance activities.

2.2.4 San Martin

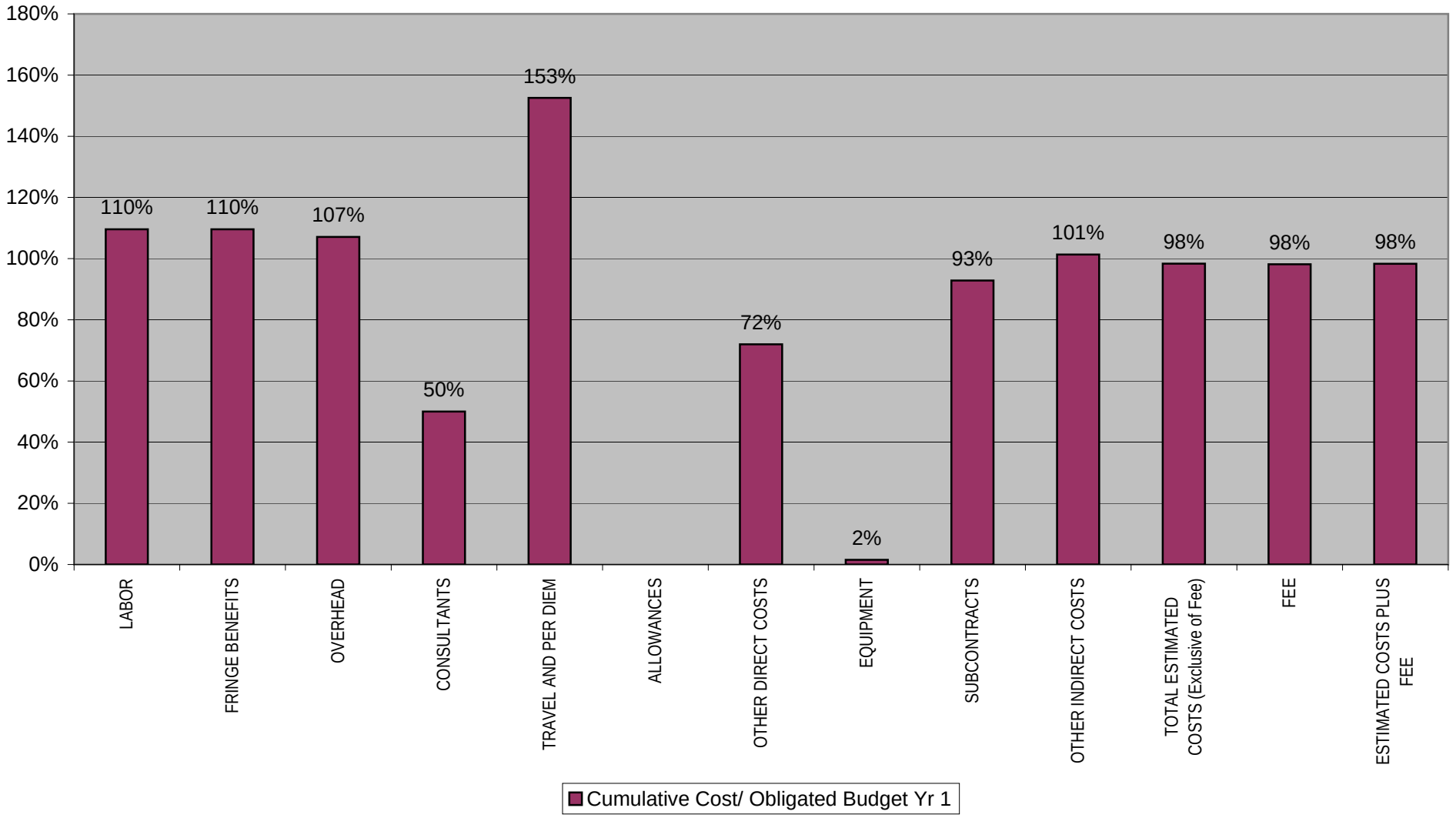
- After the November regional elections and the appointment of the regional authorities, it will be necessary that USAID assesses the situation and perspectives for the work of PRAES in the region. If the conditions are favorable, an *ad hoc* technical assistance plan will have to be developed for San Martin. If political conditions do not improve, it would be recommendable that USAID defines another intervention area for PRAES.

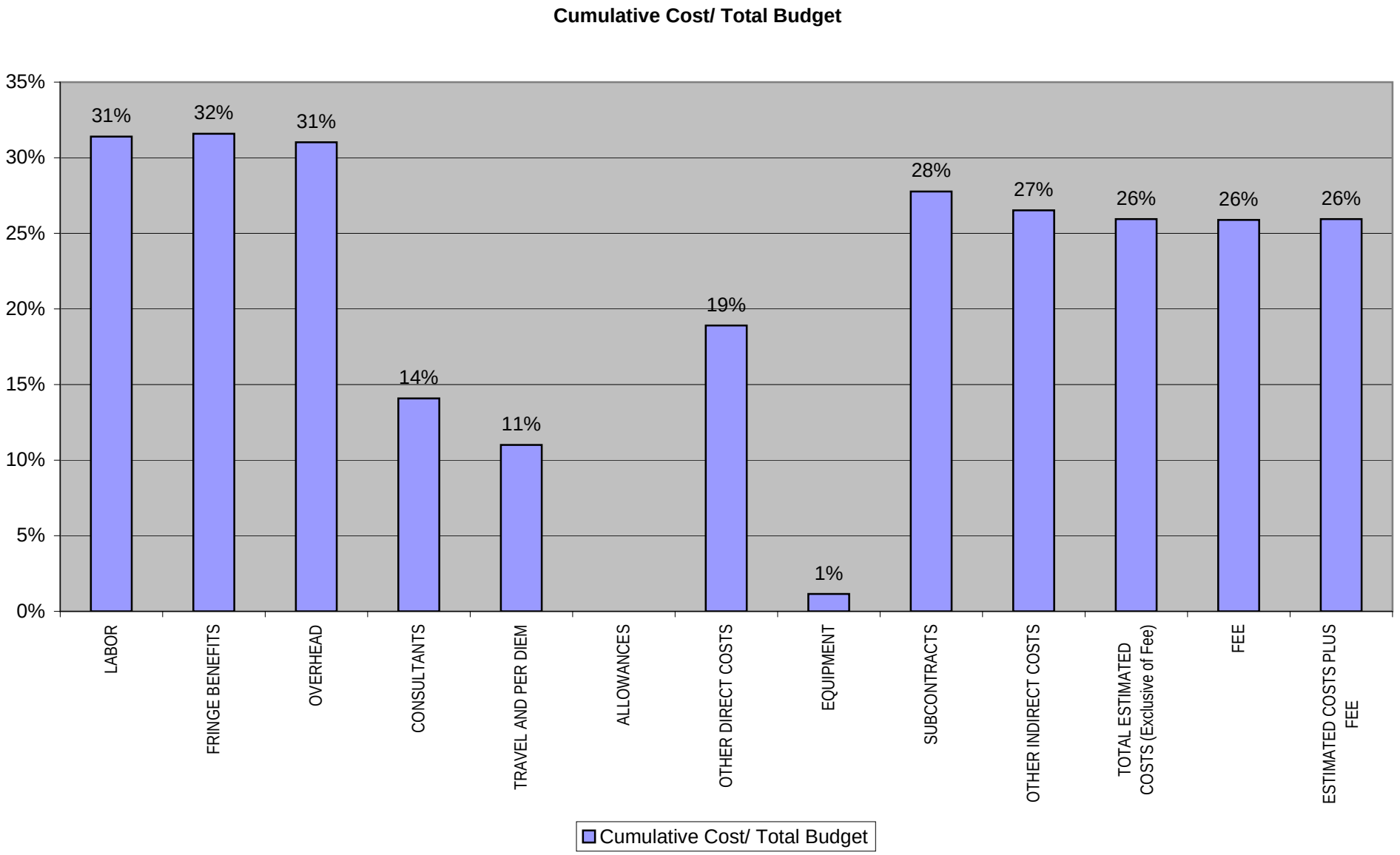
3. Financial Report

Contract No: GHS-I-00-03-00039-00, Task Order 333
TASC2 Peru: Improved Health for Peruvians at High Risk
Abt Associates Inc.

EXPENDITURE BY BUDGET ELEMENTS AND FUNDING SOURCES
FINANCIAL STATEMENT CONTRACT YEAR ONE

		Total Budget	Obligated Budget (Year 1)	Cumulative Expenditures through 09/30/06	Total Budget Remaining	Obligated Budget Remaining	Cumulative Cost/ Total Budget
BY BUDGET ELEMENT							
I.	LABOR	$1,988,868	$569,791	$624,437	$1,364,431	($54,646)	31%
II.	FRINGE BENEFITS	$830,308	$239,312	$262,263	$568,045	($22,951)	32%
III.	OVERHEAD	$545,562	$158,064	$169,252	$376,310	($11,188)	31%
IV.	CONSULTANTS	$245,911	$69,289	$34,634	$211,277	$34,655	14%
V.	TRAVEL AND PER DIEM	$512,588	$36,995	$56,431	$456,157	($19,436)	11%
VI.	ALLOWANCES	$0	$0	$0	$0	$0	
VII.	OTHER DIRECT COSTS	$1,200,356	$315,298	$226,905	$973,451	$88,393	19%
VIII.	EQUIPMENT	$16,460	$12,359	$190	$16,270	$12,169	1%
IX.	SUBCONTRACTS	$278,410	$83,279	$77,309	$201,101	$5,970	28%
X.	OTHER INDIRECT COSTS	$1,085,990	$284,271	$288,027	$797,963	($3,756)	27%
XI.	TOTAL ESTIMATED COSTS (Exclusive of Fee)	$6,704,453	$1,768,658	$1,739,448	$4,965,005	$29,210	26%
XII.	FEE	$429,085	$113,194	$111,086	$317,999	$2,256	26%
XIII.	ESTIMATED COSTS PLUS FEE	$7,133,538	$1,882,000	$1,850,534	$5,283,004	$31,466	26%


Cumulative Cost/ Obligated Budget Yr 1
180%
160%
140%
120%
100%
80%
60%
40%
20%
0%
110%
110%
107%
50%
153%
72%
2%
93%
101%
98%
98%
98%
LABOR
FRINGE BENEFITS
OVERHEAD
CONSULTANTS
TRAVEL AND PER DIEM
ALLOWANCES
OTHER DIRECT COSTS
EQUIPMENT
SUBCONTRACTS
OTHER INDIRECT COSTS
TOTAL ESTIMATED COSTS (Exclusive of Fee)
FEE
ESTIMATED COSTS PLUS FEE
Cumulative Cost/ Obligated Budget Yr 1


Cumulative Cost/ Total Budget
35%
30%
25%
20%
15%
10%
5%
0%
31%
32%
31%
14%
11%
19%
1%
28%
27%
26%
26%
26%
LABOR
FRINGE BENEFITS
OVERHEAD
CONSULTANTS
TRAVEL AND PER DIEM
ALLOWANCES
OTHER DIRECT COSTS
EQUIPMENT
SUBCONTRACTS
OTHER INDIRECT COSTS
TOTAL ESTIMATED COSTS (Exclusive of Fee)
FEE
ESTIMATED COSTS PLUS FEE
Cumulative Cost/ Total Budget

Annex A: Annual Work Plan

Activity		Status
Health sector issues are debated publicly in the 2006-2007 political transition		
1.1.1	Dissemination of information	Completed.
1.1.2	Organization of events with political parties with national political parties	Completed.
1.1.3	Meetings with key national actors	Completed.
New	Systematisation of the consensus building process	Completed.
1.1.4 1.1.6 1.1.8 1.1.10	Organization of events with political parties with regional political parties: La Libertad Lambayeque San Martin Ucayali	Completed as planned. Last phase ongoing.
1.1.5 1.1.7 1.1.9 1.1.11	Meetings with key regional actors: La Libertad Lambayeque San Martin Ucayali	Completed.
Newly elected government as well as its appointed health authorities and officials receive key information and policy advise in a timely fashion		
1.2.1	Organization of Clearing House on health sector reform	Completed.
1.2.2	Elaboration and provision of technical reports and information on key reform issues to newly elected officials	Completed.
New	Technical report: Implementation Plan of the Political Parties' Agreement on Health	Completed.
Regional Governments have revised and updated the Medium Term Plan of Transfers of Health Competencies and Functions on the basis of a consensus building process in 4 regions		
2.1.1	Elaboration of methodological guidelines for the elaboration of the Concerted Map of Competencies	Completed.
2.1.2	Update of APTO software	Ongoing.
2.1.3	Elaboration of methodological guidelines for determination of Local Government health competencies	Completed.
2.1.4 2.1.5 2.1.7 2.1.8	Meetings with Regional Governments to elaborate 2006 Transference Plan: La Libertad Lambayeque San Martín Ucayali	Completed.
2.1.6	Workshop to validate methodological guidelines for the analysis of local health competencies	Completed.
Selected Local Governments have formulated an Annual Plan of Transfers of Health Competencies and Functions in 4 regions		
2.2.1	Elaboration of technical report of the role of Local Governments in health	Completed.
New	Organization of a multi institutional work group on local decentralization	Completed.
Regional Health Directorates permanently produce and analyze Regional Health Accounts in 4 regions		
New	Development of the Regional Health Accounts software (ACRES)	Completed.
2.4.1	Workshops to analyze Regional Health Accounts estimations	Completed. San Martin is pending.
2.4.2	Supervision trips for Regional Health Accounts 2004-2005 estimation	Completed. San Martin is pending.
Local Universities in 2 regions provide health management training and consulting services, as well as health systems research as required by the Regional Governments		
2.5.1	Elaboration of guidelines of strategic planning of training and consultancy services	Completed.

Activity		Status
2.5.2 2.5.3	Workshops for strategic planning of health management training consultancy services La Libertad Lambayeque	Completed.
PHR+	Supervision of PROGRESA (Health Management Training Program) San Martín and Ucayali	Completed.
2.6.1	Design of a monitoring and evaluation framework for health decentralization	Reprogrammed: To be completed in Year 2.
Regional Governments and Regional Health Directorates of the Macro Northern Region continuously exchange experiences and coordinate activities		
2.7.1	Elaboration of methodological guidelines for Northern Macro Regional Executive Meetings	Completed.
2.7.2	Facilitation of the for Northern Macro Regional executive meetings	Completed.
New	Northern Macro Regional Plan for the prevention and control of metaxenic diseases	Completed.
Activity		Status
Regional Governments, in coordination with Local Governments, have implemented their Participatory Regional Health Plans in 4 regions		
2.8.1	Elaboration of methodological guidelines for the formulation of PRHP	Completed.
2.8.2	Elaboration of Volume I of the 4 PRHP	Ongoing. San Martin is pending.
2.8.3 2.8.4	Guidelines for workshops to validate global strategy for PRHP implementation	Completed.
2.8.5	Technical meetings with Regional Governments to define global strategy for PRHP implementation	Completed.
2.8.6	Workshops to validate the global strategy for PRHP implementation and formulate action plans 2006-2007	Completed.
2.8.7	Elaboration of guidelines for the formulation of Institutional Operational Plans	Completed.
2.8.8	Elaboration of technical reports of annual costing of PRHP activities	Ongoing.
2.8.9	Elaboration of guidelines for budget readjustment	Cancelled. Under the MoF new guidelines for budget formulation, this activity is no longer necessary.
2.8.10 2.8.15 2.8.22	Public events for the presentation of the Participatory Regional Health Plan La Libertad Lambayeque Ucayali	Completed.
New.	Workshop and technical assistance to culminate the PRHP of San Martin	Completed.
2.8.11 2.8.16 2.8.19 2.8.23	Workshops to the formulation of the Institutional Operational Plans La Libertad Lambayeque San Martín Ucayali	Completed. San Martin is pending.
2.8.12	Workshops for Regional-Local Governments coordination for PRHP implementation	Completed.
2.8.13-14 2.8.17-18 2.8.20-21 2.8.24-25	Technical assistance for formulation of health budgets: La Libertad Lambayeque San Martín Ucayali	Completed. San Martin is pending.
New.	Technical assistance for formulation of investment profiles La Libertad Lambayeque Ucayali	Ongoing.
New.	Workshops to revise the health plan of the Local Government of Huamachuco	Completed as planned. Last phase

Activity		Status
		ongoing
New.	Workshops of capacity building of the Health Division of the Provincial Municipality of Trujillo	Completed.
New.	Workshops to strengthen the role of Social Development Division	Completed.
Regional Health Councils will develop the capability for continuous monitoring of the progress of Participatory Regional Health Plans in 4 regions		
2.9.1	Elaboration of guidelines for monitoring the implementation of the PRHP	Completed.
2.9.2 2.9.3 2.9.4 2.9.5	Workshops to monitor the implementation of PRHP La Libertad Lambayeque San Martín Ucayali	Reprogrammed to Year 2. In the framework of the approval of the global strategy of PRHP implementation, the Regional Governments reprogrammed these activities to Year 2
Regional Governments will periodically hold public meetings with civil society to coordinate Participatory Regional Health Plans implementation and assess achievement of the agreed upon goals in 4 regions		
2.10.1	Elaboration of guidelines for the implementation of the participatory assessment model of the PRHP	Completed.
2.10.2 2.10.3 2.10.4 2.10.5	Workshops to validate the participatory assessment model of the PRHP La Libertad Lambayeque San Martín Ucayali	Completed. San Martin is pending.
Increased familiarity with the goals and processes of decentralization in the health sector among public officials, private sector leaders and the public		
2.11.1	Publication of the systematization of the health decentralization process	Completed. (Web page)
2.11.2	Publication of the methodological guidelines of the Concerted Map of Competencies	Completed. (Web page)
2.11.3	Publication of the methodological guidelines for the formulation of PRHP	Completed. (Web page)
2.11.4	Publication of the 4 Participatory Regional Health Plans	Completed. San Martin is pending.
2.11.5	Publication of the 4 Participatory Regional Health Plans Summaries	Cancelled. Not required at this stage
2.11.6	Publication of the systematization of the Citizen Consultation	Completed.
2.11.7	Publication of 4 reports of Regional Health Accounts	Completed.(Web page)
2.11.8	Publication of comparative report of Regional Health Accounts	Completed. (Web page)
2.11.9	Publication of methodological guidelines of Regional Health Accounts	Completed. (Web page)
2.11.10	Publication of articles in media	Completed.
2.11.11	Publication of informative pages	Completed.
2.11.12-14	Elaboration of guidelines for the communication campaign of PRHP	Reprogrammed to Year 2. In the framework of the approval of the global strategy of PRHP implementation, the Regional Governments reprogrammed these activities to Year 2
2.11.15-17 2.11.18-20 2.11.21-23 2.11.24-26	Workshops for the design of the PRHP communication strategy La Libertad Lambayeque San Martín Ucayali	
2.11.16-17	Workshops for the design communication campaign of the PRHP	
MoH has developed a National Burden of Disease study		
4.1.1	Elaboration of technical report on international experiences of burden of disease studies	Completed.

Activity		Status
New	Technical assistance to MoH for the estimation of DALYs based on updated mortality data. This new activity replaces the activities: 4.1.2; 4.1.5; 4.1.6; 4.1.8; 4.1.9, as the presence of international experts was not needed in this period.	Completed.
4.1.3	Elaboration and coordination with MOH of work plan for the burden of disease study	Completed.
4.1.4	Elaboration and coordination with MOH of research protocol of the burden of disease study	Completed.
4.1.7	Technical assistance for the adjustment of mortality data base	Completed.
4.1.10	Elaboration of the technical report of the burden of disease study	Completed.
Ministry of Finance has implemented the Household Targeting System (SISFOH) as planned		
4.5.1	Elaboration of the technical report of update of the targeting tools to be used by the Household Targeting System (SISFOH)	Completed.
4.5.2	Elaboration of the SISFOH's operational manual	Completed.
4.5.3	Elaboration of the migration plan of SIS information to SISFOH	Cancelled. Due to delays in the implementation of SISFOH by MoF
New	Technical assistance to the Ministry of Finance (MoF) for the design of the Central Targeting Unit	Completed.
MoH has developed information systems for health service management improvement		
4.6.1	Publication of GalenHos Manuals	Completed. (Web page)
New	Development of additional features of GalenHos and institutionalization in MoH	Completed.
4.6.3	Elaboration of the technical report of the strategy for the extension of GalenHos	Completed.
4.6.4	Publication of SEEUS Manuals	Completed. (Web page)
4.6.5	Elaboration of the technical report of the strategy for the extension of SEEUS	Ongoing.
New	Validation of SEEUS and institutionalization in MoH	Completed
New	4 courses of SEEUS	Completed.
4.6.6	Monitoring of the implementation of the Hospital Information System (GalenHos) in the Belen Hospital (Trujillo)	Completed.
4.6.7 New New	SEEUS training and implementation workshops La Libertad Lambayeque San Martín	Completed.

Annex B: Meetings with Regional Political Parties

Members of the Promoter Group	Participant Political Parties	Topics covered
La Libertad		
1. Consejo Regional del Colegio Médico del Perú 2. Universidad Nacional de Trujillo 3. Consejo Regional de Salud	1. Acción Popular 2. Alianza Electoral Juntos por La Libertad 3. Alianza Para el Progreso 4. Fuerza Democrática 5. Movimiento Capacidad Ciudadana 6. Movimiento Nueva Izquierda 7. Movimiento Sí Cumple 8. Movimiento Súmate 9. Partido Aprista Peruano 10. Partido Cambio 90 11. Partido Humanista Peruano 12. Partido Nacionalista Peruano 13. Partido Popular Cristiano 14. Partido por la Democracia Social 15. Partido Renovación 16. Partido Socialista 17. Perú Posible 18. Partido Restauración Nacional 19. Unión Por el Perú 20. Solidaridad Nacional	1. Participatory Regional Health Plan (July 12th & August 9th). 2. Health and Education Decentralization (August 23rd). 3. Decentralization and Participatory Regional Health Plan Workshop (September 6th). 4. Health Financing and Health Insurance (September 13th). 5. Integrated Social Policy (September 22nd). 6. Integral Health Management Model (September 27th) 7. Citizen Participation, Transparency and Anticorruption (October 4th). 8. Presentation by the Political Parties (October 11th)
Lambayeque		
1. Consejo Regional del Colegio Médico 2. Universidad Pedro Ruiz Gallo 3. Cámara de Comercio	1. Partido Aprista Peruano 2. Acción Popular 3. Partido Justicia Nacional 4. Alianza para el Progreso 5. Sí Cumple 6. Partido Popular Cristiano 7. Unidad Nacional 8. Perú Posible 9. Unión por el Perú 10. Restauración Nacional 11. Partido Nacionalista del Perú 12. Justicia Nacional 13. Movimiento Regional de las Manos Limpias 14. Partido Humanista Peruano 15. Movimiento Regional Político ASI 16. Siempre Adelante	1. Participatory Regional Health Plan (June 20th) 2. National and Regional Education (June 27th) 3. Health and Education decentralization (August 17th) 4. Decentralization and pharmaceuticals (August 29th) 5. Presentation by the Political Parties (September 7th) 6. Integrated Social Policy (September 14th)

Members of the Promoter Group	Participant Political Parties	Topics covered
San Martin		
1. Colegio Médico de San Martín 2. Foro Salud 3. Colegio de Obstetras 4. Colegio de Enfermeras 5. Universidad Nacional de San Martín 6. Colaboradores	1. Nueva Amazonía 2. Alianza Para el Futuro 3. Acción Popular 4. Ideas 5. Restauración Nacional 6. Alianza para el Progreso 7. Somos Perú 8. APRA 9. UPP, PNP	1. Participatory Regional Health Plan (July 24th) 2. Health decentralization (September 5th) 3. Health Financing and National System of Public Investment (September 19th) 4. Child malnutrition (October 3rd) 5. Transparency and Anti corruption (October 17th)
Ucayali		
1. Colegio Médico del Perú (filial Ucayali) 2. Cruz Roja Peruana (filial Ucayali), 3. Foro Salud Ucayali 4. Colegio de Enfermeros del Perú (filial Ucayali) 5. Red Nacional de Promoción de la Mujer	1. Acción Popular 2. Avanza País 3. FREPAP 4. Movimiento Agrario Popular Ucayalino - MAPU 5. Movimiento Balsa – Bases Libres 6. Movimiento Independiente Esfuerzo Unido. 7. Movimiento Nueva Izquierda. 8. Movimiento Político regional “Integrando Ucayali”. 9. Movimiento Si Cumple 10. Partido Aprista Peruano. 11. Partido Nacionalista Peruano. 12. Partido por la Democracia Social 13. Partido Renovación Nacional 14. Partido Restauración Nacional 15. Partido Unidad Nacional 16. Partido Unión por el Perú. 17. Perú Posible	1. Participatory Regional Health Plan (July 4th) 2. Regional Health Priorities (July 19th) 3. Decentralization and health decentralization (August 11th) 4. Workshop on Health Decentralization (August 25th) 5. Citizen Participation, Transparency and Anti corruption (September 8th) 6. Health Financing and Insurance (September 15th) 7. Articulation of national and regional education policies (September 22nd) 8. Integrated Social Policy (September 29th) 9. Sexual and Reproductive Health Policies (October 6th)

Annex C: Northern Macro Region Executive Meetings

Executive Meeting	Participants	Agenda
IX Executive Meeting January 13th & 14th - Lima	Members: • RHD and RDD Lambayeque • RHD and RDD La Libertad • RHD and RDD San Martin • RHD Tumbes • RHD Piura • RHD Cajamarca • RHD Amazonas • RHD Loreto • RHD Ucayali Other participants: 1. RHD y RDD Huancavelica 2. MoH (DGSP) 3. Vigía Project 4. PAMAFRO Project	1. Assessment of the Northern Macro Region (NMR), definition of priorities and 2006 agenda 2. The decentralization process 3. Pharmaceuticals and Free Trade Agreement 4. Program of Malaria Control of the Andean Community
X Executive Meeting February 17th and 18th - Tarapoto	Members: • RHD Lambayeque • RHD La Libertad • RHD and RDD San Martín • RHD Piura • RHD Cajamarca • RHD Amazonas • RHD Loreto Other participants: • MoH (DGSP) • Vigía Project	1. NMR "Reglamento" 2. The decentralization process 3. Plan of Prevention and Control of Metaxenic Diseases
XI Executive Meeting May 5th and 6th – Tumbes	Members: • RHD Lambayeque • RHD and RDD La Libertad • RHD San Martín • RHD and RDD Tumbes • RHD Piura • RHD Amazonas • RHD Loreto • RHD and RDD Ucayali Other participants: 1. Selected Northern Local Governments 2. MIMDES 3. PRODES	1. Approval of the NMR "Reglamento" 2. The decentralization process: 2006 Annual Transfer Plan 3. Plan of Prevention and Control of Metaxenic Diseases

Executive Meeting	Participants	Agenda
XII Executive Meeting July 14th and 15th - Chiclayo	Members: • RHD and RDD Lambayeque • RHD La Libertad • RHD San Martín • RHD Cajamarca • RHD Piura • RHD Amazonas • RHD Loreto • RHD de Ucayali Other participants: • MoH (DGSP) • Vigía Project	1. Plan of Prevention and Control of Metaxenic Diseases 2. The decentralization process: revision of the 2006 accreditation criteria 3. Participatory Health Planning 4. Health service users satisfaction monitoring and evaluation
Extraordinary Meeting: September 6th - Lima	Members: • RHD Lambayeque • RHD La Libertad • RHD San Martín • RHD Tumbes • RHD Piura • RHD Amazonas • RHD Loreto • RHD Ucayali Other participants: • RHD Ancash • MoH (DGSP) • MoH (Decentralization Office)	1. Increase in the supply of health services in the Northern Macro Region 2. Decentralization guidelines of the new government 3. Nacional Vaccination Campaign

Annex D: Action Plans of the Participatory Regional Health Plans

La Libertad: Resumen del plan de corto plazo 2006-2007 del Plan Participativo Regional de Salud	
Fortalecimiento de la capacidad resolutiva de las microrredes de servicios de salud (infraestructura, recursos humanos, equipamiento y organización), con énfasis en atención integral del niño, la gestante, planificación familiar	
Diseño y aprobación de plan de fortalecimiento de la cadena de frío	2006
95% de menores de 2 años con esquema completo de vacunación en zonas priorizadas	2007
Definición oficial de protocolos, estándares e indicadores para la atención integral de salud: materna, niño(a) y adolescentes, y violencia intrafamiliar (Lista de chequeo)	2006
20% de microrredes de salud en las zonas priorizadas que cumplen con estándares de atención integral de salud: materna, niño(a) y adolescentes, y violencia intrafamiliar	2007
Definición de la cartera de servicios de hospitales y redes de servicios de salud en función de sus niveles de atención.	2006
3 hospitales de la región con mejora de la capacidad resolutiva según necesidades y perfil epidemiológico (Otuzco, Huamachuco, Santiago de Chuco)	2007
Diseño y ejecución de plan de monitoreo del cumplimiento de las normas en las buenas prácticas de almacenamiento	2006
90% de EESS cuentan con un stock regular de medicamentos e insumos esenciales con énfasis en las prioridades regionales (especialmente los de las zonas priorizadas)	2007
Diseño, y aprobación de plan de medición de la satisfacción de usuarios en los EESS	2006
Diseño y aprobación de la directiva para la implementación de mecanismos de escucha al usuarios	2006
40% de EESS de las zonas priorizadas con procesos de gestión de la calidad implementados	2007
70% de usuarios satisfechos en EESS que tienen procesos de gestión de la calidad implementados	2007
Programa de capacitación permanente a proveedores del primer nivel en atención de salud sexual y reproductiva diseñado y aprobado	2007
Fortalecimiento de trabajo extramuros de las microrredes de servicios de salud para la atención integral para las familias en riesgo	
50% de los establecimientos de salud de Sanagoran, Marcabal, Sartinbamba, Chugay, Cochorco, Sarín, Huayo, Chillia, Huaso y Santa Cruz de Chuca tienen sectorizada a su población adscrita, identificadas a las familias de riesgo y realizan visitas selectivas	2007
Diseño, aprobación y difusión de guías regionales para la vigilancia familiar de las prioridades sanitarias	2006
100% de seguimiento para casos de neumonía	2007
100% de seguimiento de casos de EDAs con deshidratación	2007
70% de viviendas en distritos con mayor prevalencia de neumonías son intervenidas para identificar y controlar factores de riesgo	2007
5% de reducción de embarazos en adolescentes	2007
Diseño y ejecución de plan de implementación piloto de cocinas saludables en el ámbito de una microrred	2006
10% de cocinas saludables implementadas en zonas priorizadas en el area rural para mejorar la calidad del aire domestico	2007
Promoción de la salud para introducir comportamientos saludables en la población asociados a las prioridades sanitarias	
4 campañas de comunicación realizadas y evaluadas	2007
Programa de capacitación y asistencia técnica para los docentes en la aplicación en los contenidos del currículo escolar referido a las prioridades sanitarias	2006
50% de los docentes de las escuelas de Sanagoran, Marcabal, Sartinbamba, Chugay, Cochorco, Sarín, Huayo, Chillia, Huaso y Santa Cruz de Chuca reciben capacitación y asistencia técnica en la aplicación en los contenidos del curriculo escolar referido a las prioridades sanitarias	2007
Dotación de agua potable y servicios de saneamiento básico en zonas prioritarias donde hay mayor deficit de servicio	
Elaboración y aprobación de Plan Integral de la Supervisión de la Calidad de los Alimentos	2006
20% de lugares de expendio de alimentos en zonas priorizadas cuentan con un adecuado control y vigilancia sanitaria	2007
Elaboración y aprobación de Plan Maestro concertado (gobierno regional, gobiernos locales y JASS) de desarrollo de infraestructura de agua y saneamiento	2006
75% de la población urbana consumen agua apta para el consumo humano en las zonas priorizadas	2007

La Libertad: Resumen del plan de corto plazo 2006-2007 del Plan Participativo Regional de Salud	
50% de la población rural consumen agua apta para el consumo humano en las zonas priorizadas	2007
45% de la población cuenta con infraestructura de saneamiento adecuados en las zonas priorizadas	2007
20% de instituciones de la CAR incorporan en sus planes institucionales las actividades formuladas y propuestas por el PPR	2007
Fortalecimiento de las iniciativas para la seguridad ciudadana	
Diseño, aprobación y difusión de plan y normatividad concertados para la intervención interinstitucional de la violencia intrafamiliar	2006
Centro piloto de servicio de atención integral de familias víctimas de VIF en funcionamiento	2007
20% de victimas registradas de VIF ha sido atendido en el Sistema de Atención Interinstitucional	2007
Estudio de victimización	2007
10% de gobiernos locales han iniciado la implementación de Plan Maestro de Seguridad Ciudadana	2007
Fortalecimiento de la capacidad del gobierno regional y de los gobiernos locales para la conducción, implementación y seguimiento del PPR	
Diseño y aprobación del proceso participativo de evaluación del PPR	2006
Ejecución de 1ra Evaluación Participativa del PPR	2007
Formulación de Plan Integral de Inversiones en salud (capacidad resolutiva) concordado con el PPR Salud	2006
95% de ejecución de presupuesto asignado para inversiones	2007
Arreglos financieros para abordar las prioridades regionales	
Negociación con MEF (Presupuesto Público) para la flexibilización del uso de RdR	2006
30% de incremento de los recursos ordinarios orientados a gastos corrientes asignado al sector salud en las zonas priorizadas y destinados a actividades del PPR	2007
Negociación de gerentes de red con 30% de Gobiernos Locales para incorporar en su plan de desarrollo local 2007 acciones de salud concordantes con el PPR	2006
Negociación de gerentes de red con 50% de Gobiernos Locales para incorporar en su plan de desarrollo local 2008 acciones de salud concordantes con el PPR	2007
30% de gobiernos provinciales considera en sus planes de desarrollo local acciones en salud en concordancia con el PPR y Plan Integral de Inversiones para Capacidad Resolutiva en Salud	2007
Negociación de gerentes de microrred con 10% de Gobiernos Locales para incorporar en su plan de desarrollo local 2007 acciones de salud concordantes con el PPR	2006
Negociación de gerentes de microrred con 25% de Gobiernos Locales para incorporar en su plan de desarrollo local 2008 acciones de salud concordantes con el PPR	2007
10% de gobiernos distritales considera en sus planes de desarrollo local acciones en salud en concordancia con el PPR y Plan Integral de Inversiones para Capacidad Resolutiva en Salud	2007
Diseño y ejecución de plan de entrenamiento del personal encargado de la afiliación para el cumplimiento de los procedimientos SIS	2006
75% de cobertura de afiliación de la población priorizada por los Planes A y C en distritos pobres	2007
Diseño, aprobación y ejecución de plan de entrenamiento del personal en el cumplimiento de los estándares SIS para el reembolso de prestaciones	2006
50% de rechazo de prestaciones SIS respecto del basal	2007
Negociación con la Unidad Central de Focalización (MEF) para la inclusión de la ciudad de Trujillo en el padrón SISFOH (zonas urbanas)	2006
50% de subsidios asignados (excluyendo el SIS) cumplen con las políticas regionales establecidas	2007

Lambayeque: Resumen del plan de corto plazo 2006-2007 del Plan Participativo Regional de Salud	
Intervención 1: Incremento de la cobertura de agua potable y saneamiento básico al 35% de viviendas	
71 sistemas de agua nuevos	2007
21 sistemas de agua rehabilitados	2007
20 localidades de la región tienen sistemas de agua y saneamiento (desagüe y letrinas) operativos dando prioridad a los sistemas de agua en los distritos de Kañaris, Inkawasi, Mesones Muro, Chochope y Olmos	2007
Elaboración / actualización del Plan Maestro 2006-2010 de desarrollo de infraestructura de agua y saneamiento	2006
10% de ejecución del Plan Maestro 2006-2010 de Agua y Saneamiento para la zona rural	2007
25% de ejecución del Plan Maestro 2006-2010 de Agua y Saneamiento para la zona urbano marginal	2007
Estudio de costo/beneficio para la implementación de rellenos sanitarios vs usina ejecutado Elaboración y aprobación de PIGARS	2007
Organización de la red tripartita (DIRESA, DIREVI, GL y JASS) de vigilancia y control de calidad de agua	2007
Ejecución de plan de capacitación en detección de problemas de calidad de agua	2007
50% de JASS que vigilan la calidad del agua	2007
Elaboración y aprobación de plan de capacitación a la comunidad en gestión de sistemas de agua y saneamiento	2006
10% de JASS que reciben entrenamiento para la gestión de sistemas de agua y saneamiento	2007
Intervención 2: Fortalecimiento de la capacidad resolutiva (infraestructura, recursos humanos, equipamiento y organización) de los servicios de salud, con énfasis en desnutrición, salud mental y salud materna	
Elaboración y aprobación de proyecto de inversión para fortalecer la capacidad resolutiva de CS y PS estratégicos para la atención obstétrica-perinatal y del menor de cinco años.	2006
4 microrredes y 2 centros referenciales (Salas, Kañaris e Inkahuasi) para atención materna e infantil implementados y organizados realizan atención obstétrica-perinatal, de planificación familiar, de adolescentes e infantil, con niveles óptimos de calidad y cobertura en su población	2007
Elaboración y aprobación de proyecto de inversión para fortalecer la capacidad resolutiva de los centros de salud y puestos estratégicos para la atención de salud mental.	2006
4 microrredes prioritarias (Salas, Kañaris e Inkahuasi) y 3 microrredes de zonas urbanas (San Antonio, La Victoria y José Leonardo Ortiz) para salud mental implementadas y organizadas realizan atención de salud mental de calidad	2007
Elaboración y aprobación de proyecto de inversión para fortalecer la capacidad resolutiva de establecimientos de complejidad intermedia para la atención obstétrica-perinatal, del menor de cinco años y de salud mental.	2006
1 centro referencial (I-4) de Ferreñafe cuenta con capacidad resolutiva para la atención obstétrica-perinatal, del menor de cinco años y de salud mental.	2007
10% de establecimientos públicos miden el nivel de insatisfacción con el servicio de salud que reciben	2007
10% de establecimientos privados y públicos aplican recomendaciones para mejorar su calidad de atención obstétrica	2007
Intervención 3: Organización de la atención integral para las familias en riesgo mediante sectorización del ámbito poblacional en microrredes de salud prioritarias	
Sectorización geográfica del ámbito de las microrred prioritarias (basado en el mapa de pobreza distrital) y asignación de los sectores priorizados al personal de cada EESS	2006
Las microrredes de Inkahuasi (Uyurpampa y Moyán), Salas y Kañaris implementadas, sectorizadas y organizadas realizan intervenciones bajo el modelo de atención integral a familias en alto riesgo para la atención materna e infantil	2007
50% de instituciones educativas de las 6 micorredes prioritarias son salubres y desarrollan los ejes temáticos en nutrición salud mental, SS/SR, hábitos de higiene y en el cuidado de los sistemas de aguas	2007
20% de población meta informada sobre aspectos de salud sexual y reproductiva, nutrición, salud mental y hábitos de higiene y uso de agua de zonas prioritarias	2007
Plan de entrenamiento de personal en medidas de adecuación cultural del servicio aprobado	2007
Plan de entrenamiento al personal en el manejo del plan de parto y el "score" de riesgo aprobado	2007
Estándares de calidad definidos y aprobados	2007
Convenio de cooperación técnica con las universidades de Lambayeque y Lima para el desarrollo de protocolos	2007
1 protocolo de atención elaborado, aprobado e implementado	2007
4 CLAS de las zonas prioritarias (Salas, Kañaris e Inkahuasi) cumplen metas consideradas en PSL sobre desnutrición, salud mental, materna e infantil	2007

Lambayeque: Resumen del plan de corto plazo 2006-2007 del Plan Participativo Regional de Salud	
Intervención 4: Formulación e implementación de un programa multi-institucional de seguridad ciudadana en zonas urbanas de riesgo	
Diagnóstico de base de salud mental del Plan Maestro de seguridad ciudadana en ocho localidades urbanas (En base a estudio de victimización)	2007
Sistema de vigilancia epidemiológica implementado y estandarizado en una zona piloto	2007
Intervención 5: Arreglos financieros para abordar las prioridades regionales	
Definición de las prestaciones que serán agregadas al plan de beneficios del SIS	2007
67 % de la población beneficiaria del Plan A y 85 % de la población beneficiaria del Plan C del SIS hacen uso de sus beneficios	2007
Propuesta técnica de reasignación intra regional de fondos aprobada (incluye redistribución de RRHH)	2007
30% de sub cobertura y filtración a programas de soporte alimentario	2007
80% de las exoneraciones los dos hospitales y el 100% de establecimientos de dos micro redes de la ciudad de Chiclayo aplican tarifas escalonadas establecidas por la DIRESA	2007
20% de proyectos de inversión en saneamiento del periodo 2006-2010 que cuentan con financiamiento asegurado y en ejecución	2007
Intervención 6: Fortalecimiento de la capacidad del gobierno regional y de los gobiernos locales para la formulación, evaluación y gestión de proyectos de inversión	
60% de perfiles PPR presentados obtienen su aprobación por el SNIP	2007

Ucayali: Resumen del plan de corto plazo 2006-2007 del Plan Participativo Regional de Salud	
Intervención 1: Dotación de agua potable y servicios de saneamiento básico en zonas prioritarias donde hay mayor déficit de servicio	
Plan Maestro de desarrollo de infraestructura de agua y saneamiento formulado y aprobado	2006
Negociación con los GL para la ejecución del plan maestro realizada	2006
10% de la población rural y 40% de la población urbana accede a servicios de agua y desagüe de acuerdo con la tecnología diferenciada	2007
Plan de mejora de la gestión de EMAPACOPSA elaborado por el GL de Coronel Portillo, con participación del GR y la sociedad civil	2007
Red tripartita (GR-GL-JASS) de vigilancia de calidad de agua organizada	2006
10% de los JASS rurales y urbano marginales garantizan el abastecimiento y calidad de agua que proveen a sus usuarios.	2007
Intervención 2: Fortalecimiento de la capacidad resolutiva (infraestructura, recursos humanos, capacidades, equipamiento, organización y procesos/sistemas de gestión) de los servicios de salud, con énfasis en desnutrición, infecciones respiratorias agudas, ITS y VIH-SIDA y el acceso a medicamentos e insumos sanitarios	
Proyecto de inversión para fortalecer la capacidad resolutiva de los centros de salud y puestos estratégicos para la atención integral del menor de 5 años elaborado	2006
Delimitación de microrredes aprobada	2006
Servicios con enfoque de inter culturalidad según la normatividad del MINSA readecuados	2006
3 microrredes (Atalaya, Bolognesi y Sepahua) cuentan con infraestructura adecuada, equipamiento básico y RRHH con competencias para la atención integral del menor de cinco años, en todos sus centros de salud y sus puestos de salud estratégicos	2007
100% de centros de salud de Callería, Aguaytía y Yarinacocha cuenta con ambientes acondicionados y personal entrenado para el manejo sindrómico de las ITS	2007
Proyecto de inversión para el fortalecimiento de hospitales seleccionados, aprobado	2007
DIREMID cuenta el número de químico farmacéuticos requerido	2007
25% de sedes de Red y Micro Red cuentan con químico farmacéutico	2007
Plan de fortalecimiento del laboratorio referencial y de los establecimientos centinelas para famaco vigilancia, aprobado	2007
Laboratorio Referencial cuenta con la capacidad resolutiva para los análisis para enfrentar las prioridades regionales (ITS-VIH/Sida, neumonía, TBC, malnutrición)	2007
Proyecto de inversión para el fortalecimiento de la red regional de bancos de sangre, aprobado	2007
Intervención 3: Organización de la atención integral para las familias en riesgo mediante sectorización del ámbito poblacional en microredes de salud prioritarias	
Plan de capacitación en AIEPI Comunitario en Micro Redes, aprobado	2006
80% de los agentes comunitarios de salud de Sepahua, Tahuanía, Raymondi (Atalaya), Masisea, Iparía, Yuruá son seleccionados y entrenados en el AIEPI Comunitario	2007
50% de los establecimientos de salud EESS de Masisea, Iparía, Tahuanía, Raymondi, Sepahua y Yurua se encuentran implementados, con su ámbito sectorizado y su personal organizado para realizar intervenciones bajo el modelo de atención integral a familias en alto riesgo	2007
Mapeo de población objetivo HSH y TS formulado	2006
Establecimientos de entretenimiento y comercio sexual identificados	2006
25% de población objetivo HSH y TS que recibe condones en forma gratuita y regular	2007
25% de establecimientos de entretenimiento y comercio sexual que cuentan con dispensadores de condones gratuitos	2007
60% de los pacientes menores de 5 años con neumonía que acudieron a los EESS de Sepahua, Tahuanía, Raymondi (Atalaya), Masisea, Iparía, Yuruá ha culminado el tratamiento	2007
50% de pacientes con ITS (no VIH/SIDA) que acudieron a los EESS de Callería, Yarinacocha y Aguaytía ha culminado el tratamiento	
Intervención 4: Organización de la atención integral para las familias en riesgo mediante sectorización del ámbito poblacional en microrredes de salud prioritarias	
95% de niños menores de 2 años de Sepahua, Tahuanía, Raymondi (Atalaya), Masisea, Iparía, Yuruá tienen cobertura de inmunizaciones completas	2007
50% de los niños entre 1 y 15 años y gestantes (2do y 3er trimestre de gestación) de Sepahua, Tahuanía, Raymondi (Atalaya), Masisea, Iparía, Yuruá reciben el tratamiento antiparasitario	2007

Ucayali: Resumen del plan de corto plazo 2006-2007 del Plan Participativo Regional de Salud	
30% de los niños menores de 3 años y las gestantes de Sepahua, Tahuanía, Raymondi (Atalaya), Masisea, Iparía, Yuruá reciben atención nutricional integral: evaluación nutricional periódica, suplementación de hierro, vitamina A (excepto en gestantes), ácido fólico y zinc	2007
60% de los establecimientos de primer nivel Sepahua, Tahuanía, Raymondi (Atalaya), Masisea, Iparía, Yuruá realizan seguimiento longitudinal de niños menores de 3 años	2007
50% de establecimientos de salud de Sepahua, Tahuanía, Raymondi (Atalaya), Masisea, Iparía, Yuruá abastecidos con medicamentos trazadores e insumos suficientes en cantidad y calidad	2007
Intervención 5: Arreglos financieros para abordar las prioridades regionales	
La DIRESA y las Unidades Ejecutoras del Hospital Regional de Pucallpa y el Hospital de Yarinacocha garantizan los recursos oportunamente para el abastecimiento de medicamentos trazadores y el paquete para el tratamiento de ITS para el 50% de los EESS de Callería, Yarinacocha y Aguaytía	2007
La DIRESA y la Unidad Ejecutora de Atalaya garantizan los recursos oportunamente para el abastecimiento de medicamentos trazadores, suplementos de hierro, vitamina A, acido fólico, zinc, el paquete antiparasitario, para el tratamiento de ITS e insumos para actividades extramurales para el 50% de los EESS de Sepahua, Tahuanía, Raymondi (Atalaya), Masisea, Iparía y Yuruá	2007
Zona Rural: 65% de la población menor de 5 años y gestantes de Sepahua, Tahuanía, Raymondi (Atalaya), Masisea, Iparía, Yuruá está afiliada al SIS y accede a los servicios cuando lo requiere	2007
Zona Urbana: 65% de la población menor de 5 años y gestantes clasificadas como pobres de Callería, Yarinacocha y Padre Abad (Aguaytía) está afiliada al SIS y accede a los servicios cuando lo requiere	2007
Las microrredes de Sepahua, Tahuanía, Raymondi (Atalaya), Masisea, Iparía, Yuruá, Callería, Yarinacocha y Padre Abad (Aguaytía) firman Acuerdos de Gestión sobre las prioridades regionales de salud	2007
Intervención 6: Fortalecimiento de la capacidad del Gobierno Regional y de los gobiernos locales para la formulación, gestión y evaluación de proyectos de inversión	
90% de los perfiles de proyectos de inversión PPR presentados serán aprobados por el SNIP	2007
Intervención 7: Intervenciones intersectoriales	
10% de las instituciones clave miembros de la CAR que incorporan en sus planes institucionales actividades formuladas y acordadas en la agenda regional	2007

Annex E: Investment profiles of the Participatory Regional Health Plans

Region	Province	Health Network	Hospital	District Health Micro Network (MN)	WATER & SANITATION	OTHER
La Libertad	Julcán			MN Huaso		
	Otuzco	Otuzco	Berovides Hospital			
	Pataz			MN Pataz Norte		
	Sanchez Carrión	Sanchez Carrión	Leoncio Prado Hospital	MN Aricapampa	Marcabal	
				MN Markahuamachuco	Sarín	
				MN Pallar		
				MN Curgos		
	Santiago de Chuco	Santiago de Chuco	Cesar Vallejo Hospital	MN Cachicadán		
	Trujillo					Medicine supply system
Lambayeque	Ferreñafe			MN Cañaris	Cañaris	
				MN Uyurpampa		
				MN Moyán		
				Ferreñafe referencial health center		
	Lambayeque			MN Salas		
				Motupe referencial health center		
	Highland districts				Water & sanitation program (1/)	
Ucayali	Atalaya			MN Atalaya		
				MN Bolognesi		
				MN Sepahua		
				Obenteni health centers (2/)		
	All provinces					Medicine supply system
	Pucallpa					Investment management

1/ A program is an investment profile of several communities that share common characteristics

2/ Obenteni is a regional border zone within MN Atalaya jurisdiction, but is geographically separated. This project requires special activities such as intercultural adecuation and approach of the services to the population

Annex F: Public Institutions trained in SEEUS

	Institution	Region
1	DISA II - Lima Sur	Lima
2	DRS - SJM - VMT - DISA II	Lima
3	Red Baranco - DISA II	Lima
4	Centro de Salud 7 de Octubre - DISA IV	Lima
5	Hospital Huaycan	Lima
6	Dirección de Salud IV Lima Este	Lima
7	DISA V - Lima Ciudad	Lima
8	Hospital Sergio Bernales	Lima
9	Hospital Hermilio Valdizán	Lima
10	Hospital de Emergencias José Casimiro Ulloa	Lima
11	Hospital Nacional Daniel Alcides Carrión	Lima
12	Hospital María Auxiliadora	Lima
13	Hospital Víctor Ramos Guardía - Huaraz	Ancash
14	Hospital Barranca Cajatambo	Lima
15	Hospital María Auxiliadora	Lima
16	Hospital Nacional "Hipolito Unanue"	Lima
17	Hospital Nacional Docente San Bartolome	Lima
18	Hospital Santa Rosa	Lima
19	Hospital Nacional Arzobispo Loayza	Lima
20	Hospital Nacional "Dos de Mayo"	Lima
21	Instituto Nacional de Oftalmología	Lima
22	Hospital de Emergencias Pediatricas	Lima
23	Hospital General de Huacho	Lima
24	Hospital Rezola de Cañete	Lima
25	Dirección de Salud I Callao	Lima
26	Instituto Nacional de Enfermedades Neoplasicas	Lima
27	Instituo Nacional de Rehabilitación	Lima
28	Instituo Nacional de Ciencias Neurologicas	Lima
29	Instituto Nacional Materno Perinatal	Lima
30	Insituto Nacional de Salud del Niño	Lima
31	Hospital Nacional Cayetano Heredia	Lima
32	Hospital de Puente Piedra	Lima
33	Direccion Regional de Salud La Libertad	La Libertad
34	Hospital Belen	La Libertad
35	Hospital Regional	La Libertad
36	Dirección Regional de Salud Lambayeque	Lambayeque
37	Hospital Belén Lambayeque	Lambayeque
38	Hospital Regional de Lambayeque	Lambayeque
39	Red Chiclayo	Lambayeque
40	Red Ferreñafe	Lambayeque
41	Red Lambayeque	Lambayeque

	Institution	Region
42	CLAS El Bosque	Lambayeque
43	CLAS Colaya	Lambayeque
44	CLAS Posope Alto	Lambayeque
45	CLAS Lagunas	Lambayeque
46	CLAS Salud y Vida	Lambayeque
47	CLAS Atusparia	Lambayeque
48	CLAS Pubelos Unidos	Lambayeque
49	CLAS Olmos	Lambayeque
50	CLAS Tumi	Lambayeque
51	C.S Oyotún	Lambayeque
52	C.S. Puebl Nuevo	Lambayeque
53	C.S Chongoyape	Lambayeque
54	P.S. Colaya	Lambayeque
55	C.S Pimentel	Lambayeque
56	C.S San José	Lambayeque
57	P.S. Moyán	Lambayeque
58	C.S Illimo	Lambayeque
59	C.S. Pítipo	Lambayeque
60	C.S Picsi	Lambayeque
61	C.S Salas	Lambayeque
62	C.S. Olmos	Lambayeque
63	C.S. Atusparia	Lambayeque
64	C.S. Jorge Chavez	Lambayeque
65	C.S. Mórrope	Lambayeque
66	Hopital Regional Bellavista	San Martin
67	Red Moyobamba	San Martin
68	Red Picota	San Martin
69	Red Saneamiento	San Martin
70	Red Bellavista	San Martin
71	Red Mariscal Cáceres	San Martin
72	Red Huallaga	San Martin
73	Red Tocache	San Martin
74	Red El Dorado	San Martin
75	Red Rioja	San Martin
76	Red Moyobamba	San Martin
77	Red San Martín	San Martin
78	Red Lamas	San Martin
79	C.S. Morales	San Martin
80	C.M.P. Tarapoto	San Martin
81	C.S SAC	San Martin
82	C.S. 09 de Abril	San Martin
83	C.S Morales	San Martin
84	C.S Sauce	San Martin
85	C.M.P. Tarapoto	San Martin
86	Hospital Regional de Huamanga	Ayacucho

Annex G: Travel by staff members

Destination	Date	Staff member
La Libertad	December 2005	
	1 /12 /05	Midori de Habich, Oscar Ugarte, Ada Pastor
	6 / 12 / 05	Miguel Madueño
	January 2006	
	19/ 1 / 06	Ada Pastor
	22/ 1 / 06	Arturo Granados, Oscar Bueno
	March 2006	
	1 / 03/ 06	Midori de Habich
	3 / 3 / 06	Oscar Bueno
	15/ 3 / 06	Arturo Granados
	20/ 3 / 06	Giovann Alarcon
	20/ 3 / 06	Miguel Madueño
	22/ 3 / 06	Javier Linares
	27/ 3 / 06	Midori de Habich, Arturo Granados
	29/ 3 / 06	Arturo Granados
	April 2006	
	02/ 4 / 06	Carlos Bardales
	20/ 4 / 06	Arturo Granados, Oscar Bueno
	27/ 4 / 06	Oscar Ugarte
	May 2006	
	10/ 5 / 06	Giovann Alarcón
	June 2006	
	19/ 6 / 06	Oscar Ugarte
	July 2006	
	11/ 7 / 06	Giovann Alarcón
	12/ 7 / 06	Oscar Ugarte
	13/ 7 / 06	Javier Linares
	August 2006	
	9 / 8 / 06	Oscar Ugarte
	21/ 8 / 06	Miguel Madueño, Ada Pastor
	22/ 8 / 06	Oscar Ugarte
	September 2006	
	5 / 9 / 06	Oscar Ugarte
	11/ 9 / 06	Carlos Bardales
Lambayeque	November 2005	
	5 / 11 / 05	Ada Pastor
	21/ 11 / 05	Midori de Habich, Arturo Granados
	January 2006	
	24/ 1 / 06	Carlos Bardales
	February 2006	
	27/ 2 / 06	Carlos Bardales
	March 2006	
	6 / 3 / 06	Alfredo Sobrerilla, Arturo Granados, Javier Linares, Giovann Alarcón
	17/ 3 / 06	Alfredo Sobrevilla, Javier Linares
	30/ 3 / 06	Raúl Molina
	April 2006	
	4 / 4 / 06	Giovann Alarcón

Destination	Date	Staff member
	May 2006	
	18/ 5 / 06	Arturo Granados
	June 2006	
	8 / 6 / 06	Oscar Ugarte
	20/ 6 / 06	Ada Pastor
	20/ 6/ 06	Oscar Ugarte, Arturo Granados, Ada Pastor
	July 2006	
	4 / 7 / 06	Arturo Granados
	5 / 7 / 06	Miguel Madueño
	12/ 7 / 06	Oscar Ugarte, Arturo Granados
	August 2006	
	4 / 8 / 06	Oscar Ugarte, Arturo Granados
	17/ 8 / 06	Oscar Ugarte
	29/ 8 / 06	Oscar Ugarte
	September 2006	
	7 / 9 / 06	Carlos Bardales
	7 / 9 /06	Miguel Madueño
	18/ 9 / 06	Miguel Madueño, Ada Pastor
San Martín	February 2006	
	16/ 2 / 06	Carlos Bardales, Arturo Granados, Raúl Molina, Ada Pastor
	March 2006	
	7 / 3 / 06	Carlos Bardales; Aníbal Velásquez
	26/ 3 / 06	Aníbal Velásquez
	July 2006	
	24/ 7 / 06	Oscar Ugarte , Jaime Díaz
	September 2006	
	4/ 9 / 06	Oscar Ugarte
	18/ 9 / 06	Oscar Ugarte, Giovann Alarcón
Ucayali	November 2005	
	24/ 11 / 05	Midori de Habich, Arturo Granados
	January 2006	
	30/ 1 / 06	Giovann Alarcón
	February 2006	
	8 / 2 / 06	Alfredo Sobrevilla, Giovann Alarcón, Arturo Granados
	March 2006	
	22/ 3 / 06	Carlos Bardales, Giovann Alarcón
	May 2006	
	25/ 5 / 06	Arturo Granados, Oscar Ugarte
	26/ 5 / 06	Arturo Granados
	29/ 5 / 06	Arturo Granados, Jaime Díaz
	June 2006	
	14/ 6 / 06	Oscar Ugarte, Jaime Díaz
	15/ 6 / 06	Arturo Granados
	July 2006	
	3 / 7 / 06	Oscar Ugarte
	4 / 7 / 06	Giovann Alarcón
	18/ 7 / 06	Oscar Ugarte
	August 2006	
	10/ 8 / 06	Oscar Ugarte
	24/ 8 / 06	Oscar Ugarte
	May 2006	
Tumbes	4 / 5 / 06	Carlos Bardales, Arturo Granados, Aníbal Velásquez, Oscar Ugarte
	Mayo 2006	
Washington	29/ 5 / 06	Midori de Habich Giovann Alarcón
Ohio	Septiembre 2006	
	14/ 9 / 06	Arturo Granados

Annex H: Short Term Consultants

	Short Term Consultant	Tepic	CLIN
1.	Jorge Alania	Dissemination of projects activities and products through web page, electronic bulletin and informative pages.	Main Operations
2.	Roberto Vera	Maintenance of the Peru site office server and network	Main Operations
3.	Iván Mendoza	Systematization of the consensus building process which led to the "Political Parties Agreement in Health"	CLIN 1
4.	Raúl Molina	Review of decentralization technical reports	CLIN 2
5.	Hugo Rodríguez	Development of APTO software	CLIN 2
6.	Miguel Ángel Vargas	Development of ACRES software	CLIN 2
7.	Oscar Cosavalente	Technical assistance to the formulation of operational plans and resource allocation linked to PRHP in La Libertad and Lambayeque.	CLIN 2
8.	Alejandro Bernaola	Investment profile templates	CLIN 2
9.	Eugenio Narváez	Investment profile templates	CLIN 2
10.	Francisco De la Cruz	DALY estimation for the Burden of Disease Study	CLIN 4
11.	Marco Bardales	Adjustment of mortality database 2004	CLIN 4
12.	Alfredo Sarmiento	Recommendations for operational design of SISFOH	CLIN 4
13.	William Castro	Development of GalenHos software	CLIN 4
14.	José Revoredo	Training in GalenHos and SEEUS	CLIN 4
15.	Osvaldo Artaza	Health insurance and decentralization presentations	CLIN 2 and CLIN 4