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PARTNERING FOR PROGRESS: A HISTORY OF
COLLABORATION IN HEALTH WITH

PERU





COVER PHOTO:
A woman with her child in a remote village along the Inca Trail in Peru.
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Support for this report was provided by USAID Peru through the K4Health Project, Cooperative Agreement No. AID-OAA-A-13-00068. The views expressed herein do not necessarily reflect those of the U.S. Agency for International Development or the U.S. Government.

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Partnering for Progress: A History of Collaboration in Health with Peru

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First Edition: August 2015
Print run: 160 copies (English Version)

Printed at: "Tarea Asociación Gráfica Educativa"
Pasaje María Auxiliadora 156, Lima 5, Perú

Hecho el Depósito Legal en la Biblioteca Nacional del Perú N° 2015-11292

ACKNOWLEDGEMENTS

The authors would like to express their gratitude to all the USAID Mission Directors, Health and Education Office Chiefs, and all USAID staff who did important work in Peru for many decades. This report is dedicated to the past Mission Directors and Health Officers of USAID/Peru, including:

Mission Directors

Bob Culbertson (1961-1965)
William Dentzer (1965-1968)
Samuel Eaton (acting interim 1968-1969)
George Greco (acting interim 1970)
Louis Perez (1970-1973)
Donald Finberg (1973-1977)
Leonard Yaeger (1977-1981)
John Sanbrailo (1981-1986)
Donor Lion (1986-1988)
Craig Buck (1988-1993)
George Wachtenheim (1993-1996)
Erik Zallman (1996-1997)
Don Boyd (1997-2002)
Patty Buckles (2002-2004)
Ken Yamashita (acting interim 2004-2005)
Bambi Arellano (2005-2008)
Paul Weisenfeld (2008-2011)
Dick Goughnour (2011-2013)
Deborah Kennedy (2013-2014)
Ted Gehr (acting interim 2014-2015)
Lawrence Rubey (incoming)

Health Officers

Norma Parker (1984-1986)
John Burdick (Population) (1986-1990)
Charles Mantione (Health) (1986-1990)
Heather Goldman (1991-1993)
Paul Cohen (1993-1994)
Susan K. Brems (1994-1999)
Richard Martin (1999-2004)
Susan Thollough (2004-2008)
Erik Janowsky (2008-2011)
Jo Jean Elenes (2011-2015)
Clifford Brown (2015-2016)

Additional thanks...

...to the team who authored, contributed to, and/or enhanced this report:

Betty Margot Alvarado, Michele Aruca, Anne Ballard, Maria Estela Calderon, Stacey Irwin Downey, Maria Rosa Garate, Gabrielle Hunter, Emily Ianacone, Emma Posner, Basil Safi, Katherine Sanchez, Victoria Villanueva, and the MSH/Peru Office staff.

...to those who contributed their keen eyes, thoughtful feedback, and technical expertise:

John Borrazzo, Susan Brems, Jaime Chang, Miriam Choy, Kimberly Cole, Armando Cotrina, Jo Jean Elenes, Elizabeth Fox, Natalia Machuca, Rachel Marcus, Richael O'Hagan, John Sambrailo, Myriam Sarco, Jane Silcock, Susan Thollaug, Merri Weinger, Veronica Valdivieso, Mary Vandenbroucke, and all those who generously gave their time from USAID, beneficiaries and all levels of the Peruvian government to participate in interviews, workshops, or respond to the survey.

Report layout by Erin Dowling Design.

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ACRONYMS

ABC	abstinence, be faithful, and correct and consistent use of condoms
ACT	artemisinin-based combination therapy
APPF	Peruvian Association for Family Protection
APROPO	Population Program Support (<i>Apoyo a Programas de Población</i>)
ARI	acute respiratory infection
ART	antiretroviral therapy
CDC	US Centers for Disease Control and Prevention
CSAP	Child Survival Action Project
DHS	Demographic and Health Survey (<i>Encuesta Demográfica y de Salud Familiar or ENDES</i>)
DIRESA	regional health directorate
DOTS	directly observed therapy, short-course
FETP	Peru's Field Epidemiology Residency Program
FFP	Food for Peace
FP/RH	Family Planning/Reproductive Health
GOP	Government of Peru
HAART	High Activity Anti-Retroviral Treatment
HCM	Healthy Communities and Municipalities project
HPI	Health Policy Initiative
IAB	Andres Barbero Institute (<i>Instituto Andrés Barbero</i>)
INEI	Peru National Institute of Statistics and Informatics
IPSS	Peru's Social Security System (<i>Instituto Peruano de Seguridad Social</i>)
IRI	intermittent rice irrigation
MCPR	modern contraceptive prevalence rate
MDG	Millennium Development Goals
MMR	maternal mortality ratio
MOH	Ministry of Health
MSH	Management Sciences for Health
NFPP	Peru National Family Planning Program
NGO	nongovernmental organization
ORS	oral rehydration salts

ORT	oral rehydration therapy
PAHO	Pan American Health Organization
PAIMNI	Program of Integrated Actions to Improve Child Nutrition
PANFAR	Food and Nutrition Program for High-Risk Families
PHRplus	Partners for Health Reform Plus
PIM	performance improvement methodology
PL 480	Food for Peace program
PRAES	Promoting Alliances and Strategies Project
PROCETSS	AIDS and Sexually Transmitted Infections Control Program (<i>Programa de Control de ETS y SIDA</i>)
PSBT	Program for Basic Health for All (<i>Programa de Salud Básica</i>)
QHC	Quality Healthcare Program
RNPM	National Network for the Promotion of Women
RPM	Rational Pharmaceutical Management
SCISP	InterAmerican Public Health Service Cooperative (<i>Servicio Cooperativo Inter-americano de Salud Pública</i>)
SINEACE	Peru's national autonomous entity for the evaluation, accreditation, and certification of higher education
SIS	Comprehensive Health Insurance Program (<i>Seguro Integral de Salud</i>)
SISMED	Integrated Supply System of Medicines and Medical Supplies
SISMUNI	Community Information System
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USMP	San Martin Porres University (<i>Universidad de San Martin de Porres</i>)
VIGIA	Addressing the Threats of Emerging and Re-emerging Infectious Diseases (<i>Enfrentando a las Amenazas de las Enfermedades, Infecciosas Emergentes y Reemergentes</i>)
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

FOREWORD

by BRIAN A. NICHOLS, U.S. Ambassador to the Republic of Peru



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On behalf of the United States of America, I congratulate the Government of Peru for its hard work, dedication, and sustained excellence in advancing Peru's health systems. More than 70 years ago, the Governments of the United States and Peru embarked on a journey to transform Peru's health system. Together, our two nations have made remarkable strides to improve the health and wellbeing of all Peruvians. I am proud to celebrate the United States Government's efforts to help Peru achieve its landmark health improvements.

U.S. Government support to the Peruvian health sector began as early as 1942 with the establishment of the Servicio Cooperativo Inter-americano de Salud Pública, through which health professionals from both countries built medical dispensaries and hospitals, as well as helped train future health leaders throughout Peru. This strong start set the stage for subsequent health investments by the U.S. Agency for International Development in Peru that began in 1965 and endured through 2015.

From these ambitious beginnings we have collaborated to achieve astonishing results. Child mortality and maternal mortality decreased by 78 percent and 65 percent, respectively, over the past two decades. Today, over 95 percent of all Peruvian children receive life-saving measles vaccinations, up from 58 percent in the early 1990s. Child malnutrition dropped from 38 percent in 1990 to 18 percent in 2010, and 70 percent of all Peruvians now have health insurance. These are not just numbers on a page. They represent significant, positive transformations for millions of Peruvian families.

Despite these achievements, substantial challenges remain. Peruvian government institutions and their partners should expand services to those Peruvians, particularly in rural areas, left behind despite these incredible advances. At the same time, Peru's Ministry of Health should continue to play an important role in global health development by collaborating with other countries to develop policies and interventions for shared health threats and challenges. In doing so, the Ministry will continue to serve as a role model for other countries in Latin America.

Our successes over the past decades reflect an unwavering commitment by both governments to develop and implement health reforms for the good of all Peruvians. The United States Government is proud of our collective achievements in advancing Peru's health system, and we heartily congratulate the Government of Peru on the tremendous progress it has made to improve the health of its citizens. We look forward to partnering in new ways for further advances in the coming years.

A handwritten signature in black ink, appearing to read "Brian".

Brian A. Nichols,
U.S. Ambassador to the Republic of Peru



An infant lies amidst alpaca wool blankets for sale on the Inca Trail.



Executive Summary

Sustainability is achievable when you plan for it by bringing Peruvian institutions on board as partners, putting Peruvians in leadership positions early on, and assisting them to take ownership.



The story of health and development in Peru is a remarkable one. Over the last 50 years, despite many challenges, health outcomes in Peru have improved dramatically. This report tells the story of this success and the long history of close developmental cooperation between the US Government (USG) and the Government of Peru (GOP). Beginning in 1942, this collaboration was based on mutual respect and a shared commitment to improving lives, and set the stage for the growth of Peru's health sector.

In 1961, the US Agency for International Development (USAID) became the lead USG agency in foreign assistance in health programming. In the following decades, Peru made tremendous progress in health in spite of political, social, and economic challenges. Peru also focused on economic growth and poverty reduction, as reflected in overall GDP growth and per capita GDP growth of 787% and about 564%, respectively, between 1990 and 2013.¹ Peru's

economic progress enabled USAID to direct its health efforts toward the areas of greatest financial need and disease burden.

The long-standing collaboration between Peru's Ministry of Health (MOH) and USAID has strengthened the country's public health system in many areas. Such advances are reflected in Peru's progress on many key health indicators over the past few decades. Most importantly, this collaboration has improved child survival and maternal health, increased access to reproductive health services and family planning, improved health service quality, helped prevent HIV/AIDS and other infectious diseases, and enabled critical health sector reforms.

ABOVE: Regional workshop for quality improvement of care for people affected with tuberculosis, Madre de Dios, September 2010.

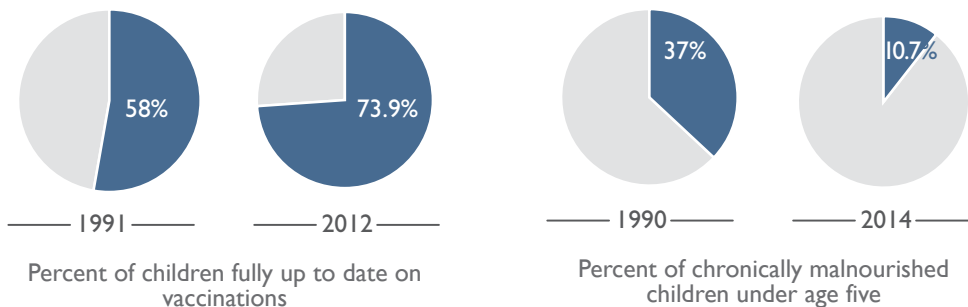
Progress on Key Health Indicators

USAID's evolving partnership with Peru has helped the country achieve impressive advances in health. For example:

- **Peruvians have greater access to family planning information and services, enabling families to choose whether, when and how many children to have.**

The decline in total fertility rate from 3.5 to 2.5 between 1991 and 2014 is significant.² During the same period, maternal mortality decreased by 65%, and the number of women who gave birth in a health care facility increased by 80%. In 1990, there were 265 maternal deaths per 100,000 live births and in 1992, the modern contraceptive prevalence rate (MCPR) was 19.9%. By 2010 the MCPR had risen to 67.2% and maternal deaths had dropped to 93 per 100,000 live births.^{3,4,5}

- **Peruvian children have higher vaccination rates and lower chronic malnutrition.** In the early 1990s, only 58% of Peruvian children were fully up to date on their vaccines. In 2012, just two decades later, 73.9% of children under 24 months had received all of their vaccinations.⁶ During those two decades, the chronic childhood



A young relative in a village in Peru proudly shows off an infant boy who has enjoyed the benefit of exclusive breastfeeding. The village is located in the catchment area of a child survival program being implemented by Project HOPE/Peru in the Department of San Martín. Interventions focused on child nutrition, including exclusive breastfeeding; the control of diarrheal disease; and immunizations.



© 2002 VIRGINIA LAMPRECHT, COURTESY OF PHOTOSHARE

Every USAID initiative and project in Peru was built around two guiding principles—partnerships based on collaboration and trust, and community engagement and empowerment.

These two principles served as the basis from which to grow and strengthen Peru's health system.



Through the Good Start or "Buen Inicio" project, USAID partnered with UNICEF to improve health in Peruvian communities from 1998-2006. The Good Start Project is an initiative for promoting optimal early growth and development of children in the peri-urban and urban zones in Apurimac, Cajamarca, Cuzco, and Loreto.

malnutrition rate in children under age five was cut in half, dropping from 37% in 1990, to just 18% in 2010 and 10.7% in 2014.⁷ These two improvements contributed to a significant decrease in child mortality. Whereas the infant mortality rate was 57 per 1000 live births in 1990, it was only 17 by 2014.⁸ In 2014, the mortality rate for children under 5 years old reached 20 per 1000 live births.⁹

- **Peruvians have made significant inroads toward controlling infectious diseases such as malaria.** Under the USAID Amazon Malaria Initiative, USAID helped Peru and seven other Amazon Basin countries adopt the best international practices in disease surveillance, diagnosis and treatment, monitoring of drug quality and resistance, and improving control of disease-transmitting insects. During the initiative, malaria cases in the Americas decreased by 65%, from 1.2 million in 2000, to 427,000 in 2013.¹⁰

Building Blocks for a Responsive Health System

USAID worked side by side with the GOP and Peru's health sector to help Peru achieve many health milestones. The Agency's ongoing collaboration with the MOH and regional governments has been fundamental to Peru's progress in the health sector. Every USAID initiative and project in Peru was built around two guiding principles:

- **Partnerships based on collaboration and trust.** High levels of participation and collaboration

among key stakeholders at every level have been essential to the success and sustainability of USAID projects in Peru. As Peru developed its health systems capacity over time, the role of the USG changed, evolving from service delivery to technical assistance and budget support, particularly at the regional level. When strong partnerships enable health authorities, government agencies, and civil society organizations to work together, powerful support emerges in the form of political ownership, local leadership, and commitments of time and resources.

- **Community engagement and empowerment.** The most effective answers to development challenges come from communities themselves. In Peru, USAID project staff consistently worked closely with community leaders, holding frequent dialogues to address their concerns, priorities and values, and partnering with them to develop and implement appropriate solutions. Whenever possible, community organizations and local authorities implemented projects themselves, and USAID provided support and technical assistance as needed. Rather than seeking solutions for specific problems, USAID's approach empowered individuals and communities, providing them with the tools and skills to navigate their own path to development.

These two principles guided USAID's many health projects and initiatives in Peru, and have contributed to strengthening Peru's health system. Among the areas that have most benefitted from USAID projects are

health surveillance, data collection, and usage for decision-making; access to services and treatment; and health service quality and management. The sections that follow describe a few of the highlights of USAID's projects in each of these areas.

Health Surveillance, Data Collection, and Decision Making

Perhaps one of the most important legacy achievements of USAID's partnership in Peru is the sustained success of Peru's Demographic and Health Surveys (DHS), which allow Peru to collect consistent, accurate data from which to make informed decisions. USAID worked with the MOH to develop a nationwide, continuous DHS. These surveys help policymakers better understand national health and population trends. Previously, data on fertility; reproductive, maternal, and child health; immunizations and disease survival; HIV/AIDS, malaria, and other infectious diseases; and stunting and nutrition status were collected every five years. Today, this information is collected on an annual basis. Health officials now have access to more current data for project design, health program monitoring and evaluation, and policy development.

Greater Access to Services and Treatment

Through its active partnerships with government agencies, NGOs, health care providers, and community groups, USAID and its implementing partners have helped the MOH improve access to health services and treatments for all Peruvians—even those living in some of the most remote and marginalized areas of the country. Some notable successes include:

- **Achieved 95% coverage of measles vaccination.**¹¹ Through collaboration on child survival and immunization initiatives with USAID, NGOs, and local communities, Peru successfully reached 95% nationwide measles vaccination coverage in 1999.
- **Increased rural women’s access to vital maternal health services.** Dedicated birthing homes staffed by trained health care professionals allow women to choose whether to use the horizontal childbirth method (lying on one’s back during the birth) or a traditional “vertical birthing” method (giving birth while standing or sitting). Offering culturally appropriate adaptations has encouraged more women to use birthing homes, which has saved lives and led to fewer maternal deaths around the country.
- **Strengthened family planning commodities security.** With support from USAID-funded projects and local NGOs, the MOH has made steady progress in strengthening its health logistics system over the years and

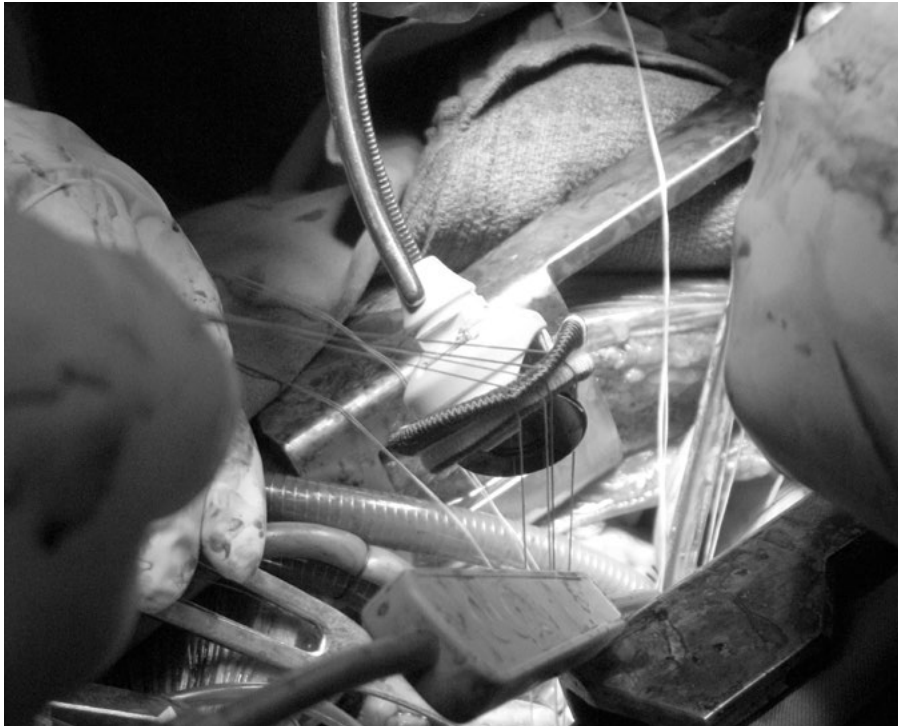
in 2004, it began fully funding access to family planning commodities. These initiatives improved the availability of contraceptives around the country.¹²

- **Dramatically reducing deaths from tuberculosis.** Peru began using the Directly Observed Therapy-Short-Course (DOTS)/DOTS-Plus strategy to diagnose and treat multi-drug resistant tuberculosis (TB) in 1991. The World Health Organization (WHO) considers Peru’s program a model for the rest of the world because it provided the first evidence that DOTS/DOTS-Plus prevents new TB cases.¹³ Between 1991 and 1999, DOTS prevented at least 70,000 cases of TB. Cure rates with the USAID-supported DOTS-Plus program exceeded 80% in Lima. Deaths from TB in Peru fell by more than half between 1991 and 2001.¹⁴ Peru is one in only a handful of high-burden countries who have met the WHO targets for TB control, with a 70% case detection rate and an 85% cure rate.¹⁵
- **Implemented universal health insurance,** strengthening health care quality and extending access to services. In 2009, the MOH developed a universal health insurance system with support from USAID. With the passage of the law that enabled this new system, health insurance coverage in Peru increased from 32% in 2000, to 70% in 2014, providing high-quality health services to many Peruvian families who previously could not afford modern health care.¹⁶

Better Health Care Quality and Management

The quality of health care relies on the capacity of health care workers and managers. USAID supported local Peruvian health care workers and devoted significant effort to building their capacity. USAID-supported projects have benefitted Peruvian health care facilities, health professionals and managers, and health system users through various cross-cutting initiatives. Some examples include:

- **Developing a hospital surveillance system** and creating evidence-based health care standards based on the performance improvement methodology (PIM). The PIM was instrumental for standardizing health service quality rules and methods in regional health systems. Following its incorporation into Peru’s national primary care strengthening plan, eight regional universities began using the methodology in their pre-service training and continuous in-service learning curricula for health care professionals.
- **Supporting the creation of several national medical accreditation systems** and training over 10,000 health technicians and managers across the country. USAID helped create accreditation systems for schools of medicine, nursing, and obstetrics. The Agency also helped create Peru’s national autonomous entity for the evaluation, accreditation, and certification of higher education *Sistema Nacional de Evaluación, Acreditación y Certificación de la Calidad Educativa*



American and Peruvian surgeons work in collaboration to replace a mitral heart valve with a mechanical one, as part of a mission dedicated to providing cardiothoracic surgery to needy Peruvian people. The mission is combined with several other humanitarian projects in the area, including a clinic in a neighboring city, a water treatment development program, and aid to a local orphanage.

(SINEACE). Now funded entirely by the GOP, SINEACE administers nationwide certification and periodic recertification exams in medicine, nursing, and obstetrics.

Looking Toward the Future

Continuous improvements in health care service quality and availability enabled Peru to make robust progress toward meeting its targets in the Millennium Development Goals (MDG) for health, particularly MDG 4 (reduce child mortality) and MDG 5 (improve maternal health).

Since 1986, with significant assistance from USAID, Peru decreased child mortality by 78%. In 2012, Peru surpassed the MDG 4 target of reducing child mortality by two-thirds between 1990 and 2015. Peru saw a 69.4% decrease in its maternal mortality ratio (MMR) between 1990 and 2010. The country continues to strive toward achieving the MDG target of 75%.

The stories behind Peru's achievements and lessons learned are relevant for other countries working to increase access to high-quality health services. The approaches, strategies, and tools developed and piloted in Peru can be adapted for use around the world.



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USAID is proud to have contributed to Peru's many accomplishments in the health sector over the past 55 years. In 2015, USAID is phasing out its bilateral health activities in Peru, certain of the government of Peru's commitment to continue improving the health of its citizens, and that the fruitful relationship developed between the US and Peru over the years will evolve into new forms of partnership on the regional and global health stage.

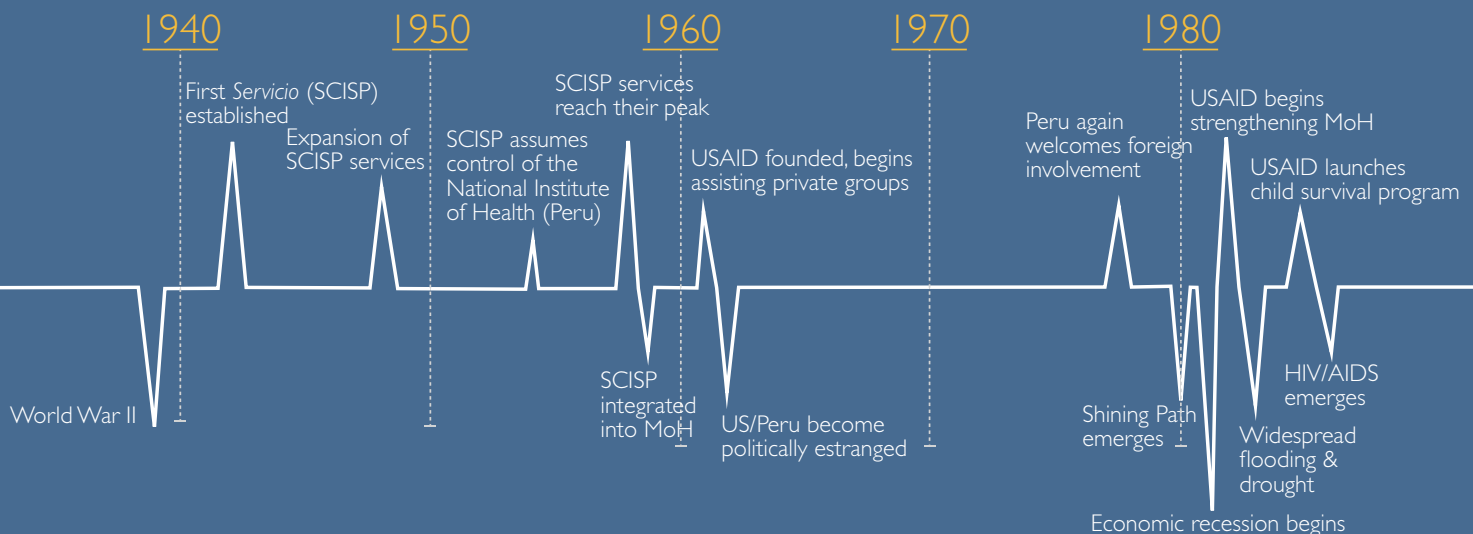


1940 – 1980

The Early Years:

USAID'S Health Partnership with Peru

The burgeoning relationship changes with political, economic, and social contractions and expansions during the 1940–1980 time period.



The 1940s & 1950s: The journey begins



6.208
1940 population in millions



6.9
1950 total fertility rate¹



n/a*
under 5 mortality per 1,000 live births



n/a*
percent of stunting in children



n/a*
women in 100,000 died of maternal causes



n/a*
gross domestic product in millions (US dollars)

SOURCE:
¹INEI Censo Nacional de Población y Vivienda

*Data not available at time of publication

The *Servicio*: A Model for Collaborative Development

In 1942, US Inter-American Affairs Coordinator Nelson Rockefeller established the Institute of Inter-American Affairs, which fundamentally changed the partnership between Peru and the United States. It was authorized and funded by the US Congress with the mandate to conduct cooperative public health and agricultural development programs with Latin American governments.

The Institute of Inter-American Affairs abandoned the USG's previous practice of providing technical advisory services and expertise to Peru in a piecemeal fashion. Instead, it took a longer-term and more collaborative, developmental approach, creating a system of jointly owned and operated bureaus called the *servicios*.

The first *servicio* in Peru, *Servicio Cooperativo Interamericano de Salud Pública (SCISP)*, was embedded within the MOH after Peru and the US created it in July 1942. The two countries would later embed additional *servicios* within the ministries of agriculture, education, and other sectors. The *servicios* quickly became technical assistance hubs for

the United States in Peru and most activities were channeled through them.

First Steps: Closing the Gaps and Balancing National Agendas

As a true joint venture, SCISP served the interests of both the US and Peruvian governments. Its first projects were in Peru's Amazon regions of San Martín and Loreto, the high jungle town of Tingo María, and the north coast village of Chimbote. These locations suited US interests because the United States needed a coastal site to build an air base, as well as medicines and other tropical products to supply war efforts. The locations also worked for Peru, because resource limitations had prevented the MOH from providing medical or health facilities in those areas.

The SCISP got to work building medical dispensaries and hospitals in Tingo María, Chimbote, Iquitos, Pucallpa, and a number of other towns and villages. In addition to installing the new medical facilities that the MOH wanted, SCISP also worked on improving public health and strengthening Peru's capabilities in preventive medicine.

SCISP's decision to use local medical and engineering staff for most of the new medical facilities provided employment and substantial training to an entire cadre of professionals. This set the stage for extensive support from USAID in later years to train Peruvian health professionals in the US. This became a key factor for Peru's success in making dramatic improvements in many aspects of public health.

Next Steps: Keep on Building and Set an Example

SCISP ramped up its preventive and public health focus after World War II ended. It continued to expand its initial operations with health centers in Iquitos, San Martín, Tingo María, and Chimbote. *Servicios* provided more public health services to the local populations than the MOH was able to provide in other parts of the country.

The SCISP health center in Tingo María provided more public health services than any other facility in Peru outside of Lima. The center provided health education, communicable and infectious disease control, midwifery, dental hygiene, vector and rodent control, water supply, sewage disposal, and

sanitary engineering. The SCISP also had a hospital in the city that provided traditional surgical and medical services, including maternity and pediatric care and tuberculosis treatment. Rural residents in the surrounding area had access to the health center's 11 health posts, as well as to mobile rural health services.

In the small coastal village of Chimbote, the SCISP not only built a 50-bed hospital and opened a health center, but it also put in water supply and sewerage infrastructure, drained swamps, managed a salt iodization plant, and established robust malaria control and public health programs. Chimbote would have had a difficult time growing as quickly as it did (today it is home to almost 370,000 people) to become the "capital city" of Peru's fishing and steel industries if SCISP had not first laid the groundwork.

Back in Lima, the Center for Preventive Medicine built by the SCISP in the Rimac District grew into a large urban health center and expanded its public health activities to include hygiene at every age, TB control, sexual health, dental hygiene, nutrition, sanitary engineering, and statistics. It also became a center for training public health



At their peak, SCISP had established eight major centers of operation, as well as many more health posts and service centers in these regions. Services not only included medical treatment, but also provided information on dental hygiene, rodent control, water supply, sewage disposal, and sanitary engineering.

Many became centers for training public health nurses and sanitary inspectors, and sent a number of Peruvians to the US to study public health.





BELOW, LEFT TO RIGHT: These photos, taken from a Facebook site (www.facebook.com/ChimpoteenBlancoyNegro/photos), are ostensibly from the May 15, 1945 inauguration of the Hospital "La Caleta" at Chimbote. Photographer unknown. The man in center, left photo, is listed as Dr. Victor Manuel del Aguila Gonzalez, former hospital director.

BELOW CENTER: Jorge Baca Luna and Dr. Honorio Durand with unknown associates.



[Comment from Facebook site about photo below] "How much nostalgia to contemplate this photograph with people whom I met in my childhood in the distant hacienda Rinconada, where I was born in 1955... Dr. Palomino and his wife Alice lived in the row of houses intended for employees, attached to the railway line. Over there was the Casa-Hacienda, the house of my uncle Santiago Mimbela, Mr Díaz (in the photo) and my godmother Susana..."

—by Luis Rios Mimbela



In the small coastal village of Chimbote, the SCISP built a 50-bed hospital, opened a health center, put in water supply and sewerage infrastructure, drained swamps, managed a salt iodization plant, and established robust malaria control and public health programs.

nurses and sanitary inspectors, and sent a substantial number of Peruvians to the United States to study public health. With so many successes under its belt, the SCISP enjoyed an excellent rapport with the MOH. The MOH asked the SCISP to provide assistance in health education, nutrition, and vital and health statistics. By the late 1940s, the MOH began asking the SCISP to get involved in activities outside the realm of public health, and in 1948, the SCISP took over the national industrial hygiene program. The program's main purpose was to study health hazards in Peru's mines and to perform medical exams on miners seeking disability compensation for occupational health problems. After just five years under SCISP management, the industrial health program became internationally renowned as one of the best operations of its kind in Latin America due to its success in serving the interests of both workers and the mining industry. Neighboring countries even began using it as a model for training purposes.

A few years later, in 1954, the MOH asked the SCISP to take over the MOH's National

Institute of Health, which meant producing vaccines and other biological products. After completely reorganizing the laboratory's administrative structure, the SCISP created a first-rate production operation. Within six years under SCISP management, confidence in Peruvian-made vaccines grew so strong that the country was not only able to substitute imported small pox, whooping cough, tetanus, and rabies vaccines with locally produced versions, it even began exporting vaccines for the first time.

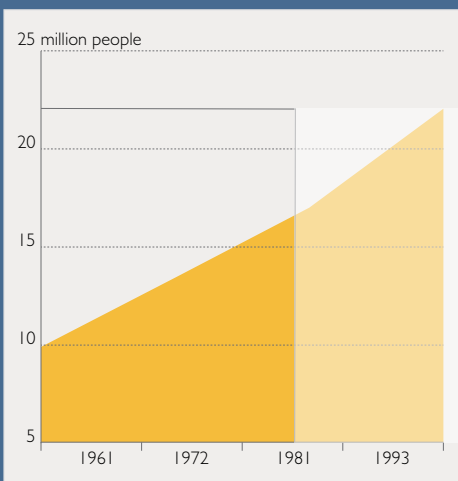
Changing Political Tides

By the early 1950s, the concept of centralized operations was gaining favor, and the US began to encourage the MOH to take over the health units and programs that the SCISP had been managing. The Loreto health unit was the first to be returned to the MOH in 1954. In the following years, the SCISP continued to return the rest of its health units and programs to the MOH. By the end of 1961, the SCISP ceased being a *servicio* and all its remaining activities were absorbed into the MOH.

With the adoption of President John F. Kennedy's Alliance for Progress plan to strengthen relations with Latin America, along with the founding of USAID in 1961, a new phase in United States-Peruvian technical and economic cooperation began. The United States signed new technical assistance agreements with the MOH to provide many of the same kinds of services that the *servicio* had provided, either with direct-hire technicians or through contract arrangements. The *servicio's* legacy as a mechanism for stimulating technology continues; the MOH continues to apply the scientific method to solve problems and modernize procedures.

Between 1961 and 1981, the population grew 65%—by more than 7 million people.²¹

The 1960s & 1970s: A time of growth



9.907
1961 population in millions



6.9
1960 total fertility rate¹



109
under 5 mortality per 1,000 live births¹



n/a*
percent of stunting in children



n/a*
women in 100,000 died of maternal causes



\$2,504
1960 gross domestic product in millions (US dollars)¹

SOURCE:
¹INEI Censo Nacional de Población y Vivienda
²World Bank

*Data not available at time of publication

Social Change in Peru

Between 1962 and 1977, Peru's population grew by an average of 3% per year. The country also experienced migration from the *sierra* (mountains) to the *selva* (jungle) and the coast, as well as from rural to urban areas, in particular Lima. Peru's six million impoverished sierra inhabitants and two million urban slum dwellers constituted some of the largest concentrations of poverty in South America.

Although per capita GDP doubled between 1960 and 1970, many Peruvian families still lived in poverty, as reflected in the country's 1970 per capita GDP of \$548.¹⁷ In 1968, the Peruvian government began to integrate the poor into the development process. The government instituted land reforms that benefited 342,000 landless families and abolished the old *latifundio* agricultural system. It also developed decentralized and bilingual education for millions of non-Spanish speaking children; and later, a comprehensive population law calling for responsible parenthood.

USAID Response to the New Social Dynamic

In the early 1960s, although general awareness about the effects of population growth was still fairly limited, USAID launched several small family planning projects in Peru. The activities consisted mainly of assisting civil society groups, such as the Peruvian Association for Family Protection (APPF)—an affiliate of the International Planned Parenthood Federation—and financing studies through the Center for Studies on Population and Development. However, the projects were short-lived. APPF was dissolved after the military resumed power and the Center for Studies on Population and Development focused solely on research. In August 1976, Peru developed a population policy commissioned by the new President General Francisco Morales Bermudez. The policy acknowledged that rapid population growth constituted a challenge to Peru's sustainable economic development, and was thus within the purview of the government. A USAID-



A mother holds her son as she looks out over a barrio comprised of shacks on stilts on the Amazon River in Belén, Iquitos.

financed demographic/economic model, implemented in cooperation with Peru's National Planning Institute in the mid-1970s, showed that the country's medium- and long-term goals for economic and social progress were not achievable with a continuing population growth rate of over 3%.¹⁸

In 1978, the Alma Ata International Conference on Primary Health Care produced the first international declaration on the importance of primary health care and outlined government roles and responsibilities for the health of citizens. The following year, the GOP formally adopted a national plan for the delivery of primary health care services to improve the health conditions of its people. Important aspects of the plan included a focus on child survival and maternal health, as

well as incorporating family planning and reproductive health under the purview of the MOH.

The new plan paved the way for renewed direct collaboration between USAID and the GOP in the health sector and, in 1979, USAID funded two integrated primary health care delivery projects. The *Sur Medio* Project was a pilot project in the Ica region, which included the delivery of basic health, nutrition, and family planning services. Subsequently, the Agency launched the Extension of Integrated Primary Health Care Project, aimed at strengthening and extending the delivery of primary health care services to rural and marginal urban areas, and integrating family planning services into health care through both the public and private sectors.^{19,20}



© USAID

A father in Peru holds his infant son at a street theater performance called "Condoms of Hope." Street theater goals were to combat myths and rumors about modern family planning methods and encourage people to seek professional information from health providers.

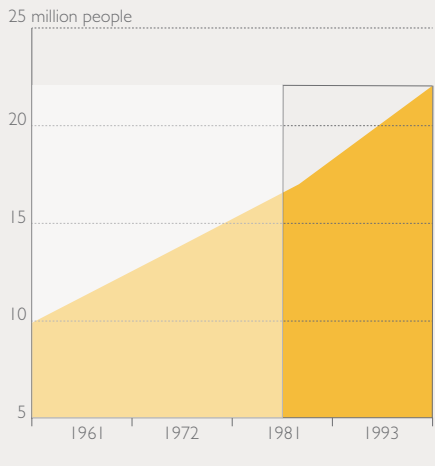
Between 1981 and 1993, the population grew by 5 million people.

The 1980s: Extraordinary events drive migration and need

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A mother shields her child from blowing sand in Alto Molino, Pisco.



17.005
1981 population in millionsⁱ



5.0
1980 total fertility rateⁱ



115
under 5 mortality per 1,000 live births, 1986ⁱ



43.9
percent of stunting in children, 1984ⁱⁱⁱ



268
women in 100,000 died of maternal causes, 1980^{iv}



\$17,656
1980 gross domestic product in millions (US dollars)^v

SOURCE:

ⁱINEI Censo Nacional de Población y Vivienda

ⁱⁱDepartment of Health Services, Peru

ⁱⁱⁱWorld Bank Indicators

^{iv}WHO Institute for Health Metrics & Evaluation

“Sendero was a real problem. [We] targeted areas that were Sendero strongholds, like Huancavelica and Apurimac. We went there to train workers at the health centers and posts, but sometimes we had to pull out because Sendero was nearby, and no one was there for us to train.”

— Luis Seminario, former Advisor to the Minister of Health and former Project Management Specialist, USAID/Peru Health and Education Office, on working in areas that were known strongholds of *Sendero Luminoso* (also known as the terrorist group, Shining Path).

The 1980s was a decade full of challenges. After 11 years of military rule that led to social unrest and a severe economic crisis, a new constitution was signed in 1979. Peru held democratic elections in 1980. However, although the Garcia administration (1985–1990) promoted equity reforms, a recession left the GOP without the necessary resources to implement a successful “growth-with-equity strategy.” The decade ended with hyperinflation at an annual average rate of 3398%.²²

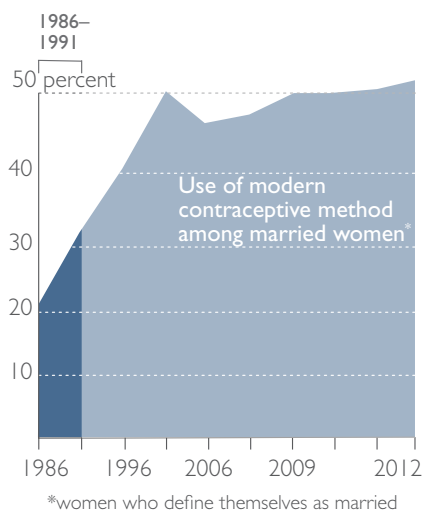
At the beginning of 1980, the population of Peru exceeded 16 million and an annual growth of 2.8%, was among the highest in Latin America.²³ The national maternal mortality ratio was 268 deaths per 100,000 live births. In 1987, 44% of all deaths occurred among children under age five, and 65% of these occurred before the age of one year. In 1986, the infant mortality rate for Peru was 79 per 1,000 live births, the highest in Latin America, and nearly 50% higher than the national average for all countries in the region.²⁴

Migration from rural areas to the cities, which had already begun to accelerate in the 1970s, continued to increase in the 1980s. The growth of the *Sendero Luminoso*, or Shining Path, terrorist group in mountainous regions in South-Central Peru between 1980 and 1992 forced many rural communities to establish military-like groups called *Rondas Campesinas* to defend themselves against the terrorists. The escalating violence between these groups led to a mass exodus, and approximately 600,000 people fled from these rural Andean communities in favor of Lima and other urban centers.²⁵ In all, terrorist activities during this period killed an estimated 50,000 people in Peru, destroyed much of the nation's infrastructure, and provoked mass economic and social turmoil.²⁶ Rural residents moved to urban areas to seek better economic and social opportunities, improved security, and to gain access to clean water, electricity, education, and health services. This rapid urbanization led to larger, denser shantytowns (known as *pueblo jovenes*).

Working to Address Poverty

The recession in the early 1980s forced a reduction in public expenditures, especially on health and education. The MOH was underfunded and could not provide adequate levels of health services to its target population, as its funds were focused on curative care rather than prevention. In an attempt to ease the pressure on the national health system, at the end of the 1980s the MOH began to decentralize health administration and resources to autonomous regional branches of the MOH, but was unable to complete the process of decentralization.

Within this context, a number of USAID projects across various sectors aimed to help Peru overcome its economic crisis and address its chronic problems of poverty while promoting human rights and strengthening the democratic process. Among the most important health issues for USAID in the 1980s were nutrition, family planning and



In July 1985, the GOP enacted a new population policy (Decreto Legislativo No. 346), which declared that couples had the right to decide their own family size and to receive family planning information and services from public agencies.

reproductive health, child survival, and strengthening the MOH. These evolved into MOH health programs known as Nutrition, Family Planning and Information, and Child Survival.

USAID focused its work in the *sierra* and in poor, urban areas. Infant mortality in the *sierra* approached 200 deaths per 1,000 live births, and women in the *sierra* had high fertility rates. In addition, 67% of rural women were illiterate.²⁷ Enabling young women and girls to avoid early pregnancy allows many to attend school longer, and women with fewer children are more able to seek employment, thereby increasing household income and assets.²⁸ USAID designed programs in health, family planning, education, and nutrition services for populations living in *sierra* regions.

The rapid population growth in Peru's cities made it challenging for the public sector to meet the ever-increasing needs for public services, including health care. In 1980, USAID launched an Integrated Health and Family Planning Project, which it

implemented jointly with the Extension of Integrated Primary Health Care Project, as both shared similar objectives—to increase contraceptive usage among Peruvian couples by roughly 60% through making family planning information and affordable contraceptives available.²⁹ Other USAID projects continued the work that had begun in 1979, further integrating primary health services, including family planning and nutrition programs, in order to serve marginal areas in Peru's big cities.

Nutrition

USAID assisted and coordinated with the GOP to identify, design, and evaluate policies and programs to alleviate malnutrition, with a particular emphasis on preschool children and pregnant and lactating women. Malnutrition has negative consequences on health, physical and cognitive growth, intellectual performance and earning potential.³⁰ USAID focused on maintaining food security in the country, providing food aid as a strategy to relieve

malnutrition among low-income people in rural areas, particularly in the *sierra* and *selva* regions. In urban areas, USAID supported urban food-for-work projects that provided jobs, created basic infrastructure for development, and benefited some 1.5 million people.³¹

Family Planning and Reproductive Health

As mentioned, the 1978 Alma Ata Conference raised awareness about family planning and reproductive health as integral components of primary health care. After this event, Peruvian policy makers began to address issues such as access to contraceptive information and services, malnutrition, and inadequate prenatal care.

In July 1985, the GOP enacted a new population policy (*Decreto Legislativo No. 346*), which declared that couples had the right to decide their own family size and to receive family planning information and services from public agencies. As the ministries of health and education developed

plans to implement the new policy, USAID provided grant funds for logistical support to organizations that offered rural and urban family services, population education, and training for health and family planning personnel.

Child Survival

USAID supported the development of a Child Survival Action Coordinating Group in Peru, which included representatives from PAHO, UNICEF and UNFPA, the MOH, Peru's social security system (*Instituto Peruano de Seguridad Social* or IPSS), and other governmental and nongovernmental groups concerned with child survival. This

group proposed that the MOH focus on its role as a normative and quality standard-setting body while supporting NGOs in implementing on-the-ground, operational aspects of child survival programs. Thus, private entities were permitted to deliver health care services and logistics directly, in conjunction with support from the IPSS.³²

USAID also worked with the MOH to strengthen Peru's decentralized system for sustainable child survival service delivery. While the MOH developed a health communication policy, conducting formative research and developing mass media messages to promote maternal and child health, USAID focused on strengthening

the MOH's nationwide health management information and epidemiological surveillance systems, as well as supporting an in-service training program for health professionals in the clinical management of selected threats to child survival. USAID launched the Child Survival Action Program in 1988.

Under the Child Survival Action Program, the MOH and IPSS delivered family planning services, often linked to other health services such as immunizations or other child survival interventions. This set the stage for the emergence of family planning in the 1990s as separate from child survival, with its own funding and projects.

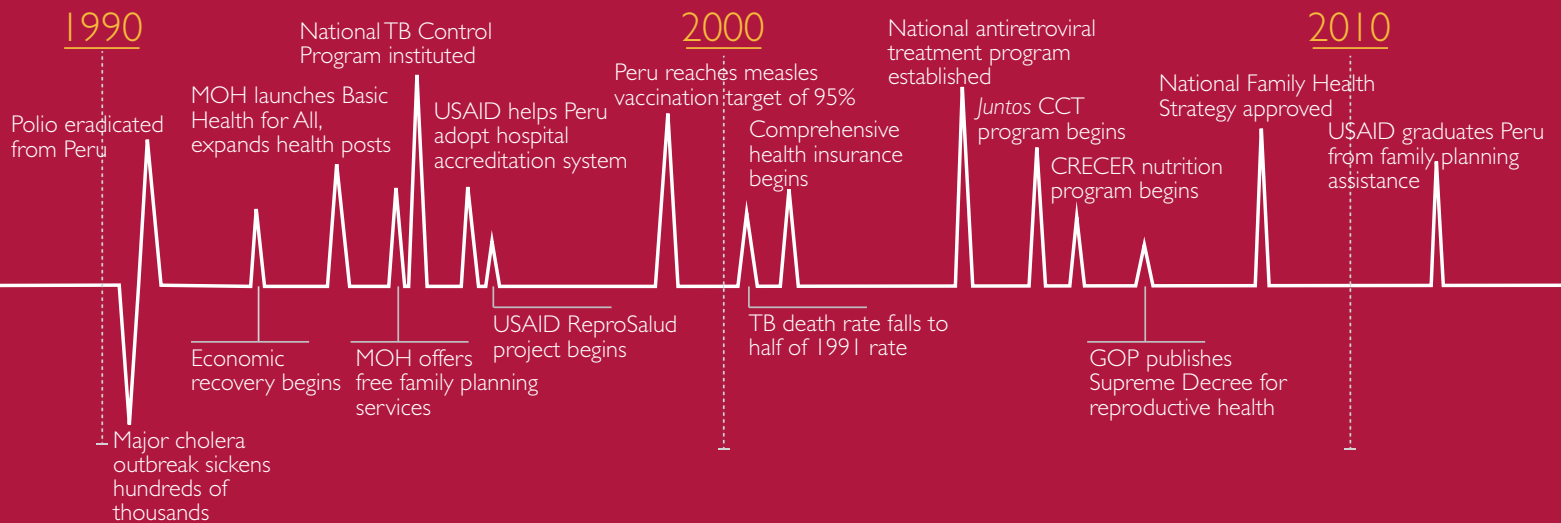


A physician meets with a group of rural clients in the Puno region to explain clinic services and prices.



1990 – 2014

The Modern Landscape: Expansion and Evolution





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The 1990s: Economic recovery brings rapid progress



22.048
1993 population in
millionsⁱ



3.5
1991 total fertility rateⁱⁱ



92
under 5 mortality per
1,000 live births, 1992ⁱⁱ



37.3
percent of stunting
in children, 1991-92ⁱⁱⁱ



265
women in 100,000
died of maternal causes,
1996ⁱⁱ



\$25,710
1990 gross domestic
product in millions
(US dollars)ⁱⁱⁱ



66
life expectancy, 1990ⁱⁱⁱ

SOURCE:

ⁱINEI Censo Nacional de Población y Vivienda

ⁱⁱDepartment of Health Services, Peru

ⁱⁱⁱWorld Bank Indicators

In 1990, Peru was a country in extreme crisis with an average inflation rate of 7481.7%.³³ The deep recession and rampant hyperinflation throughout the 1980s had exacerbated poverty and inequality, fueling terrorism, drug trafficking, and a surge in internal migration in the process. Hundreds of thousands of people fled the rural strongholds of the terrorists and drug lords in search of safety and economic opportunities in the city.³⁴

The economic crisis severely hampered the country's ability to fund the MOH and the health care system. Over the course of a decade, annual per capita spending on health declined by almost 90%, from \$6.81 in 1980 to \$0.71 in 1990.³⁵ Families across the country were struggling to put food on the table and for many, basic health care was out of reach.

At the beginning of the decade, Peru's spending on health ranked among the lowest in the Americas. The public health care system provided much of the country's health services on a budget of less than 1% of the gross domestic product. Consequently, health services were greatly reduced in the cities and completely absent in many rural areas. The limited services that were available were heavily concentrated in Lima, but even there supplies were so scarce that patients had to bring their own food and bedding to public hospitals.³⁶

Given the MOH's dire financial situation, in 1991 it began charging user fees for services in most public health establishments, especially hospitals. While the additional revenue did little to improve services, it did keep the state health system from complete collapse during the next few years.³⁷ However, as a WHO review reported, introducing user fees had the effect of significantly decreasing health service utilization in low- and middle-income countries.³⁸

In 1993, the Peruvian economy began to recover as cash flowed into the state's coffers from the sale of various government corporations, which the GOP had begun to privatize coupled with fiscal adjustments and state reform. In addition, the World Bank and the Inter-American Development Bank (IDB) had recently joined USAID in investing in Peru's health and education systems, bringing an influx of funds into those sectors.³⁹



LEFT: Through the Good Start or "Buen Inicio" project, USAID partnered with UNICEF to improve health in Peruvian communities from 1998-2006. The Good Start Project promotes early growth and development, from conception to three years, mainly through the reduction of chronic and micronutrient deficiency malnutrition (iron, vitamin A and iodine).

BELOW LEFT: Healthy girl and her mother. Santa Elena Health Center, Ayacucho.

BELOW CENTER: Villagers gather outside of an APROPO health education tent in Peru.

BELOW RIGHT: Descriptive antenatal care signs hang prominently.

© MAUD GUYE-VUILLEME



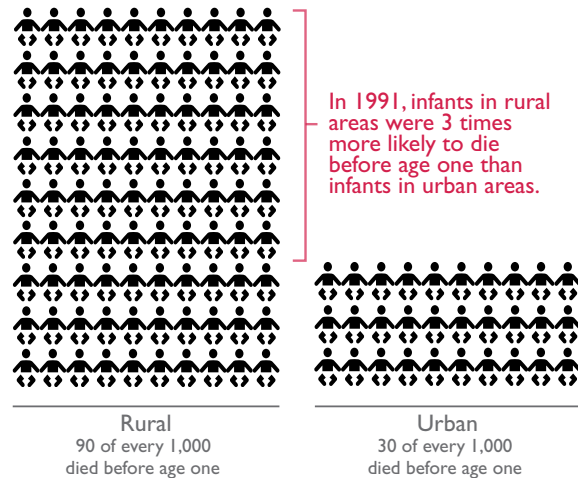
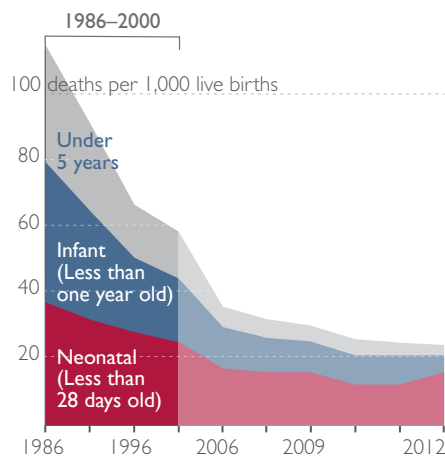
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Child mortality in the 90's

The late 1980s and early 1990s began a precipitous fall in the number of deaths per 1,000 live births for newborns, infants, and children under 5 years in general, yet where the child was born dramatically affected his or her chance of survival.

Basic Health for All Program

The recovering economy and increase in funding enabled the GOP to plan and implement several structural health sector reforms—the first of which was to sharpen the focus of MOH programs to better target people with the greatest need. To accomplish this, the MOH devised a primary health care delivery strategy that partially decentralized and democratized Peru's health system.

In 1994, it launched the Basic Health for All Program (*Programa de Salud Básica* or PSBT) to expand health coverage to the poorest of the poor. Out of 9,385 health facilities, the program targeted 2,614 health centers and posts, of which 69% were located in poor or very poor districts.⁴⁰ Using newly available government funds, the PSBT program began rebuilding national health infrastructure and hiring personnel on short-term contracts to work in marginal rural and urban areas, where many of the poorest people lived.⁴¹

Local committees for shared management were created to transfer the management of local public health posts directly to the community. Although PSBT was a centralized, MOH-owned and operated program, the local committees for shared management were autonomous in administration and management, though they retained financial ties to the government.⁴²

As the MOH was launching this new program, USAID support to the health sector focused on improving health care quality. Its strategy during the 1990s was threefold:⁴³

- Support improvements in family planning and maternal and child health services for low-income women and children in rural and peri-urban areas.
- Help people take appropriate preventive and curative actions to improve their health, and to use clinic and community-

based services for child health, family planning, and reproductive health.

- Contribute to the programmatic, social, and financial sustainability of USAID-supported health programs and services.

By providing technical assistance to the new team of public health professionals in the MOH, USAID helped develop national standards of care in several areas, particularly family planning, immunizations, and child health. In 1996, USAID helped the country adopt a new hospital accreditation system based on best practices in health service management and launched 10 new health-related projects. Through these and other projects, USAID population, health, and nutrition programs served 7 million Peruvians in the 1990s, roughly one-third of the population.⁴⁴



Ashaninca children in the isolated jungle community of Oviri, along the Rio Tambo, receive food made by women in the village.

Child Survival

After launching a “child survival revolution” with support from the US Congress in 1985, USAID ramped up its child survival program across Peru. USAID projects addressing chronic malnutrition, acute respiratory infections and safe water provision have contributed to better child health outcomes in Peru, as the country continued making great strides in reducing infant and child mortality and improving children’s health.

Infant and Child Mortality

Between 1972 and 1992, the infant mortality rate dropped from 109 deaths per 1,000 live births to 64 deaths per 1,000 live births.⁴⁵ Over the course of the 1990s, this rate continued to decline; by 2000, it had dropped to 43 deaths per 1,000 live births. The mortality rate among children under age five also dropped between 1986 and 2000,

falling from 115 per 1,000 live births, to 60 per 1,000 live births.⁴⁶ Yet in a country as diverse as Peru, such numbers hide the real story, which is as complex and multifaceted as the country itself.

In Peru, where a baby is born greatly affects his or her chances for survival. The infant mortality rate in Peru’s rural regions was three times higher than that in Lima (90 deaths compared to 30 deaths per 1,000 live births) in the early 1990s. In other words, babies born in regions such as Inka and Mariátegui were three times more likely to die before their first birthday than babies born in Lima.⁴⁷

Chronic Malnutrition

Chronic child malnutrition presented a tough challenge for the MOH. Even after years of support from USAID, particularly through the US Food for Peace (PL 480) Title II (FFP) programs, which aimed to

alleviate hunger through integrated nutrition projects, Peru’s national chronic malnutrition rate hovered around 37% in children under age five in 1991. Some regions of the country (at the time known as Inka, Libertadores, and Cáceres) reported rates as high as 50% that same year. USAID projects such as the Infant Mortality Reduction Project, which provided families with food supplements and Vitamin A in Lima and Cajamarca, reported some progress in the areas served, but it was small.⁴⁸

Peru’s economic crisis in the late 1980s had left many families in need of food assistance in the early 1990s. Many donors responded to this need; numerous food assistance programs were created for vulnerable populations as a result. While the GOP, the USG, and other donors supported such programs, most simply distributed food and there was little coordination among them or with the MOH.⁴⁹

“People rarely talked about child malnutrition or knew what caused it, but then USAID systematized and generated evidence to help several GOP ministries, academics, donors, and NGOs come to a consensus on the problem and helped Peru develop a national child nutrition strategy.”

— Miriam Choy, Regional Program Office, USAID/Peru.

One such program was the FFP program, which was administered by USAID in Peru and supplied resources for soup kitchens (*comedores populares*) in the early 1990s. The FFP program provided development food assistance to target the underlying causes of hunger and malnutrition in many countries around the world. In Peru, USAID focused its approximate \$50 million FFP food program in the rural highland and jungle areas, where the levels of extreme poverty are the highest.⁵⁰ Before the mid-1990s, most FFP-supported projects were largely feeding programs, although some provided basic nutritional messages and food-for-work opportunities.

An evaluation of FFP operations between 1990 and 1995 provided inputs for a better strategy to reduce chronic malnutrition. A series of studies and evaluations in the mid-1990s provided more evidence, supporting the Agency’s decision to shift toward integrating food assistance with basic health services. A subsequent USAID study in 1997 helped Peru develop a national child malnutrition strategy, with the goal of developing a unified message on child malnutrition and health.

Even before the new strategy was launched, USAID projects such as the Food and Nutrition Program for High-Risk Families (PANFAR) began linking food distribution with health facility visits for growth

monitoring and basic maternal and child health intervention. The economic crisis began to recede and the Agency started changing its food assistance approach. Other FFP programs shifted their focus from giving food away to teaching mothers and childcare providers about nutrition and food safety, and using locally grown foods.

Between 1995 and 2000, FFP grants became less focused on food distribution, instead emphasizing basic health, including growth monitoring, vaccinations, safe water consumption, and strategies for reducing ARIs and diarrheal diseases.⁵¹ Final project evaluations of several USAID projects confirmed the effectiveness of this approach in reducing chronic childhood malnutrition. Reports on the Child Nutrition Program and the Sustainable Networks for Food Security Program documented reductions in child stunting, a measure of chronic malnutrition, of 5.6% and 9.9%, respectively.⁵²

Acute Respiratory Infections

Acute respiratory Infections (ARIs) have long been the primary cause of death and disability in Peru among people of all ages. In the 1990s, ARIs were a growing threat to the country’s children, in part because chronic malnutrition among children increased following the economic crisis and increased their susceptibility to ARIs.⁵³

As part of the Child Survival Action Project (CSAP), USAID worked hard to support the MOH in improving children’s health and reducing child mortality rates in rural areas. For example, USAID supported the MOH’s national plan to control ARIs by training MOH personnel in early detection and treatment of ARIs, as well as teaching communities how to prevent ARIs through good hygiene and prolonged breastfeeding of infants.⁵⁴

Safe Water

In addition to lacking health care services in the early 1990s, only 44% of people in rural areas had access to a source of safe drinking water and only 16% had access to hygienic sanitation facilities in 1990. Digestive tract diseases stemming from poor hygiene and lack of potable water were among the most common causes of infant and child mortality at that time.^{55,56}

As part of its national water supply and rural sewerage plan, the MOH had been collaborating with regional governmental development organizations (known as *corporaciones departamentales de desarrollo*) to improve the country’s water and sanitation systems since the 1980s. But neither the MOH nor the development organizations had the administrative, technical, or funding capacity to build systems in the thousands of remote communities that needed them.

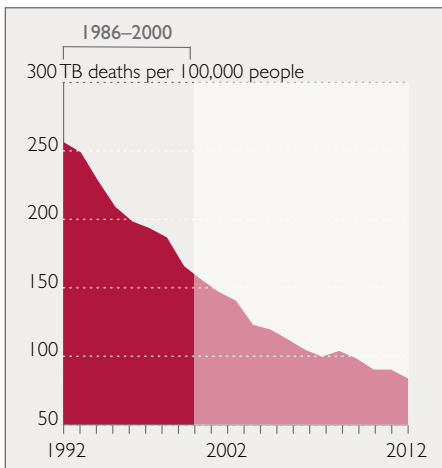


A mother and child use the Nannay River for laundry and bathing in Santa Clara de Nanay, Loreto. Rural areas had little or no access to potable water. Digestive tract diseases stemming from poor hygiene and lack of potable water were among the most common causes of infant and child mortality as late as the 1990s.



Personnel from the Yugoslavia Health Center (Ancash) creating a visual resource for tuberculosis services.

After the institution of DOTS in 1991, the rate of TB deaths fell from 256 in 1992 to 156 in 2000—and continued to fall thereafter.



USAID staff worked diligently to fill the gaps, financing projects such as the Rural Water Systems and Environmental Sanitation Project, which expanded access to clean water and hygienic sewage systems in rural areas.⁵⁷ More than 1,000 water supply systems were built in rural communities in the sierra and the jungle through that project, which indirectly supported USAID's activities under the CSAP.⁵⁸

Infectious Disease Improvements

The combined efforts of the MOH, USAID, and various other donors to improve the country's water supply were not enough to protect the population from a major cholera outbreak in February 1991. Peru reported 322,562 cases in 1991 and 210,836 in 1992, with 4,396 deaths from cholera between 1991 and 1994.⁵⁹

In response to the outbreak, the GOP launched an intense campaign to teach people how to avoid getting sick. This campaign was successful—it reduced all types of diarrheal diseases, even those that were not related to cholera. It also educated families on the effectiveness and use of oral rehydration therapy (ORT) to treat diarrheal diseases, which affected almost 1 in 5 children in Peru at that time.⁶⁰

The use of ORT for diarrheal disease control was also an important element of USAID's child survival strategy. However, the Agency had to revise its policy on ORT after a tragedy occurred in March 1986; four infants died from oral rehydration solution (ORS) that had been purchased with USAID funds and was later found to have contained an incorrect electrolyte balance. After that tragedy, USAID stopped importing ORS and worked with the MOH to help the country produce its own ORS through the CSAP.⁶¹

The CSAP also worked to prevent infectious diseases through an immunization component, since despite massive campaigns by the MOH to promote child vaccinations, only 58% of Peruvian children were fully up to date on their vaccines by the early 1990s. While this was an improvement from five years earlier when the coverage was just 36%, it was still well below the WHO's 1991 Expanded Program on Immunization target of 80% immunization coverage for six vaccines: polio, measles, diphtheria, pertussis, tetanus, and TB.⁶²

According to data from the 1991–1992 Demographic and Health Survey (DHS), Peru had only met the 80% vaccination target for two of the six diseases—TB and polio. By 1990, national TB vaccination coverage had reached 83%. Polio was eradicated in the country in 1991 with support from USAID, PAHO, and Rotary, among others.^{63,64} The MOH and USAID celebrated a major success after their collaboration with local NGOs and communities on child survival and immunization initiatives through the CSAP and other projects, which brought Peru's national measles vaccination coverage to meet the global target of 95% in 1999.⁶⁵

In addition to strengthening immunization coverage for the measles, TB, and other diseases, Peru's MOH also improved TB case detection and cure rates during the 1990s. It was so successful in this regard that the WHO viewed the country as a model. Peru's directly observed therapy short-course DOTS program reached the WHO targets of 70% case detection and 85% cure, and cut the rate of TB deaths by more than half between 1991 and 2001 (see sidebar).⁶⁶ USAID supported this work with its Addressing the Threats of Emerging and Re-emerging Infectious Diseases (VIGIA) project, beginning in 1997, which addressed populations at high risk of contracting emerging and re-emerging infectious diseases and trained MOH epidemiologists in disease identification, prevention, and control.

DIAGNOSING AND TREATING TB THROUGH DOTS

The strategy of diagnosing and treating TB through DOTS, used in Peru between 1991 and 2001, is considered by the WHO as a model for the rest of the world and an example that should be replicated in other high-burden countries.⁶⁷ Peru's implementation of DOTS was remarkable because it helped achieve WHO targets of 70% case detection and 85% cure rates within key populations.⁶⁸

Other accomplishments included:

- **Developed an innovative analysis of alternative strategies** for malaria control, yellow fever control, and for the provision of antiretroviral therapy (ART) in Peru.
- **Developed an intermittent dry irrigation system** for rice farmers that reduced populations of mosquitoes that transmit malaria and ensured a viable rice harvest. This was a strong model of how multisectoral and transdisciplinary approaches work together to improve health.
- **Produced standard technical documents** and manuals for the prevention, control, and treatment of sexually transmitted infections (STIs) and HIV/AIDS.
- **Improved the national public health laboratories network** by supporting its reorganization, providing equipment, and implementing a level 3+ biosafety laboratory.
- **Consolidated and built the capacity of the national epidemiological surveillance network** by supporting a training program that was tailored to Peru's needs. The program trained 850 basic-level epidemiologists to work at a health facility or district, and 55 high-level epidemiologists (equivalent to graduates of a master's degree program) to conduct surveillance and comprehensive analysis of epidemiological and sanitary information.
- **Trained 4,000 health workers from 70 hospitals** in Peru on prevention and control of nosocomial infections, including measures such as handwashing, aseptic techniques, isolation, and installation of hospital epidemiological surveillance systems.
- **Improved capacities for the appropriate use of antimicrobials** by formulating national guidelines on adequate management and dispensation of antimicrobials and on pharmacological surveillance; supported the formulation and implementation of plans for the rational use of antimicrobials at the hospital level.
- **Collaborated with schools to integrate health content**, such as dengue control, into academic curricula.

SOURCE: Assessment of Three USAID/Peru Health Projects Implemented by the MOH. February 2010.

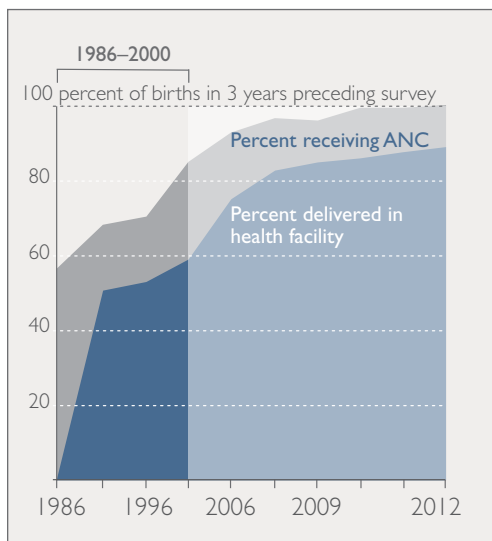
A group of first graders enjoy recess at their school in Altos de los Mores. Altos de los Mores is an impoverished community in Peru's northern desert near Piura.



“In the 1990s, USAID focused on raising awareness about the importance of family planning: There was availability of diverse contraceptives, good data and contraceptive security, and a good number of organizations were offering family planning services in Peru.”

— Lindsay Stewart, HIV/AIDS and Family Planning Advisor, Latin America and the Caribbean Bureau, USAID

Between 1986 and 2000, the number of pregnant women receiving antenatal care (ANC) rose from 55.7 to 83.4 percent.



The Good Start Project promotes early growth and development, from conception to three years, mainly through the reduction of chronic and micronutrient deficiency malnutrition (iron, Vitamin A and iodine).

UNICEF



Maternal Health

The story of child survival in Peru begins with the state of the mother's health and the level of health care that she receives before, during, and after childbirth. Although the country's infant mortality rate had been declining steadily over the few decades before the 1990s, Peru's MMR of 265 deaths per 100,000 live births was among the highest in Latin America in 1991–1992.^{69,70}

Lack of maternal health care, limited access to family planning information and services, and malnutrition were all major contributors to Peru's high MMR, particularly for women in rural areas.⁷¹ For example, at the end of the 1980s, only 39% of pregnant women in rural areas received prenatal care, and as few as 15% of births in rural areas took place in some kind of health facility.⁷² In addition, in 1986, only 23% of married women reported using modern contraceptives.^{73,74}

In 1994, the MOH undertook an ambitious primary health care program—the Program for Basic Health for All (*Programa de Salud Básica* or PSBT)—to expand its network of primary health care facilities, including maternal health care and family planning. Between 1995 and 2000, the GOP increased the number of public health posts, clinics, and centers by more than 50% and added more than 10,000 medical and paramedical staff across the country.⁷⁵

USAID supported the MOH throughout this expansion with integrated projects that strengthened maternal and child health care on both the supply and demand side. Projects

focused on building the capacity of health professionals and systems in rural and peri-urban areas and working with mothers and families in remote communities on health education and disease prevention. These projects contributed to the decline in Peru's maternal mortality ratio from 265 maternal deaths per 100,000 live births in the 1990–1996 period to 185 maternal deaths in 1994–2000.⁷⁶

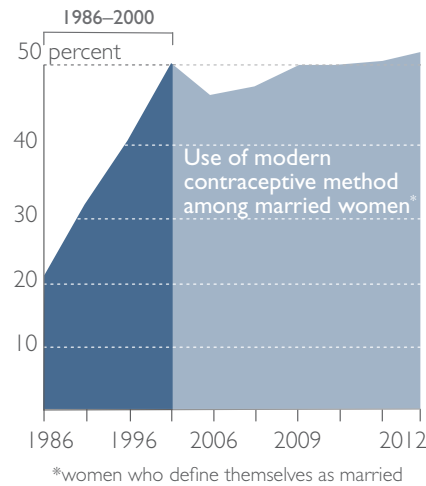
Family Planning and Reproductive Health

As mentioned earlier, President Alan Garcia's administration created the National Population Policy (NPP) in 1985 to provide Peruvians with information, health services, and contraceptive methods (other than sterilization), enabling them to make better-informed decisions on family size.⁷⁷

Following its enactment, USAID funding helped the MOH implement Peru's first National Family Planning Program (NFPP, 1987-1990).⁷⁸ Through projects such as the Integrated Health and Family Planning Project, USAID provided family planning supplies and information to mothers and couples, as well as capacity building and technical assistance to community health promoters and pharmacists in peripheral urban areas.⁷⁹ As more families gained access to family planning information and methods, the national fertility rate dropped from 4.1 in 1986 to 3.5 in 1991.⁸⁰

Declaring 1991 to be “The Year of Family Planning” in Peru, the GOP launched the second NFPP (1991-1995), further expanding family planning programs in underserved, rural areas.⁸¹ Donors, including USAID, continued to provide 100% of the contraceptive commodities for the MOH, as well as significant technical assistance, training resources, management and oversight capacity, information, and communication support. This support enabled the MOH to use its own funds to build health posts, clinics, and centers across the country, primarily in rural areas, in order to expand primary care and family planning services.⁸² Such services were sorely needed, as rural fertility rates were more than double those in urban areas in 1991-1992

By the end of the 1990s, contraceptive use had grown to 50 percent.



(6 children per family, compared to 3), and over half of pregnancies in rural areas were unintended.⁸³

Meanwhile in the global arena, family planning and reproductive health were getting plenty of attention following the United Nations' 1994 International Conference on Population and Development in Cairo, Egypt and the 1995 Fourth World Conference on Women in Beijing, China. These conferences brought the world together in affirming that women and girls should have access to voluntary sexual and reproductive health services, promoted women's rights and empowerment, and raised awareness on the health benefits of family planning. Reproductive health and women's rights were in the global spotlight, which helped set the stage for several significant changes in Peru.

With the support of USAID, the Peruvian NGO APROPO devised a social marketing campaign to support family planning

demand generation and empower families to make smart reproductive health decisions. Launched in the 90s, in close coordination with the MOH, APROPO's three-phased “*Las Tromes*” y “*Los Tromes*” (local slang for ‘champions’) campaign was highly regarded among women and men, media stakeholders, and civil society representatives.

In 1995, the MOH attempted to eliminate financial barriers to contraceptive use by offering free family planning products and services to everyone who wanted them. This change represented a major policy shift. Before then, free family planning had only been available to poor residents in rural areas. That same year, the government legalized surgical sterilization as a method of contraception. With the expansion in service delivery and sudden availability of free contraceptives, use of modern methods climbed to 41.3% of married women by 1996, compared to just 23% a decade earlier.^{84,85}

While the increased usage of contraceptives was very welcome, financial realities soon got in the way of the MOH's new free-for-all policy. Demand for family planning methods began outstripping supply, and problems surfaced as several NGOs and the Catholic Church accused the MOH of assigning numerical targets and quotas to the health personnel who were performing

Peruvian health champion: DR. LUCY LÓPEZ

Enabling Peru's first national pharmaceutical purchase

In her role as Reproductive Health and Family Planning Advisor for USAID/Peru in the 1990s, Dr. Lopez was instrumental in helping the Mission start collaborating with the MOH, working first at Development Associates, a U.S.-based NGO, then directly for USAID/Peru.

One year after she transferred to USAID/Peru in 1996, Dr. Lopez was called upon to negotiate with the MOH on contraceptive financing. At that time, Dr. Lopez explained, the annual budget appropriation rules did not allow spending on contraceptives, and USAID had little choice but to directly fund purchase of family planning commodities. With USAID funding, the MOH contracted PRISMA, a Peruvian NGO, to improve the entire contraceptive procurement, distribution, and training system in Peru.

In 1999, the GOP passed a new law permitting national purchases of contraceptives. Initially, the MOH was reluctant to allocate funds for purchasing contraceptives, and sent a letter to USAID requesting the Agency to continue to fully fund Peru's contraceptive purchases.

Dr. Lopez explained that USAID funding was insufficient to meet the demand, so they negotiated with the MOH on ways to better target USAID support for contraceptive purchases. At first, USAID agreed to fund condoms and pills if the GOP would commit to financing injectables, which were the most popular method. "The ultimate goal was to completely stop purchasing contraceptives for Peru," says Dr. Lopez. "The quickest way to do that was to encourage the GOP to buy inputs for the most popular method, right from the start."

Following these negotiations, the MOH made its first national purchase of contraceptives through the UNFPA's procurement mechanism in 1999. Over time, the GOP gradually increased funding for contraceptive purchases for MOH family planning facilities, persuaded by persistent arguments from Dr. Lopez and USAID/Peru that taking on those costs would help the country ensure program sustainability and would demonstrate the GOP's respect for human rights.

A change in government in 2001 resulted in the MOH not purchasing contraceptives for a year, although it had a line item in the budget to do so. For political reasons, the Minister at that time refused to buy family planning commodities and there were serious stockouts throughout the country. Due to strong civil society advocacy in mass media for women's reproductive rights, (stemming from work done over the years by USAID with local NGOs on advocacy), the Minister's position changed and the purchase of family planning commodities resumed. However, serious stockouts in the public sector lasted for about 18 months until orders could be filled and distributed. At the same time, public sector VSC services were largely unavailable.

After seven years of continual negotiations and monitoring, Dr. Lopez and her USAID/Peru colleagues finally achieved their objective—the MOH purchased its entire stock of contraceptives using its own funds for the first time in 2004.

“The ultimate goal was to completely stop purchasing contraceptives for Peru. The quickest way to do that was to encourage the GOP to buy inputs for the most popular method, right from the start.”

DR. LUCY LÓPEZ

former Deputy Healthy
Manager of the Municipality
of Lima and former USAID/
Peru Reproductive Health and
Family Planning Advisor

“USAID always looked for ways to make their interventions sustainable over the long term. They knew that NGOs were the hardest hit when the funding goes away, so they supported our efforts to develop and market a brand of condoms that we are still selling in the private sector today.”

— Trixsi Vargas, Sexual and Reproductive Health Specialist, APROPO, Commercial Family Planning Project

sterilizations. This led to accusations that the GOP was pressuring citizens to undergo surgery without providing full information or obtaining voluntary consent, and that there were fatalities due to poor quality procedures.⁸⁶

No USAID funds were used to support the GOP's sterilization campaigns.⁸⁷ Nevertheless, in response to these reports and reports of coercive sterilization programs in other nations, US Congress passed what is known as the Tiahrt Amendment.⁸⁸ The Tiahrt Amendment codified USAID's long-standing principles of voluntarism and informed choice and established requirements that were designed to prohibit the use of US foreign assistance funds in coercive family planning programs.⁸⁹

By this time, the debt crisis had come to an end, Peru's economy had begun to improve, and the US had begun phasing out contraceptive commodity donations to the MOH.⁹⁰ Prior to the phase-out, USAID projects such as the Private Commercial Family Planning Project began using social marketing, counseling services, and communication campaigns to steer those who could afford it toward private family

planning products and services.^{91,92} In addition, USAID launched the 10-year ReproSalud project in 1996, which used a unique “self-diagnosis” methodology to help clients in poor, rural areas better understand family planning and reproductive health needs. The project worked closely with women to teach them about their reproductive health rights and hired men to run male-focused health workshops to explore the relationship between traditional male roles and health. In addition to improving knowledge and attitudes about reproductive health and contraceptive outcomes, ReproSalud was credited with increasing the use of health services and empowering individuals, households, and communities.

Throughout the 1990s and the early 2000s, USAID continued supporting a number of local NGOs that provided a broad range of high-quality fixed and itinerant FP/RH services to paying clients in urban and rural sites through the ALCANCE project. These local NGOs had close links with the communities they served, provided market segmentation, and offered a “back-up” to service provision by the MOH.

After the passage of the Tiahrt Amendment, USAID had also begun providing support to help the MOH conduct an annual family planning survey. In 2000, findings from that survey revealed evidence that the Tiahrt Amendment had been violated at one USAID-supported clinic. USAID reported the violations to the US Congress and brought the survey findings to the GOP, which took immediate action to ensure that the activities that were in violation of the Tiahrt Amendment were stopped. This included ensuring that there was no denial of rights and benefits to individuals who choose not to use family planning. It also meant ensuring that individuals were not given incentives in exchange for accepting family planning. The MOH and the Ombudsman's office, with USAID support, worked together to change the MOH's service delivery strategy. The changes included requiring all service providers to be trained on voluntarism and informed choice, explicitly prohibiting incentives or denial of benefits, and putting measures in place to improve quality of care, including procedures to ensure informed consent for sterilization.



TOP LEFT: Ceremony for USAID condom donation to the Peruvian Ministry of Health in November, 2010.

ABOVE: ANC through the Buen Inicio project promoted early growth and development from conception to three years.

LEFT: Families, such as the one pictured, accessed services from the conditional cash transfer program, called *Juntos*, which aimed to serve the poorest families in rural and urban communities. The USAID-funded Health Policy Initiative Task Order I collaborated with the program to strengthen the reproductive health information and counseling components by integrating the cultural beliefs, practices, and relationships of indigenous groups.

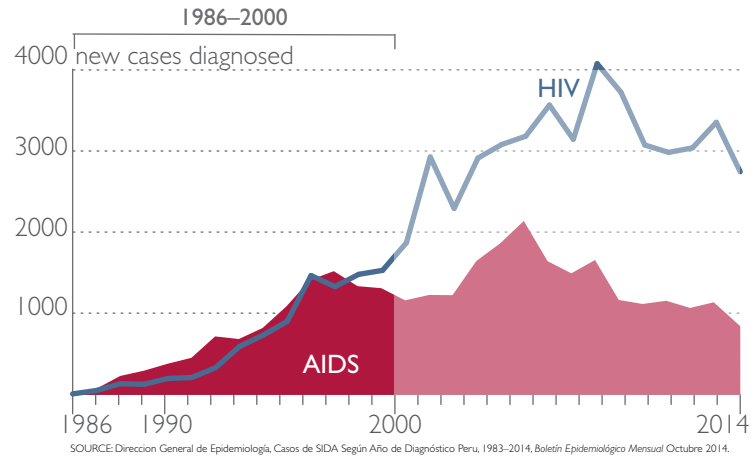


Condom use for men who have sex with men began to be promoted in venues such as this nightclub.

HIV/AIDS

At the end of the 1980s, HIV/AIDS emerged as an infectious disease threat and reports of AIDS cases in Peru expanded rapidly through the early 1990s. By the late 1990s, incidence of AIDS had reportedly stabilized at roughly 1,000 cases per year. Most of the infections were geographically concentrated among urban areas (particularly in Lima), other coastal cities, and in the jungle.⁹³ Infections were demographically concentrated among young men, specifically men who have sex with men and male sex workers.

In Peru, young men bore the brunt of the AIDS burden throughout the 1990s. Men accounted for 75% of all reported AIDS cases in 1998 and 70% occurred among those aged 20 to 39. While men who had sex with men and male sex workers were the most affected, an increasing number of women and heterosexual men contracted the disease. By 1998, women accounted for about 25% of all reported AIDS cases.⁹⁴



In the late 1990s, HIV and AIDS diagnoses diverged as people living with HIV became more numerous.

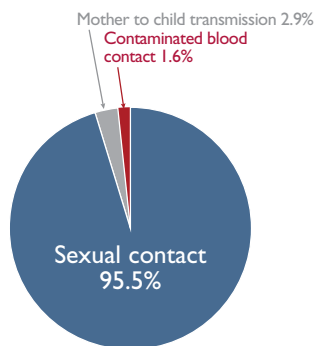
In 1986, the GOP responded to the emerging HIV/AIDS epidemic by creating a multisectoral AIDS commission. As the number of cases in the country continued to grow, the MOH founded its AIDS and Sexually Transmitted Infections Control Program (PROCETSS) for HIV/AIDS and STI prevention and care in 1995.⁹⁵

One of PROCETSS' first accomplishments was a collaboration with the Peruvian Congress to pass a law in 1996 that protected the rights of people living with HIV/AIDS, the Reglamento de Ley No. 26626.⁹⁶ With support from the USAID AIDS Help Project, PROCETSS established a National Advisory Council on HIV/AIDS with representatives from the government, NGOs, military, private sector, and HIV/AIDS community. Meanwhile, USAID worked with UNAIDS and other organizations to start a donors group to encourage support for HIV/AIDS prevention, care, and programming in Peru.⁹⁷

The broad collaboration among stakeholders on solutions to HIV/AIDS yielded many

benefits. Participating NGOs received training and technical assistance to strengthen their technical and management capabilities and improve sustainability. The MOH gained new knowledge and experience in planning, managing, and monitoring decentralized HIV/AIDS operations, as well as technical support to improve its capacity to secure financial resources for HIV/AIDS prevention, care, and support. NGOs and the private sector gained a greater voice in the planning, design, and implementation of activities geared toward HIV/AIDS and STI prevention and care.⁹⁸

When the AIDS Help Project ended in 1999, many of its best practices and some of its activities were transferred to VIGIA, a project that addressed the threats of emerging and re-emerging infectious disease. Other activities were taken on by NGOs and other organizations that had gained a sense of ownership through their participation in the project.⁹⁹



The AIDS burden early in the 1990s was largely borne by men who have sex with men and male sex workers.

Perhaps the greatest testament to the project's success was the financial and institutional sustainability that PROCETSS gained from the GOP. Between 1997 and 2000, the MOH more than doubled PROCETSS' budget, increasing it from \$2.42 million to almost \$6 million, so that it could scale up HIV/AIDS and STI prevention activities across Peru.¹⁰⁰

Seeing the high level of support for PROCETSS at the national level inspired regional and local governments to follow suit, enabling the program to obtain many additional resources. For example, in Iquitos, PROCETSS only had funding for one position: the regional PROCETSS coordinator. However, the regional government paid the salaries of more than 35 employees involved in HIV/AIDS and STI prevention or care, several of whom worked full-time on managing or providing HIV/AIDS and STI services as coordinators, counselors, clinicians, or laboratory technicians.¹⁰¹

PERU'S AIDS AND SEXUALLY TRANSMITTED INFECTIONS CONTROL PROGRAM (PROCETSS): A MODEL FOR PREVENTION IN THE REGION

As the team at Peru's newly created HIV/AIDS prevention and treatment agency, PROCETSS, studied the fast-paced growth of HIV/AIDS infections in the country, they became concerned. They needed to do something to prevent more infections. Turning to USAID for help, the staff at PROCETSS worked with the health team at USAID to develop the AIDS Help Project. With technical assistance from the AIDS Help Project, the team studied evidence on HIV/AIDS transmission risk factors and mechanisms.

Among their findings was a nuanced understanding of how Peruvians are more susceptible to becoming infected with HIV/AIDS if they already they have an STI. PROCETSS was one of the first to adopt an innovative strategy known as STI syndromic management that enabled STI clinics to initiate appropriate treatment at the first sign of STI symptoms, rather than waiting for laboratory confirmation of disease. Thus, in 1996, the program became one of the first in Latin America to link HIV prevention with STI control through a deliberate and concerted management system.

To address mother-to-child transmission of HIV, PROCETSS implemented yet another innovative strategy in 1996. It began using zidovudine prophylaxis to prevent

transmission of HIV/AIDS during childbirth, again becoming one of the first countries in Latin America to do so.

In addition to employing biomedical prevention strategies, PROCETSS also worked with USAID, NGOs, and other institutions on reaching out to men who have sex with men, sex workers, and other high-risk groups to promote safe behaviors. In 1997, under the AIDS Help Project, PROCETSS supported the formation of the *Red SIDA Perú*, or Peruvian AIDS Network of NGOs, to work directly with people in high-risk communities. After receiving training and peer education materials through the AIDS Help Project, members of the network became peer educators and worked with young people, men who have sex with men, and sex workers in Lima, Callao, Iquitos, and other cities to promote condom use and facilitate access to STI/HIV prevention services. Since the peer educators usually belonged to the same high-risk groups, they tended to be very effective in engaging their peers and promoting healthy behaviors.

Recognizing the many successful interventions of PROCETSS, UNAIDS heralded the program a model STI/HIV prevention program in the Andean region in the late 1990s.

Health Systems Strengthening

In the early 1990s, the MOH had to contend with a number of major shortcomings in the health system: high turnover, chronic and debilitating strikes, inadequate logistical support, and an inability to extend services to the most remote and needy areas of the country.¹⁰² Overcoming these challenges meant strengthening the system at all levels, and improving coordination between the national and community levels.

Testimonials gathered from families across Peru under Project 2000, ReproSalud, and other projects demonstrated that building strong health care networks required more than just technical expertise. Collecting relevant data and getting input from stakeholders such as NGOs, community leaders, and health care providers to policy makers at all levels is essential for creating high-quality health systems and effective health policies.

At the national level, USAID helped the MOH develop a nationwide continuous DHS so that policy makers would have a better understanding of health and population trends in the country. Since 1986, Peru has used the DHS to collect information every five years on fertility; reproductive, maternal, and child health; immunizations and survival; HIV/AIDS, malaria, and other infectious diseases; and stunting and nutrition status. Health officials and others use this data, now collected on a continuous basis, to design projects, monitor and evaluate health programs, and develop policies.¹⁰³

Through projects such as Project 2000 and the Child Survival Action Program, health managers from the MOH, USAID, and NGOs supported the MOH in developing and implementing new processes, models, and information systems at the national level. They created a nationwide health and management information system, a cost-based planning and budgeting system, an

active epidemiological surveillance system, patient monitoring systems for health care facilities, and a system to set services fees according to family income. They also developed national quality standards for maternal and child health care and created national teaching hospitals to train health care providers to apply these standards. In addition, they began developing strong, decentralized pharmaceutical management programs around the country, implementing standard treatment and storage guidelines in national-, regional-, and hospital-level drug formularies.^{104,105}

Advocacy and coalition building were key elements for strengthening health policies and systems at the local level. Through USAID's POLICY Project, for example, regional members of organizations such as the RNPM received advocacy training and learned how to work with local authorities on issues around sexual and reproductive health.¹⁰⁶

EMPOWERING COMMUNITIES TO IMPROVE HEALTH CARE

The mission of Peru's RNPM is to put sexual and reproductive health on the agendas of local health care providers and local governments. In May 1998, RNPM organized the Symposium on Citizen Oversight for Healthy and Safe Motherhood to determine best practices for improving sexual and reproductive health programs; out of this emerged the concept of citizen committee oversight of health services. USAID gave RNPM a grant to form oversight committees in three regions.

Committee members, many from grassroots organizations such as community kitchens, local mothers' clubs, and Vaso de Leche (Glass of Milk) organizations, monitored pregnant women and gathered their perceptions of available health services. The MOH supported the committees by distributing standards of care, which the committees have used to develop parameters for oversight.

The initial committees were so successful that, a year later, a national

forum on sexual and reproductive rights recommended that every region in Peru form committees to manage the controversy over voluntary surgical contraception. Country-wide regional offices agreed to work with the committees to monitor and improve health services. Currently, citizen oversight committees are operating in 11 of Peru's regions, and the UNFPA is supporting similar initiatives in other regions of the country.

“*Citizen oversight is an attitude of ongoing commitment, participation, and awareness to create change in favor of the community and influence decision-makers so that policies and their application are truly to our benefit.*”

— RNPM Symposium on Citizen Oversight for Healthy and Safe Motherhood, May 1998

A boy in rural Tabaconas Valley



Indigenous women queue in the main plaza of Combapata to receive monthly benefits. The *Juntos* (Together) program, a conditional cash transfer (CCT) government program, provides cash to the poorest families if they meet certain criteria. Recipients must have children under the age of 14, enroll their children in school and have them vaccinated. Pregnant mothers are required to utilize mandatory pre- and post-natal healthcare programs. The Peruvian *Juntos* program was launched in 2005.

The 2000s: Expanding partnerships, building friendships



27.412
2007 population in millionsⁱ



2.8
2000 total fertility rateⁱⁱ



60
under 5 mortality per 1,000 live births, 2000ⁱⁱⁱ



31.3
percent of stunting in children, 2000ⁱⁱⁱ



185
women in 100,000 died of maternal causes, 2000ⁱⁱⁱ



\$50,936
2000 gross domestic product in millions (US dollars)ⁱⁱⁱ



71
life expectancy in 2000ⁱⁱⁱ

SOURCE:

INEI Censo Nacional de Población y Vivienda

ⁱDepartment of Health Services, Peru

ⁱⁱⁱWorld Bank Indicators

Compared to the political, economic, and social turmoil of prior decades, Peru was in a better place by the beginning of the new millennium, at least from a macroeconomic standpoint. Nevertheless, the country was still in a recession and the outward-facing macroeconomic improvements had not benefited the majority of the country's families. Over half the population remained poor at the start of the 2000s, and about 25% continued to live in extreme poverty.

In 2000, the Peruvian economy began to falter once again following President Fujimori's resignation. Later that year, the transitional government merged the Child and Mother Insurance and the Free School Insurance programs to create a more efficient program and a better procedure for targeting beneficiaries. The consolidated programs served as the basis for the Comprehensive Health Insurance (SIS) program.

Alejandro Toledo succeeded the transitional government. During Toledo's administration, HIV/AIDS, family planning, and reproductive health programs, among others, merged into larger umbrella programs; individual programs lost their visibility. In addition, tuberculosis, child immunization, and other programs suffered cuts in funding and management capacity.^{107,108}

However, President Toledo created a national roundtable on poverty in the initial years of his presidency, giving civil society a voice in designing and monitoring social policies and programs. A group of women's organizations, NGOs, health professionals, and academics formed the Bureau of Health Surveillance, Sexual and Reproductive Rights to pressure the government to renew support for family planning. In 2004, Peru's new Minister of Health, Dr. Pilar Mazetti, ushered in a new climate of support for women's health, family planning, and other neglected programs.¹⁰⁹

“USAID was always willing to go into the areas where people had the greatest needs—the ones that were hardest to reach.”

— Edita Herrera, Participation Coordinator, POLICY Project





A newborn is treated for jaundice in a phototherapy incubator at Puno Regional Hospital. Due to government funding, Puno Hospital is able to afford expensive phototherapy units like this one.

BELOW LEFT: Washing hands, rubbing with water and soap, at Iguain primary school.

BELOW CENTER: Health center staff demonstrating how the "Parto vertical" or "vertical birth" station works at Pomabomba Health Clinic in Ayacucho.

BELOW: Festival celebrating and promoting clean water.



© JANE SILCOCK/USAID



“We have seen [USAID] not as strangers that come to collaborate with us, but as friendly colleagues that come to coach us. I always told them how happy I was to see them. I am also thankful [to] them for coming to work with us in the San Martín region, in our network, in our micronetwork, and our health facilities, to see how we work and implement the tools.”

— Excerpts, Dr. Marcia Rios, Head of Moyobamba Health Network, San Martín region

The *Juntos* conditional cash transfer program was also created under President Toledo's administration to encourage families to use available health, education, and nutrition services to break the cycle of poverty across generations. After Alan García regained the presidency in 2006 (his first presidency was in 1985–1990), the GOP improved health assistance for the poorest Peruvians by expanding the *Juntos* program.

By 2007, the Peruvian economy was one of the most vibrant in the region, and the GOP launched a national nutrition strategy called CRECER to reduce the country's stubbornly high child malnutrition rates. The SIS was also strengthened in 2008, and a universal health insurance policy was approved in 2009. USAID supported both CRECER and the universal health insurance policy through projects such as the Good Start Project, Healthy Communities and Municipalities, the Child Nutrition Alliance Project, and the Program of Integrated Actions to Improve Child Nutrition (PAIMNI), in the case of CRECER, and the Promoting Alliances and Strategies (PRAES) project, the Health Policy Initiative, Health Systems 20/20, and Healthy Policy Project in the case of the universal health insurance policy.^{110,111} Since assuming the presidency

in 2011, current President Ollanta Humala's administration has continued to expand access to high-quality, socially and culturally inclusive health care across the country in an environment of healthy economic growth.

USAID continued to support Peru's poverty alleviation work in the 2000s through social investment projects in many sectors, including the health sector. One of its strategic objectives was to improve the quality of primary health care and family planning services, and to increase access to these services among Peru's poorest families. USAID partnered with private sector and civil society organizations to promote and provide preventive and curative health care. USAID worked with those organizations and all levels of the MOH to strengthen viable institutions.¹¹²

Over time, USAID's support for Peru evolved from direct service delivery and donations of supplies and contraceptives to the provision of high-level technical assistance to help deliver high-quality health services to the Peruvian people. In the early 2000s, USAID began targeting its programs, including its health care programs, to regions with high levels of narcotrafficking and illegal natural resource exploitation, namely

San Martín, Ucayali, Amazonas, Loreto, Madre de Dios and Huanuco.¹¹³ USAID promoted development opportunities and services, including high-quality health care, to serve as alternatives to illegal activities. Such activities helped to strengthen subnational governments, which ultimately enabled USAID to begin extending direct financial support to regional government initiatives, such as in the case of PAIMNI project in the San Martín Region.

Family Planning and Reproductive Health

New challenges for Peru's family planning and reproductive health initiatives arose at the start of the new millennium. Between 2001–2004, the MOH downsized its family planning program and reassigned the staff to other divisions.¹¹⁴ Consequently, the MOH lost its core expertise in family planning at the central level, along with its ability to plan, supervise, and monitor family planning services.

These losses led to more frequent contraceptive stock-outs and irregularities, including instances where women were charged informal fees for public services. Not surprisingly, the use of modern contraceptive methods declined by 6% among poor



women nationwide in Peru, while use of traditional methods increased by 9% during the early 2000's.

Throughout the ups and downs in this decade, some family planning and reproductive health projects forged ahead, driven by popular demand and strong support from NGOs, health personnel, USAID, and other donors. For example, in the early 2000s, USAID worked on the Catalyst Project with a consortium of international and Peruvian NGOs, to provide low-cost contraceptives through a network of 650 private midwives in five of the country's poorest regions.

Other USAID projects, such as the ReproSalud project, even managed to expand and evolve, in spite of the challenging circumstances. By the time the project ended in 2005, it had reached almost half a million people and had grown in scope. In addition to family planning and reproductive health, the project focused on training and supporting community leaders on related issues including income generation, domestic violence, women's empowerment, and social isolation, working hand-in-hand with projects such as POLICY (see sidebar opposite).

Before the ReproSalud project ended, the climate for family planning and reproductive health began to improve. In 2004, many barriers were finally lifted following the consecutive appointments of two ministers of health: Dr. Pilar Mazetti with the Toledo administration in 2004 and Dr. Oscar Ugarte under the second administration of President Alan Garcia in 2006. Under their leadership and with USAID support through projects such as Rational Pharmaceutical Management (RPM) and its successor, RPM Plus, the GOP took on full responsibility for financing national contraceptive procurements and for distributing those commodities to health facilities throughout the country.

In 2006, USAID's Health Policy Initiative (HPI) continued where ReproSalud had left off, working with in-country partners to design and test strategies to meet the family planning and reproductive health needs of poor women, this time in the Junín Region. However, unlike ReproSalud, HPI worked with health authorities at every level. This enabled the project team to work with policy makers on integrating local findings into national policies, guidelines, and programs.

After working with the MOH to include family planning in the package of services offered to poor women through social insurance, the GOP published Supreme Decree N°004-2007-SA in 2007, which included reproductive health counseling and family planning on a list of eight national preventive priorities. In practical terms, the policy requires facilities that receive SIS funding to offer family planning services and supplies. In addition, the MOH incorporated findings from HPI in its guidelines on culturally appropriate counseling, which were approved in 2008 for use in health facilities in all areas with substantial indigenous populations.¹¹⁵

Such policies were important stepping-stones for the country. Peru was identified in 2006 as one of the Latin American and Caribbean countries that could fit the criteria for "medium-term graduation" (graduation in 3-6 years) from USAID family planning assistance and a graduation plan was put in place. Countries meet USAID's criteria for family planning graduation when they reach key indicators, including a total fertility rate of 3.2 or less and a modern contraceptive prevalence rate (MCPR) of at least 48

“The topic of violence against women as a public health problem emerged from our work on sexual and reproductive health. We supported the MOH in creating a new unit on gender and cultural rights, and in producing a national technical guide on gender-based violence that’s still used today at every level of the health system.”

— Edita Herrera, Participation Coordinator, POLICY Project

percent. Peru graduated from USAID family planning assistance in 2012.

With stronger health facilities and programs, sound policies, a cadre of skilled health professionals, and a robust economy, Peru is now much better equipped to provide its citizens with access to contraceptives and reproductive health care. However, high rates of adolescent pregnancy continue to be a challenge. Until recently, Peruvian law prohibited sexual relations, even consensual relations, between or with minors ages 18 or younger, which in effect, made it impossible to provide birth control or sexual education to this age-group. In 2013, advocacy efforts on the part of youth groups around the country, some with USAID support, succeeded in convincing the Peruvian high court to decriminalize consensual sexual relations between adolescents ages 14 to 18, finally opening the door to allowing Peru’s youth to receive reproductive health services and education.

POLICY LESSON: PARTICIPATION FROM CIVIL SOCIETY LEADS TO BETTER HEALTH POLICIES

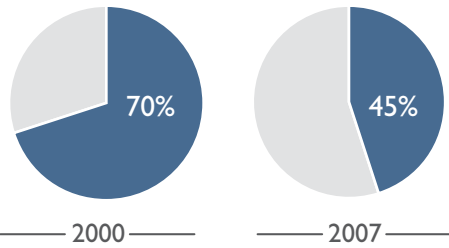
USAID’s POLICY Project used a tiered advocacy training program, in which the initial trainees became the trainers in their communities, to build the skills of local women’s groups through the country’s National Network for the Promotion of Women (RNPM). RNPM was founded in 1990 and is comprised of 25 department offices and 21 provincial offices made up of public institution representatives, nongovernmental organizations, and individuals. Through this work, USAID helped Peru to view civil society organizations as equal partners to identify problems and implement solutions, and groups like RNPM continue their good work today.

After completing courses on sexual and reproductive health policies, women’s health, and advocacy, women from all 25 of Peru’s regions became trainers in their own regions. They trained community leaders and representatives of NGOs, Ministries of Health and Education, and local governments. By involving the public sector in the workshops, the RNPM enlisted them

as allies, which helped reach key decision-makers, such as the regional ministry directors, mayors, and regional council heads.

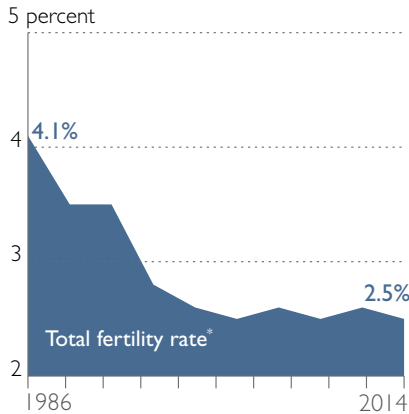
As they work more closely with local authorities, government agencies recognize and value the input of civil society organizations. They become more receptive to working with them, including participating in mechanisms for ongoing collaboration, such as citizen oversight committees. The Ministry of Women and Human Development hired the RNPM to train its staff on the issue of violence against women, and the MOH hired RNPM to raise awareness of sexual and reproductive rights among health care providers.

The alliance between the POLICY Project and the RNPM led to the creation of a network of skilled civil society advocates throughout Peru. The alliance showed that a decentralized network of women’s organizations can have nationwide impact and that partnerships between civil society and government are the foundation for responsive policies.

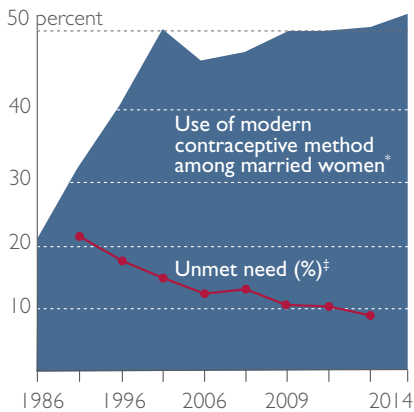


Percent of deliveries in rural areas that took place outside of health facilities

Although the fertility rate was falling quickly in 2000, contraceptive use and percentage of deliveries performed in health facilities, particularly in rural areas, still lagged.¹¹⁶



*Total fertility rate is the average number of children that would be born to a woman if all women lived to the end of their childbearing years.



*women who define themselves as married
 ‡ Unmet need refers to those women who say they want to delay or avoid pregnancy but are not using any method of contraception.

Maternal and Child Health

At the turn of the millennium, Peru still had one of the highest levels of maternal mortality in Latin America, with a maternal mortality rate (MMR) of 185 deaths per 100,000 live births.¹¹⁷

Moreover, the MMR varied significantly by geographic region. In some low-income regions, the MMR was over 500 deaths per 100,000 live births.¹¹⁸ This meant that women living in areas such as Ayacucho, Amazonas, or Puno were 14 times more likely to die in childbirth than women who had moved to Lima before having children.

Underlying the high MMR was the fact that many women in Peru were still delivering babies at home, far away from the closest health facility and often with birth attendants who were not equipped to handle complications. This was particularly true in rural, low-income areas, where almost 75% of births occurred in non-institutional settings in 2000, in spite of the GOP's efforts to provide free prenatal and delivery care services there.^{119,120}

USAID continued to support the MOH's efforts to improve maternal health through a portfolio of projects in the 2000s, including

Project 2000, Coverage with Quality, and Quality in Healthcare, which together worked directly with national, regional, and local government authorities; health service providers; and community service organizations to improve the quality and reach of primary health services, including maternal care.

These projects produced important culturally appropriate innovations, including dedicated birthing homes, where rural women could await childbirth during the final weeks of their pregnancies. During delivery, women were free to choose whether to use the traditional “vertical birthing” method (i.e., giving birth while standing or sitting) or the modern horizontal childbirth method of lying on one's back. Regardless of which method a woman selected, trained healthcare professionals attended each birth, ready to step in if complications arose. Such adaptations proved to be lifesaving for many women, and as more women began to use birthing homes around the country, maternal deaths began to drop.

Peru's focus on maternal health created a safer environment for women giving birth and maternal deaths had dropped from 185 per 100,000 between 1994 and 2000 to 93 per 100,000 live births between 2004 and 2010.¹²¹



There were dedicated birthing homes, where rural women could await childbirth during the final weeks of their pregnancies. Women were free to choose whether to use the traditional “vertical birthing” method or the modern horizontal childbirth method of lying on one’s back.



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A Quechuan family in Huaraz. Despite the laborious work in which they are involved, women often have many children. Beginning to live such a lifestyle at relatively young ages, they become accustomed to these responsibilities, carrying their children on their backs as they work throughout the day.

Child Health and Nutrition

In 2000, chronic malnutrition for children under age 5 was still high, at 28% nationally. Tremendous geographic differences were also still evident, with rates as high as 43% in some rural areas, compared to 10% in the cities.¹²² Peru also had one of the highest rates of anemia in Latin America among children—almost 50% for children under age 5 and 69% for children under age 2. In rural areas, rates were even higher.¹²³

In spite of Peru's high child malnutrition rates, US funding for the country was on the decline, in large part due to Peru's impressive economic recovery and high growth rates in the mid-2000s. In 2006, the US PL 480 Title II program (Food for Peace) closed in Peru, eliminating an important source of funding for child malnutrition projects.¹²⁴ That same year, President Alan Garcia declared that combating chronic malnutrition was a national priority.

The GOP began consolidating and integrating some of its social initiatives several years earlier when it approved the Comprehensive Childhood Healthcare Model in 2003 and the Integrated

Management of Childhood Illnesses strategy in 2005. However, the 2007 launch of the CRECER (“Grow”) strategy, which aimed to reduce chronic childhood malnutrition among vulnerable and at-risk groups and improve children's prospects for escaping poverty, took its efforts toward integration to a whole new level.¹²⁵

USAID's Good Start project, carried out in partnership with UNICEF, NGOs, and community groups, which promoted integrated support for child nutrition, health, hygiene and early development, supported the creation of Peru's Integrated Management of Childhood Illnesses strategy. Results included a reduction in child malnutrition of at least 20% in each region and provided important lessons that helped inform the development of Peru's CRECER strategy after the project had finished.¹²⁶

USAID supported the MOH in implementing the country's CRECER strategy through projects such as the Healthy Communities and Municipalities (HCM). Continuing the progress achieved through Title II programs and Good Start, the HCM Project helped local community

organizations teach families how to adopt healthy habits, including incorporating nutritious foods in their children's diets, and how to monitor each family's progress.^{127,128} It also helped strengthen local community organizations and worked with local, regional and national authorities to transfer project methodologies and initiatives into Peru's national and regional health and early child development programs.¹²⁹

USAID's assistance helped Peru reduce its national chronic child malnutrition rate to 10.7% in 2014, almost a two-thirds reduction from the malnutrition rate in 2007 (28%). In San Martín, which implemented its Program of Integrated Actions to Improve Child Nutrition (PAIMNI) with USAID's support, the reduction in child malnutrition was especially impressive: in just a few years, the regional rate dropped by almost half in three years, from 28.2% in 2009 to 14.3% in 2012 (see opposite). The PAIMNI project was one of several USAID-supported programs (CRECER Wari in Ayacucho was another) that successfully implemented a regional version of the national CRECER strategy, adapted to the local regional reality.¹³⁰

Peruvian health champions: Improving chronic malnutrition through intergovernmental and intersectoral intervention

SAN MARTÍN REGIONAL HEALTH TEAM

When Regional President Cesar Villanueva of San Martín was preparing his accountability report after four years in government at the end of 2010, he and his team were shocked to realize that although his region had the highest levels of regional investments in health over the last four years (800 million *soles*), it also had a 28.6% rate of chronic malnutrition, higher than the national average of 26.06%.¹³¹

Villanueva committed to an ambitious goal of decreasing the rate of chronic malnutrition by 10 points over four years and asked Social Adjunct Manager Sofia Velasquez and Regional Health Director Neptalí Santillán to lead this effort.¹³²

The regional staff shared its priorities with the Health Policy USAID project team, led by Midori de Habich with Dr. Anibal Velásquez, to collaborate with local authorities on applying a multidimensional model in the program design previously validated and published in *Lancet/PAHO*.¹³³

Their coordinated efforts created the Program for the Control of Chronic Childhood Malnutrition (PAIMNI) that implemented cost-effective health interventions, such as service quality improvements and early education for children under age five. The main strategy of the project was (and continues to be) to help align decisions made at local, regional and national levels. The participation of families, communities, and municipalities under USAID's Healthy Communities and Municipalities (HCM) project was an important element of PAIMNI's success.¹³⁴

The innovative financing agreement between USAID and San Martín Region proved successful. The regional malnutrition rate dropped from 28.6% to 14.3% from 2009 to 2012, becoming one of the lowest chronic malnutrition rates in the country.¹³⁵ As Ms. Velasquez explains, it was the first time USAID transferred funds directly to a regional government. "The process for the region to directly receive USAID funds for PAIMNI was very demanding and stringent," she says, "but we complied with the requirements and secured the financing."

Today, the PAIMNI project is continuing to help the region reach its public health goals.



“ [USAID staff] came here; they walked on the roughest roads in our region. That’s why we considered them our allies, because they participated with the communities; they looked at the needs and helped find the best strategies to solve problems.”

— Lic. Sofia Velasquez, former Social Adjunct Manager and current Monitoring Chief of Social Sectors, San Martín regional government

“One of most important activities of the POLICY I and II projects was working with civil society leaders who were living with HIV... it was such a rich experience working with those leaders... because they had to work themselves and as a result, they were able to [understand] the modification of the Law 26226 [1996] concerning the counseling area...”

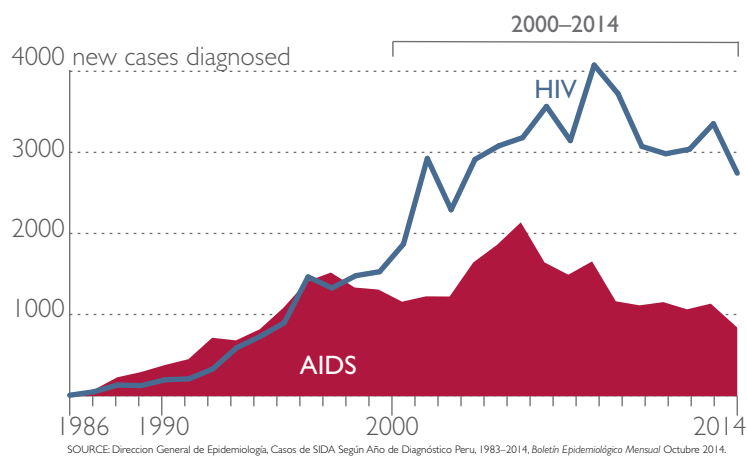
— Patricia Mostajo, former USAID chief of party for POLICY I and POLICY II projects (1998–2005)
(interview on October 17, 2014 and the Dialogue Workshop on October 23, 2014)



TOP: An HIV patient in Iquitos Hospital.

ABOVE: A health worker tests for malaria along the Mazan River in the Peruvian Amazon.

RIGHT: A health worker evaluates a child who has tested positive for malaria along the Mazan River in the Peruvian Amazon.



In the late 1990s, HIV and AIDS diagnoses diverged as people living with HIV became more numerous.

HIV/AIDS

In the 2000s, the burden of HIV/AIDS infections in Peru continued to be heavily concentrated in major cities in the Amazonian region and along the coast, including the capital of Lima and the main port city of Callao. It was still most prevalent among men who have sex with men and sex workers.¹³⁷

Although men accounted for 74% of adult infections by 2000, the gap between men and women was narrowing. In Peru, most cases of heterosexual HIV transmission occur in women whose partners are bisexual men or clients of sex workers. When women of childbearing age are infected with HIV and then become pregnant, they run the risk of passing the infection onto their babies during childbirth. In 2000, some 4,500 Peruvian children under the age of 15 were living with HIV, and there was concern that their numbers would increase if the epidemic became more generalized.¹³⁸

Tuberculosis patients, people with STIs, and indigenous populations also had high HIV infection rates, particularly in the Amazonian regions, where prevention and treatment services were scarce.¹³⁹ Since the most at-risk populations were also among the most marginalized, reaching them was difficult.¹⁴⁰

Although highly active ART was introduced in Peru in 1999, government-controlled resources became more limited in 2001, and the PROCETSS biomedical program was downsized.¹⁴¹

In 2002–2003, USAID funded a study at the request of the MOH to assess the conditions for implementation of a national ART program in Peru.¹⁴² Following that study, the country established a national ART program in May 2004.¹⁴³ Although the new program was a step in the right direction, national laws and guidelines around HIV/AIDS were outdated or in some cases, completely lacking. For example, there were no clinical guidelines for managing HIV-TB co-infections.¹⁴⁴ Much work was also needed at the regional level to improve surveillance,

prevention, and treatment, and coordination among sectors and regions.

USAID supported the MOH and regional health authorities to address issues related to HIV/AIDS on many levels. For example, the VIGIA project helped build capacity among health care providers at the regional level. Technical advisors from the MOH were brought to the Amazonian regions to strengthen the epidemiological surveillance system and to build the capacity of local personnel to identify, treat, and prevent emerging and re-emerging infectious diseases, including HIV/AIDS and STIs. When the project ended, some of those advisors returned to the MOH, thereby strengthening its understanding of regional processes, capacity, and challenges in regard to HIV/AIDS and STIs, and improving its decision-making ability.¹⁴⁵

Shortly after the VIGIA project ended in 2007, Peru's Council of Ministers approved a 2007–2011 Multisectoral Strategic Plan for HIV/AIDS. USAID was involved



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FAR LEFT: Regional workshop for quality improvement of care for people affected with TB in Madre de Dios, September 2010.

NEAR LEFT: Multisectoral workshop on prevention and control of TB in Madre de Dios, March 2011.

in supporting the national consultative process that led to the approval of the plan.¹⁴⁶ USAID provided support for its implementation via the Quality Healthcare (QHC) Program.¹⁴⁷

The QHC Program promoted multisectoral involvement in HIV/AIDS efforts among stakeholders at the national, regional, and local levels. At the national level, the project team assisted the ministry in updating current norms and guidelines and issuing new ones, including Peru's first national guidelines for the diagnosis and management of HIV-TB co-infection in adults, which was approved in 2006.¹⁴⁸

At the regional level, the QHC program brought together an extensive variety of stakeholders in various regions, including government agencies and private organizations, such as local associations of lesbians, gays, transgender, and bisexual and sex worker associations. Acting as a facilitator, the project helped these organizations work together to develop, implement, fund, and monitor their own regional multisectoral plans. Also, since the MOH had begun a decentralization effort several years earlier, the QHC

project's experiences in Loreto and Ucayali were documented as examples of effective decentralization in a report that is expected to serve as a roadmap for other regions.¹⁴⁹ In Ucayali, the project enabled seven health care facilities to provide High Activity Anti-Retroviral Treatment (HAART) or periodic medical exams to the populations most at-risk for HIV/AIDS. Between 2008-2012, the number of sex workers who received medical exams increased by more than five-fold, from 227 to 1,315; and among men who have sex with men, 1,802 received such exams in 2011, compared to 414 in 2008.¹⁵⁰

USAID continued to support community outreach in the 2000s, working through NGOs to develop prevention campaigns using the ABC approach (abstinence, be faithful, and correct and consistent use of condoms). It also trained peer health educators and funded a project to expand the supply of condoms through commercial providers, which included providing support for consumer counseling services through telephone hotlines and other venues.¹⁵¹

Several successful USAID-led interventions promoted the use of condoms for responsible parenthood and sexual activity

to prevent early pregnancies. For example, the Peruvian NGO APROPO launched a social marketing initiative to target sexually active 18- to 29-year-olds who did not use condoms or modern contraceptives. The strategy used private sector distribution channels to improve coverage and was implemented in 10 cities. The results showed that the private contraceptive market grew in the poor areas of those cities.

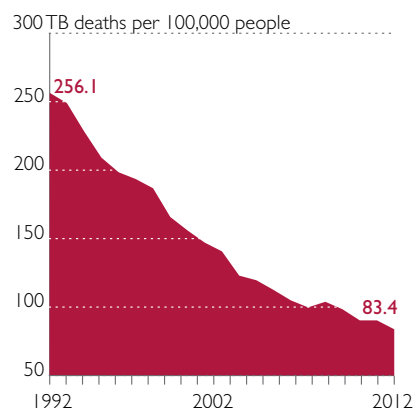
Over the course of the decade, the GOP began to assume responsibility for funding community-based peer outreach efforts and providing free ART therapy for newborns and pregnant women living with HIV, among others. Such support attests to the GOP's strong commitment to HIV/AIDS and STI prevention.^{152,153}

Infectious Disease

Infectious disease has been a problem in Peru for decades, and in the early 2000s, the problem was getting worse. One bright spot was the drop in incidences of TB from 256 cases per 100,000 people in 1992, to 156 cases per 100,000 people in 2000.¹⁵⁴

“Tuberculosis is largely an urban problem in Peru, and the country has a strong national TB program. The program did a cultural assessment and then developed a community treatment mechanism for the disease. It was discussed in a recent global TB conference at the WHO in Geneva.”

— Elizabeth Fox, Director, Office of Health, Infectious Diseases and Nutrition, USAID



Deaths from TB fell from 256 to 83 between 1992 and 2012.

Although the Amazonian region was the hardest hit by infectious diseases, other regions were also affected. For example, the north coast and the northeastern and central Amazonian regions all reported many cases of both malaria and dengue.^{155,156} Prior to the 2000s, the MOH’s ability to respond to infectious disease threats facing the country was hampered by its organizational structure. At the time, each disease had its own, separate program at the MOH and there was little coordination between them.

COMMUNITY SURVEILLANCE KEEPS TUBERCULOSIS PATIENTS FROM FALLING THROUGH THE CRACKS


Tuberculosis is one of the most important urban public health problems in the Americas. Peru has more TB cases than any other country in the region except for Brazil, with 28,598 cases in 2000, more than half of which in Lima’s most vulnerable populations.

Peru’s National TB Control Program sought to reach TB victims in so-called “hot spots.” It asked for USAID’s help in engaging local NGOs, churches, and community-based organizations to reach out to community members and provide a link to clinics. In 1995, with support from USAID, the National TB Control Program established community surveillance units to help monitor the community for TB victims and to ensure patient adherence to treatment. This program had impressive results. In five years of implementation, over 48,000 volunteers working with 22,000 community surveillance units served 750,000 families, often with help from mothers’ groups, patient and family support groups, and family parents associations. The rate of

treatment abandonment fell from 5.9% in 1995 to 2.8% in 2000.

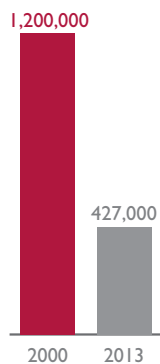
One group of health promotion volunteers, called el Grupo de Agentes Comunitarias de Salud de El Agustino, was recently recognized by the Pan American Health Organization (PAHO) for its work. PAHO supports people with multidrug-resistant TB in obtaining at-home treatment to reduce their risk of withdrawing from the program. This group also coordinates social support activities for TB patients and their families.

Such efforts have led to improvements in TB control indicators in the district of El Agustino, including fewer new TB cases, improved treatment adherence, fewer deaths, and a higher cure rate. In 2014, PAHO/WHO invited the mayor of El Agustino to commemorate World TB Day in Washington, DC, and to share their experience in engaging the community in local TB control. The program’s community surveillance units continue to receive support through a USAID grant.

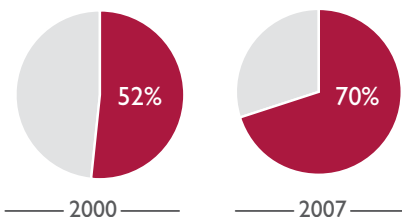


pueblo Limpio
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A young girl beside a cartel sponsoring the fight against dengue in Iquitos, Belen district. "A healthy people in a healthy village—All against dengue" reads the sign.



After the implementation of the Amazon Malaria Initiative, the number of new cases fell by 65%.



Timely treatment of respiratory ailments through access to care was critical to higher cure rates.



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Through its VIGIA project, USAID worked with the MOH to develop a 10-year coordinated plan to control infectious diseases with the highest disease burden, including malaria, dengue, TB, yellow fever, STIs, and HIV/AIDS.¹⁵⁷ The project strengthened the capacity of local health personnel in regions with high disease burdens to prevent intra-hospital infections and inappropriate use of antibiotics, and to conduct epidemiological surveillance and applied research. Programs, policies, and guidelines in each area were transferred to the MOH at the end of the project. The national health system benefited from lessons learned in regions with high disease burdens that could be applied to other regions.¹⁵⁸

In 2005, the VIGIA project conceived an intermittent rice irrigation initiative that reduced mosquito proliferation and

represented an important advance in the fight against infectious diseases, particularly malaria. The initiative (see page 41) was implemented in subsequent years under USAID's Amazon Malaria Initiative. As part of the Malaria Initiative, USAID helped ensure that malaria control programs in Peru and seven other Amazon Basin countries took advantage of international best practices to standardize surveillance, improve disease diagnosis and treatment, monitor drug quality and resistance, and improve control of disease-transmitting insects and other so-called vectors.^{159,160} During the project's implementation period, effective treatment for malaria in the Amazonian region contributed to a 65% reduction in new cases in the Americas, from 1.2 million in 2000 to 427,000 in 2013.

The MOH was also committed to controlling childhood infectious diseases such as measles, diphtheria, pertussis, and tetanus. USAID supported the MOH in this effort through its Millennium Challenge Corporation Immunization Threshold Program, aiming to expand vaccination coverage in targeted rural areas throughout Peru. This entailed training local health workers, providing technical assistance to ensure safe vaccine storage and transport, and improving cold chain management and logistics processes, all of which were addressed through the program.¹⁶¹



Health System Strengthening

“PHRplus, PRAES, and other projects followed a continuum. Each included elements related to health reform. The projects were connected to each other, and the human capital that was created through still serves the country today. This continuity is one of USAID’s strengths.”

— Midori de Habich, Former Minister of Health

“USAID recently supported health systems strengthening through a decentralized care project in San Martín that reduced chronic childhood malnutrition by 40%. The tools created during this project will remain in Peru for public health managers to use in their efforts to improve the quality and efficiency of decentralized health care.”

— Jo Jean Elenes, Acting Health and Education Office Chief, USAID/Peru

Although many health indicators in Peru had significantly improved by 2000, the health system still faced challenges in meeting the needs of its citizens, especially marginalized and dispersed populations. The Peruvian health sector was severely underfunded in 2000 and unable to cover the needs of the population, particularly the poor. Clients paid 39.3% of health care costs out-of-pocket, while the public health system covered just 24.3% of health costs and social security (payroll deductions) financed 33.5%.¹⁶²

USAID helped the MOH meet the needs of Peru’s vulnerable populations by supporting health system strengthening efforts on several broad fronts. These included projects to support the MOH’s health system decentralization efforts, improve health care access and quality, and develop more robust health information systems.

Health Sector Decentralization

Given the lack of health sector funding in the early 2000s, the MOH began a major integration and decentralization effort in 2001 to improve health service efficiency and reduce costs. It began by merging 14 national health programs into an integrated, life-stage-based health model. This involved eliminating autonomous program budgets, reorganizing the MOH, and transferring primary responsibility for health service delivery and some management functions from the central MOH to regional health offices (DIRESAs) and health facilities.¹⁶³

It also created policies and models to support the health system decentralization process and the newly integrated health programs. For example, in 2003, the GOP approved the Comprehensive Childhood Healthcare Model, which sought to prioritize and consolidate child health services and address local factors that contributed to complex conditions, such as chronic child malnutrition.¹⁶⁴

USAID projects supported the MOH’s health sector decentralization and consolidation process throughout the 2000s. The Promoting Alliances and Strategies (PRAES) and POLICY projects, among others, helped the MOH to uncover barriers to health service delivery and to mobilize communities, regional and local health officials, and civil society to participate in local health decisions and health networks.¹⁶⁵ The POLICY Project facilitated dialogue via organizations such as Foro Salud, a prominent group of civil society organizations that engages in policy dialogue and builds consensus on the way forward for Peru’s health system in the context of decentralization. The PRAES project worked with political parties on strengthening their capacity to analyze health priorities and advocate reform. It also helped to broker the Political Party Health Agreement, which secured commitments from 16 political parties to advance health reform policies.¹⁶⁶ Obtaining input from a variety of stakeholders illuminated barriers to health service access among the poor and facilitated

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“The idea was to help civil society, community groups, and health system officials discuss health needs and realities in a non-confrontational way. They ended up being great allies and achieving big things.”

— Edita Herrera: Policy I & II Participation Coordinator, POLICY Project/Peru

coordination among the national, regional, and local levels of government and civil society on health sector reforms and decentralization.

The GOP created a National Public Investment System methodology in 2000 to guide public entities in allocating scarce public-sector resources, which served to support decentralization. Aiming to improve access to funds for local governments and civil society, USAID’s Health Policy Initiative (HPI) and pro-decentralization projects worked on including a focus on health issues in the GOP’s methodology.¹⁶⁷ In addition, the Quality Healthcare and the Healthy Communities and Municipalities II projects joined forces to provide local governments and health workers in Ucayali, San Martín, and Ayacucho with a practical template for developing minor public investment projects and accessing funds to implement them.¹⁶⁸

By 2012, the government had improved funding levels for public health. Public health expenditures increased to 29%, from 25.2% in 1995, while out-of-pocket

PERFORMANCE IMPROVEMENT METHODOLOGY

The performance improvement methodology (PIM) consists of quality standards for care and prevention to improve health care. It contains five implementation mechanisms:

1. Communication and alliances between actors and institutions, or “actor mapping.”
2. Collaboration with a quality implementation team to identify performance improvement priorities and a health care delivery approach.
3. An evaluation of best practices and areas for improvement through a baseline assessment conducted by a quality assessment team, with a focus on efficacy and minimizing barriers.
4. A six-month assessment to highlight improvements and gaps in implementation or quality. At six months, a plan is devised to address emerging gaps or needs.
5. Acknowledgment of successes and achievements in local governments through non-monetary incentives, such as learning visits and certificates recognizing positive outcomes, among others.

SOURCE: Adapted from the 2009 Peru Quality Healthcare Report

“USAID funded small teams of health professionals and staff from the Ministry of Health to travel to other countries to learn medical best practices and bring them back to Peru.”

—Dr. Luisa Hidalgo Jara, Deputy Chief of Party, Health Policy Initiative (HPI)

LLUYLLUCUCHA MICRO NETWORK PROVES THAT PERFORMANCE IMPROVEMENTS PAY OFF

Many rural health facilities in Peru face the challenge of providing high-quality maternal and child health services. The Lluyllucucha micro network in San Martín proves that it can be done using the PIM.

From May 2009 to November 2011, births attended by skilled professionals increased from 52% to 90%. Since January 2010, there have been zero maternal deaths in this territory of around 26,000 people. Prenatal care rates increased from 55% to 82%, child immunization increased from 80% to 98%, teenage pregnancy decreased from 28% to 12%, and the number of cases of infants with diarrhea fell from 4% to just 1%.

Senaida Mariñas is the health technician in charge of the facility's Flor de Primavera health post. “In 2009, when I first came here, there wasn't a dirt road for cars,” she says. “I am the only one who works here and I see an average of 20 to 25 patients daily and serve a population of about 1,100 people. I am still here after four years.”

Since 2009, USAID has provided technical assistance to the Lluyllucucha facilities to implement PIM at 11 health posts, 2 health centers, and 1 community pharmacy. Network improvement plans have standardized services, reduced wait times, improved patient privacy, and increased adherence to sanitation procedures at

facilities serving 26,000 people in the Amazonian region.

The PIM includes a guide to community action. This guide has helped health personnel like Mariñas effectively interact with community leaders, turning Flor de Primavera into a model health post that exemplifies effective coordination. By seeking support from local authorities and midwives, the health post has seen an increase in demand for health services and undertaken further quality improvements.

The process relies heavily on the health care staff's commitment to patient satisfaction and their willingness to use best practice guides when providing day-to-day services and training new employees. Fortunately, their dedication to their patients outweighs any resistance to change, and performance improvement is now a daily activity.

Dr. Marcia Rios Noriega, head of the Lluyllucucha health network area, said, “In 2008, we were only attending 52% of pregnant women in the area, and in October 2012, we were seeing 96% of them. We no longer have maternal deaths in this area. We are saving children from chronic malnutrition. What motivates the staff now is their good performance.”

expenditures decreased to 37%, from 45.8% in 1995. Social security coverage (that is, health insurance financed through payroll deductions) increased from 25.6% to 30.1% between 1995 and 2012.¹⁶⁹

Health Care Quality and Access

As part of health sector decentralization, the MOH charged the DIRESA agencies with taking the lead on health service provision and financing. However, the DIRESAs initially lacked the capacity to handle these new responsibilities. Chronic understaffing, insufficient resources and training, and high turnover made administering health services very difficult, especially in rural areas. Officials at the MOH realized that stakeholders at every level of the health system needed assistance in developing the necessary technical and management capacity to support decentralization.

With help from USAID, the MOH worked with the DIRESAs, civil society organizations, universities, and health facilities around the country to strengthen local leadership and management skills. Following the 2005 approval of Peru's national policy guidelines for human



LEFT: Workshop on prevention of nosocomial diseases in Moyobamba, San Martín, October 2009.

BELOW: A nurse with Plan International vaccinates a young girl at her school in Altos de los Mores as her classmates look on. Altos de los Mores is an impoverished community in Peru's northern desert near Piura. Several local and international organizations work with the residents on issues such as health, nutrition, education, and microfinance.

A participant in the Buen Inicio program reads educational information.



“*The Demographic Household Survey (DHS) is a great example of USAID’s support, transfer and sustainability efforts. USAID funded the first DHS survey, which is now fully funded by the Peruvian government.*”

—Jo Jean Elenes, Acting Health and Education Office Chief, USAID/Peru

UP-TO-DATE INFORMATION IS A MUST FOR DECENTRALIZATION

For almost 30 years, Peru has participated in USAID’s DHS Program, which is implemented in Peru by the National Institute of Statistics and Informatics (INEI). The country conducted its first DHS in 1986, producing a repository of data on reproductive, maternal, and child health and infectious disease prevalence. The DHS data provided health officials in the MOH with detailed information on the population’s overall health status and flagged areas for health system improvement; however, the surveys were conducted at five-year intervals and only national-level data was available. As Peru’s health system decentralization process was underway in the 2000s, it became apparent that health authorities needed more current information. After the approval of Peru’s decentralization strategy in 2002, stakeholders began

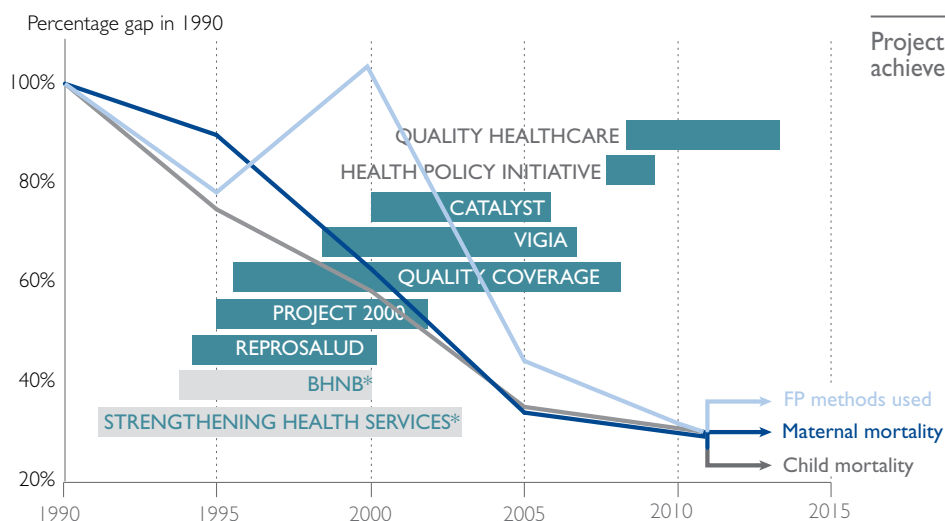
demanding data to track nutrition programs in the country’s 24 regions. USAID proposed implementing a continuous DHS survey in Peru as an alternative to interim surveys, in response to increasing demands from the government and donors for annual updates to health indicators.

USAID project staff worked with the MOH to begin collecting and publishing data on a regular (annual or semiannual) basis through a new, permanently maintained DHS unit within INEI.

Peru launched its continuous DHS in 2004, making it the first country to undertake a continuous survey within USAID’s DHS Program. The country continued improving and expanding the continuous survey through 2009, and incorporated regional data on an annual basis. The regional expansion was driven by an annual reporting requirement

in Peru’s results-based budgeting framework, which allocated funds based on each region’s attainment of annual health program goals.

At first, USAID Peru financed local continuous survey costs, since a steady stream of funding was necessary to ensure continuity during initial implementation. The continuous survey has since been institutionalized in Peru, and the GOP funds the cost of all survey operations, including maintaining the DHS unit within INEI. Today, the Peruvian legislative and executive branches rely on the data generated by the continuous survey for determining the health program budgets for Peru’s 24 regions.



Project synergy contributed to the achievement of quality health outcomes.

SOURCE: Adapted from Chaw and Spelucin, 2012.

*These projects were funded through loans from the government of Peru with multilateral agencies and with technical assistance from USAID projects.

“USAID was smart. It adapted its systems to the needs of the country, the needs of each region. It helped us when needed and built our human resource and financial management capacity, but it didn’t do our jobs for us.”

— Dr. Gustavo Rosell, Regional Health Director, San Martín

resources development, USAID projects supported regional health facility accreditation and helped create regional competency centers.

USAID projects such as Partners for Health Reform Plus (PHRplus) provided technical assistance and built the management capacity of regional authorities, health service directorates, regional councils, and municipalities in areas such as the use of regional health accounts and epidemiological data for health financing and prioritization. Building capacity in such areas helped

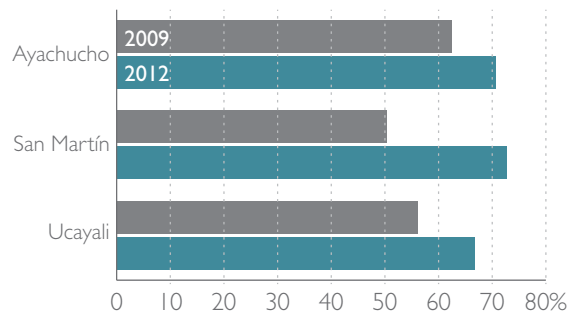
the MOH map competencies, functions, and responsibilities at each level of the decentralized health system.¹⁷⁰

Other projects such as Quality Coverage, VIGIA, Catalyst, and Quality Healthcare (QHC) trained over 10,000 health technicians and managers across the country, strengthening their management skills and improving health service quality. They also helped create accreditation systems for schools of medicine, nursing, and obstetrics, and later, Peru’s national autonomous entity for the evaluation, accreditation, and

certification of higher education (SINEACE). Now funded entirely by the GOP, SINEACE administers nationwide certification and periodic recertification exams today in medicine, nursing, and obstetrics.

USAID’s QHC project also supported the regions in adopting the MOH’s quality management system through the development and implementation of a hospital surveillance system, evidence-based health care standards based on the performance improvement methodology (PIM, see box page 59), and regional health

Adherence to best practices improved under the QHC project.



service quality rules and methods. After incorporating the PIM into Peru's national primary care strengthening plan, eight regional universities used the methodology in their pre-service training and continuous in-service learning curricula for health care professionals.^{171,172}

The QHC project also strengthened the capacity of 84 micronetworks to provide in-service training, supervision, and evaluation in maternal and child health and family planning and reproductive health. Peru's micronetworks are carefully organized by location and function to efficiently provide the largest possible array of health services to local populations in a coordinated fashion. At the beginning of QHC in 2009, adherence to best practices was 62.5% in Ayacucho, 50.3% in San Martín, and 55.9% in Ucayali, averaging 56.2% among all the micronetworks in those regions. By the end of 2012, the average had increased

to 70.7%–72.8% in Ayacucho and San Martín, and 66.7% in Ucayali. Much of this success was made possible through the data infrastructure created by the USAID-supported Integrated Systems of Medical Supplies (SISMED), which QHC used to improve supply logistics and reduce commodity stockouts (see box next page).¹⁷³

At the same time, the micronetworks from those three regions (Ayacucho, Ucayali and San Martín), have covered PIM activities with their own funds since 2012 supporting in-service training, supervision, and evaluation activities (see box page 60).

In addition to improving medical education and testing standards and creating a quality management system, the MOH approved the national health quality policy in 2009 that enabled the implementation of patient-centered universal health insurance.¹⁷⁴

Developed by the MOH with support from USAID, the new universal insurance

scheme strengthened health care quality and extended access to services. Unlike previous cost-driven insurance schemes, universal health insurance prioritized coverage according to disease burden. It also incorporated quality guarantees for patients and required the use of standardized, evidence-based health care practices.¹⁷⁵

Many health indicators improved as the quality of health care improved. For example, the rate of chronic malnutrition in children under age 5 dropped by more than half between 1990 and 2010 (37% versus 18%). Both MMR and infant mortality rate decreased by more than two-thirds over the same period, dropping from 265 deaths per 1,000 live births in 1990 to 93 deaths per 1,000 live births in 2010, and from 64 deaths per 1,000 live births in 1990 to 20 deaths per 1,000 live births in 2010.^{176,177}

“Launching SISMED enabled Peru to estimate the needs of all the regions and make its first large national pharmaceutical purchase, which resulted in a cost savings of 40 million soles and got the supplier to handle distribution to the various agencies.”

—Delia Haustein van. Ginhoven, PRISMA

“Training the nurses to make sure the vaccines stayed at the right temperature was so important, especially in Amazonian region; if they get too hot or too cold, there’s nothing you can do except throw them out!”

— Rocio Mosquera, Monitoring Specialist, Millennium Challenge Corporation’s Immunization Threshold Program

PERU’S MEDICAL LOGISTICS SYSTEM BUILDS LATIN AMERICAN CAPACITY

In 2002, the MOH asked PRISMA, a Peruvian NGO, to create a medication and medical supplies logistics system. Building on its many years of experience working in food distribution and contraceptive procurement, PRISMA designed a robust system called El Sistema Integrado de Suministro de Medicamentos e Insumos Medico-Quirurgicos (SISMED) to handle all the logistics involved in ordering, procuring, and distributing medicines and supplies. Between 2002 and 2006, USAID contributed to this initiative and aligned USAID-funded projects to work on strengthening this system. In 2006, PRISMA installed the system in six regions. The MOH then expanded it to every region in the country. SISMED was also integral in the support of vaccine-related cold chain inventory systems. This included using the drug information system to track stocks of immunizations, order new supplies, and help ensure appropriate provision. Interventions for strengthening of drug supply systems were spread across a continuum that addressed the core functions of:

- Selection
- Estimating and Programming
- Acquisition
- Storage
- Distribution
- Use
- Information System
- Supervision and Monitoring
- Citizen Participation and Oversight
- Capacity Building

Each of these core functions of the SISMED system included associated national and regional interventions. With the small amount of funds left at the end of the project in 2006, PRISMA constructed an online capacity-strengthening platform for SISMED, called PRISMA Virtual (www.sismed.minsa.gob.pe/). Today, that platform is still used to provide general medical supply chain management technical assistance to countries throughout Latin America. Additionally, this virtual space is cited by public health experts as being a key resource for both capacity building, specifically, as it relates to the logistical approaches to purchasing any number of medicines throughout the continent.

MSH, SIAPS



Loreto warehouse before improved storage practices

MSH, SIAPS



Loreto warehouse after improved storage practices

The Systems Behind the Health System

Having reliable performance data has been essential for improving health service quality and access, especially in the context of decentralization and health program integration. Health professionals and authorities at every level of the country's health system needed up-to-date data to devise, execute, and evaluate the effectiveness of health services and interventions.

Building and integrating health and management information systems across the levels of Peru's health sector has been an important element of many USAID health projects in the country in the 2000s, as demonstrated in the list below. These systems have been the backbone of the decentralization process, supporting the quick flow of information between communities and the national authorities in Lima. This information has enabled health managers to allocate resources where they

are needed most, ensuring that vulnerable families in Peru's most remote communities have access to healthcare services.

KEY HEALTH INFORMATION SYSTEMS SUPPORTED BY USAID IN THE 2000s

- **SICI (Revenue and Expense Information System):** Financial management system to help hospitals and health facilities track and analyze expenses and revenue.
- **SPP (Budgeting and Planning System):** System for helping regional health authorities prepare their annual budgets.
- **STE (Fee and Exemption System):** System to help public health facilities improve cost recovery and targeting of public expenditures.
- **SISMED (Integrated Supply System of Medicines and Medical Supplies):** Logistics system for procuring and distributing medical supplies and pharmaceuticals.
- **DHS (Demographic and Health Survey):** Collects data on health indicators (e.g., reproductive, maternal, and child health, and nutrition) as well as infectious disease prevalence (ongoing).
- **Health information system:** System for reporting and analyzing health determinants, population health status, and available health system resources.
- **SISMUNI (Community Information System):** Municipal public health information system for local demographic and economic information.
- **SEEUS (User Satisfaction Survey Analysis Software):** System for analyzing and following up on patient complaints; used at the local, regional, and national levels.
- **SISGALENPLUS (Perinatal Information System 2000 [SIP 2000 v3] and the Comprehensive Hospital Management System):** Used by hospitals and health facilities for operational and management decision-making, reporting, billing, administration, and managing patient medical histories and records.

“One of the unique aspects of SISMUNI is that it brings health data from the bottom up. It initiates the communication flow from the communities up to the regions, something new in the health system.”

— Dr. Edgar Medina,
Director of Health Communities
and Municipalities (HCM) Project

QUE DIFICULTADES
EXISTEN PARA LOGRAR
EL RESULTADO
ESPERADO?

- Factor económico,
- Factor Tiempo
- Factor distancia
- Desconocimiento
- por tener miedo
del idioma que
NO nos entiendan

QUE VAMOS
HACER ?

- Organizarse
para conseguir
dinero, en forma
de apoyo unas
a otros.
- Existencia de
establecimientos

QUIEN ES LA PERSONA
GRUPO RESPONSABLE.

QUE RECURSOS
NECESITAMOS
PARA HACERLO

FOR MUNICIPALITIES, INFORMATION IS POWER

Nestled among the fertile hills of the San Martín Region in northern Peru lies the municipality of Saposoa, a town of approximately 5,000 people. Saposoa is made up of 52 communities, the most remote of which is more than a 12-hour walk from the town center, where the only full health center exists. The provincial mayor of San Martín, Fernando Grandez Veintemilla, worked with the Office of Local Development and USAID's HCM project on a systematic development process for the agriculture-based municipality. He was a strong believer in local management. "Local development should be managed by local teams," he explained. "With our communities spread out so far, we need reliable information for making decisions that impact the lives of our citizens."

The HCM project designed and implemented a municipal public health information system known as the community information system (SISMUNI), and the HCM project now provides support for the system. The HCM model enables communities to perform needs assessments, document demographic and economic

information, and identify community health priorities.

In July 2006, communities in the San Martín region began monitoring maternal and child health indicators, such as numbers of adolescent pregnancies and children consuming clean water. This information was stored in SISMUNI so that local government officials could easily access the data and use it for policy development and decision-making.

"We use the system to look at each community," said the mayor of Tres Unidos, another municipality working with the HCM project. "In it, we can see which communities don't have health posts, and how long it takes people in each community to get to the nearest health facility. We use that information to determine where to build new health posts."

Having this type of information on hand has helped the municipality maximize the value of its investments while staying within its annual budget. SISMUNI is now used in 557 communities through the HCM project.

During community mobilization activities with health providers, a community resident from the Puno region of Peru adds to a list of actions the community can take to strengthen relationships with providers.

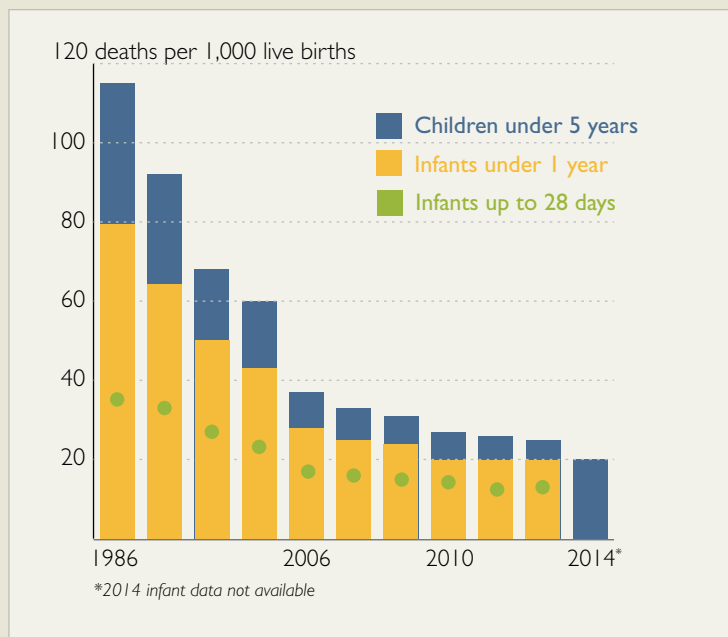


A Healthy Future for Peru

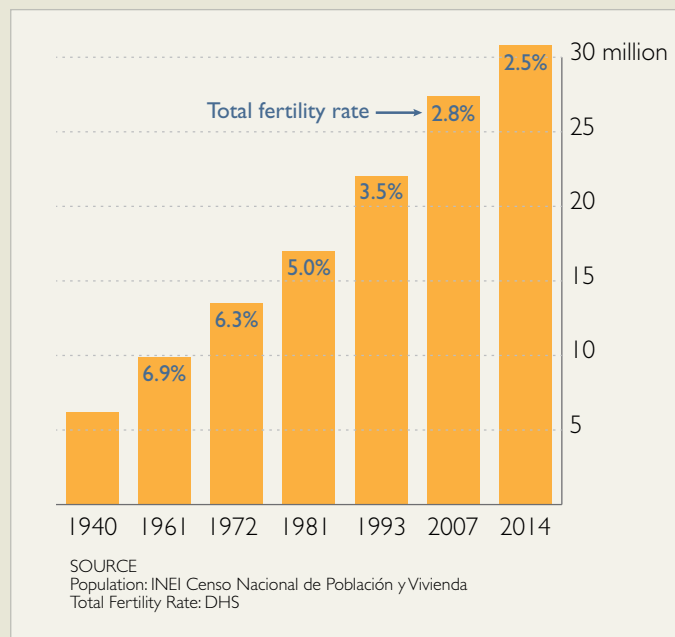
“We knew that USAID support would eventually end, and that we needed to find a way to sustain the gains we had made. We have already institutionalized many of the processes we learned while receiving technical support from USAID; now, we are ready to develop initiatives on our own in the regional health directorate (DIRESA).”

— Dr. Gustavo Rosell, Regional Health Director, San Martín

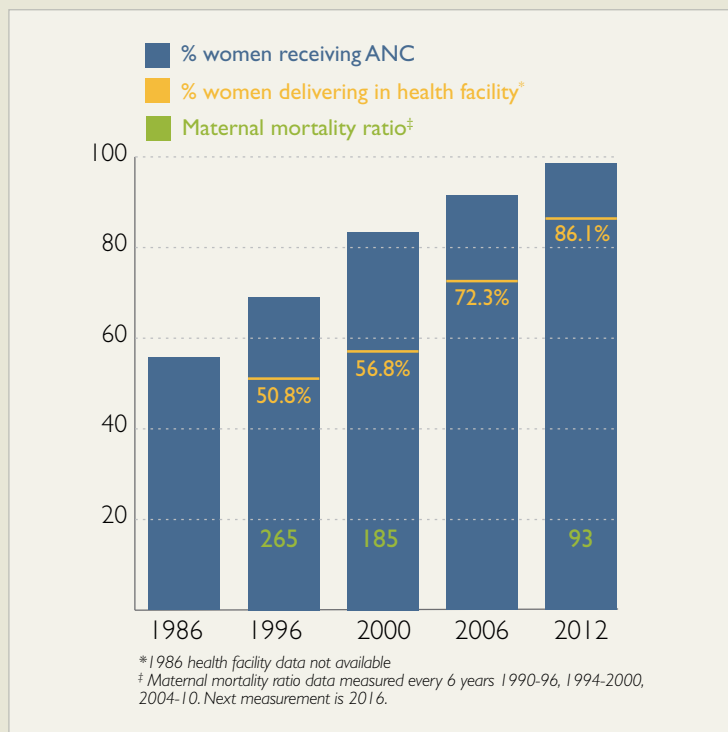
Child mortality indicators



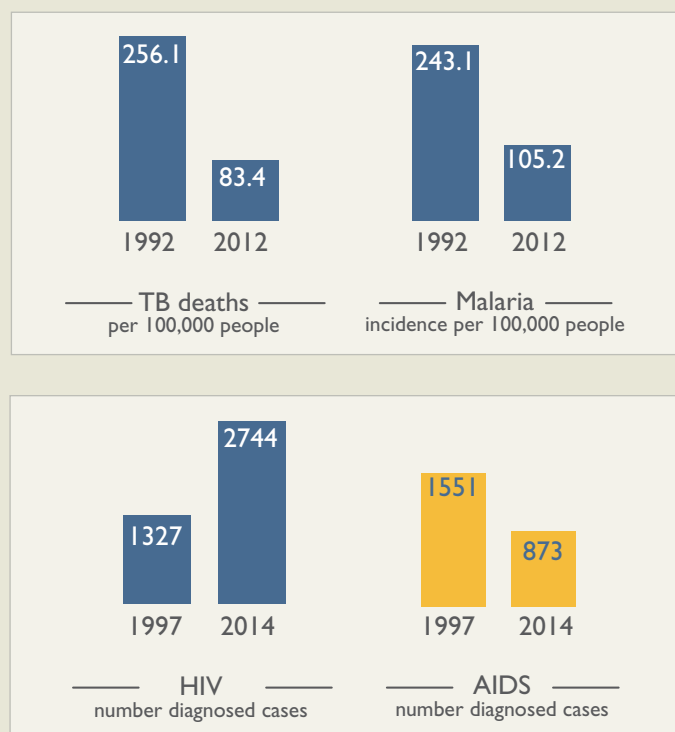
Population growth indicators



Maternal health indicators



Infectious disease indicators



The Final Years of USAID Support for Peru's Health Sector

Peru's health indicators paint a clear picture of how far the country has come in the more than 50 years of collaboration with USAID. Peru has made robust achievements toward meeting its targets under the Millennium Development Goals for health. National survey data tell the dramatic story of Peru's progress, particularly in meeting MDG 4 and advancement in MDG 5, to reduce child mortality and improve maternal health, respectively.

Peru's health indicators

Child mortality

Reducing child mortality has been an important goal for Peru. In 1986, 115 of every 1,000 live births did not make it to age five; 75 died before the age of one, and 35 died in the first 28 days. Since 1986, Peru has decreased child mortality by 78%, reporting the greatest improvements between

the DHS collection periods of 2000 and 2004–2006 (a 38% decrease). In 2012, Peru surpassed the MDG 4 target of reducing child mortality by two-thirds between 1990 and 2015. Infant and neonatal mortality also dropped dramatically during the same period, contributing to this achievement.

Diarrheal disease and acute respiratory infections (ARIs) are major causes of child mortality and morbidity worldwide, despite the fact that both are preventable and treatable. USAID projects supported activities that reduced both diarrheal disease and ARIs during the Agency's partnership with Peru. Infections causing diarrhea are spread through contaminated food, hands, surfaces, or liquids, resulting from poor sanitation conditions, lack of access to safe drinking water, and inadequate hygiene.

USAID projects supported activities that reduced both diarrheal disease and ARIs during the agency's partnership with Peru.

During the DHS collection periods of 2000 and 2004–2006, Peru saw a 90% decrease in children with ARIs. Between 1991 and 2012, the percentage of children with ARIs who were taken to a health facility where they could receive the lifesaving care they needed increased by 33%. Increases in the use of health services often indicate improvements in service availability and access, as well as greater trust in the health system. These improvements in child health have contributed to Peru's achievement of MDG 4.

Maternal health

Peru has also made strides in improving maternal health, decreasing maternal mortality by 65% between 1990 and 2010. The MMR is seen as a general indicator of a population's health status and of the functioning of the health system because most maternal deaths can be prevented with

appropriate obstetric care and trained service providers. The indicators below demonstrate a 69.4% decrease in the MMR between the DHS collection periods of 1990–1996 and 2004–2010. This is a significant achievement. In the capital city, Lima, MMR is down to 52 deaths per 100,000 live births, although that ratio is almost seven times less than in the highland region of Puno, where MMR is 361 deaths per 100,000 live births.¹⁷⁸

Health indicators in general

The progress on these MDG targets demonstrates improvement in Peru's health system. This improvement is reflected in per capita spending on public health, which has almost tripled since 2000, climbing from \$111 to \$331 per person in 2013.¹⁷⁹

As Peruvian public health officials worked with USAID year after year to strengthen the health system, from community health posts to national operations at the MOH, USAID's support for the country changed and evolved. Over the past decade and a half, USAID provided high-level technical assistance to support Peru in delivering high-quality health services to its people.

As it prepared to phase out its work in Peru's health sector, USAID sought to ensure the continuity of the gains of the past 55 years by working closely with the MOH, NGOs, and subnational governments. The

Agency worked to support the MOH and the regional government of San Martín to develop a model of decentralized health service delivery and management, and provided funds directly to the regional governments. Additionally, the Healthy Communities and Municipalities model of local community engagement helped equip Peru's citizens with powerful tools for building on health gains made in the previous decades.

Ongoing Public Health Challenges in Peru

Perhaps the most pressing challenge facing Peru as USAID health assistance comes to an end is to complete the restructuring of the health system. This process, started by the GOP ten years ago, has shifted the primary responsibility for health service delivery from the central MOH to the Regional Health Directorates (DIRESAs). The DIRESAs will need to work with their regional governments to continue strengthening health service provision in their health networks.

Although the San Martín model, developed through USAID-supported PAIMNI project, provides a roadmap for continuing this process, most regions will require support from the MOH to strengthen local health systems and build the capacity of health network managers. Regional systems

will need to equip regional, district, and local personnel with the managerial skills necessary to set priorities, allocate funds and resources efficiently, address performance gaps, and ensure effective service delivery.

Another challenge is to strengthen capacity in order to mitigate workforce turnover, a problem that plagues the Peruvian health system. Some ways to do this include:

- Using tools such as the New Employees Orientation Program's (NEOP) mini-universities as part of the formal orientation and training of health workers.
- Operating continuous training programs in all segments of the health sector to ensure that personnel receive refreshers and stay current with new and evolving health care practices.
- Providing continued MOH support of the incentive system to address the uneven geographic distribution of workers. Improving compensation for qualified health care personnel could improve retention.

Peru's success in achieving further gains in health system decentralization will depend on its ability to establish highly participatory collaboration mechanisms, build capacity of health workers at all levels, and ensure sufficient human and financial resources for health institutions.

FOLLOWING THE CAREER OF FORMER MINISTER OF HEALTH MIDORI DE HABICH

When Midori de Habich Rospigliosi became the Minister of Health in Peru in 2012, she had already spent 17 years working with health authorities, implementing agencies, and communities to develop health projects. A longtime USAID technical assistance specialist and project implementer to chief of party, former Minister de Habich was among several former USAID project officers who were selected to serve in high-level posts in the regional or national health system, including current Minister of Health Aníbal Velázquez Valdivia.

At the beginning of her USAID career, former Minister de Habich worked on the financing development component of Project 2000. She and the component team developed tools and methodologies for improving health financing, costing, and budgeting efficiency and effectiveness, and conducted a study to improve the health sector's ability to target subsidies to reach Peru's most vulnerable families. In 2007, this study was used to develop the country's budgeting-by-results framework and its primary social protection policies, which became operational in 2010.

Peru's Household Focalization System, upon which the Ministry of Social Inclusion and Ministry of Economy and Finance now relies to effectively target social assistance to the poor, was also based on the study. "A key advantage of USAID projects is that they provide countries with an opportunity to test

their theories in the field to see if they hold up in practice in any number of regional contexts," says former Minister de Habich. "USAID projects enable countries to gather solid, first-hand evidence and to use that evidence to formulate practical, feasible policy proposals."

Former Minister de Habich continued to support USAID's technical assistance activities throughout the 2000s. As part of the PHRplus Project, she worked with Oscar Ugarte, who later became Minister of Health, to develop a model for distributing health functions among the various levels of government. The model included a government accreditation process and proposed an eight-year implementation period.

This model was approved by Peruvian President Alan García's administration, but rather than adhering to the original timeline, the GOP decided to speed up the process in a policy that came to be known as "decentralization shock." With technical assistance from the PRAES project, which also fell under the scope of former Minister de Habich's responsibilities, USAID adapted to the new schedule and continued to offer support to the GOP and the regions. "The degree of adaptability at USAID allowed us to be more effective and respond to the MOH's needs," recalls former Minister De Habich. "This

flexibility enabled the agency to adapt to national events and changing political priorities."

Eventually, the PRAES project merged with another USAID project, the Health Policy Initiative (HPI), to become the Health Policy Reform Project. The project focused on creating policy pertaining to human resources development, medicine and medical supply distribution and continued support to the financial social protection initiative.

"PHRplus, PRAES, and other projects followed a continuum," former Minister de Habich explained. "Each included elements related to health reform. The projects were connected to each other and a technical body was created that is still operational today. This continuity is one of USAID's strengths."

When Ollanta Humala became President in 2011, the Health Policy Reform Project was already underway. During his first year in office, the primary focus of the MOH was to extend universal health insurance coverage. As chief of party for the Health Policy Reform Project, former Minister de Habich supported Dr. Ugarte and the MOH in implementing universal health insurance in the context of health sector decentralization. In mid-2012, Midori de Habich was selected as Minister of Health, where she served until November 2014.

Outlook for the Future of Public Health in Peru

Peru recently experienced consistent economic growth due to a favorable external environment, prudent macroeconomic policy, and deep structural reforms. Between 2005 and 2013, the percentage of the population living in poverty dropped from 45% to 24%.¹⁸⁰ Peru is one of the region's fastest growing economies and is expected to continue growing in the medium term. According to the World Bank, most recent estimates of real gross domestic product growth for 2014 are above the regional average (3.5% for Peru, as compared to 1.2% for the region). The robust economy bodes well for the country's public health.

Health financing reforms, refining the MOH's role and sharpening its focus on establishing norms and standards, all seek to ensure health protection for all Peruvians by 2021, regardless of socioeconomic status, culture, geographic location, or whether coverage is public or private.

Peru's health sector has the capacity to be a major contributor to public health in the Western Hemisphere and the world. The MOH is well-positioned to be a role model for other countries in Latin America. Through PAHO and other regional organizations, the Peruvian MOH can play an important role in global health development by sharing its extensive

expertise and collaborating with other countries to develop public health policies and interventions.

Peru's Transition to Becoming a Leader in Development

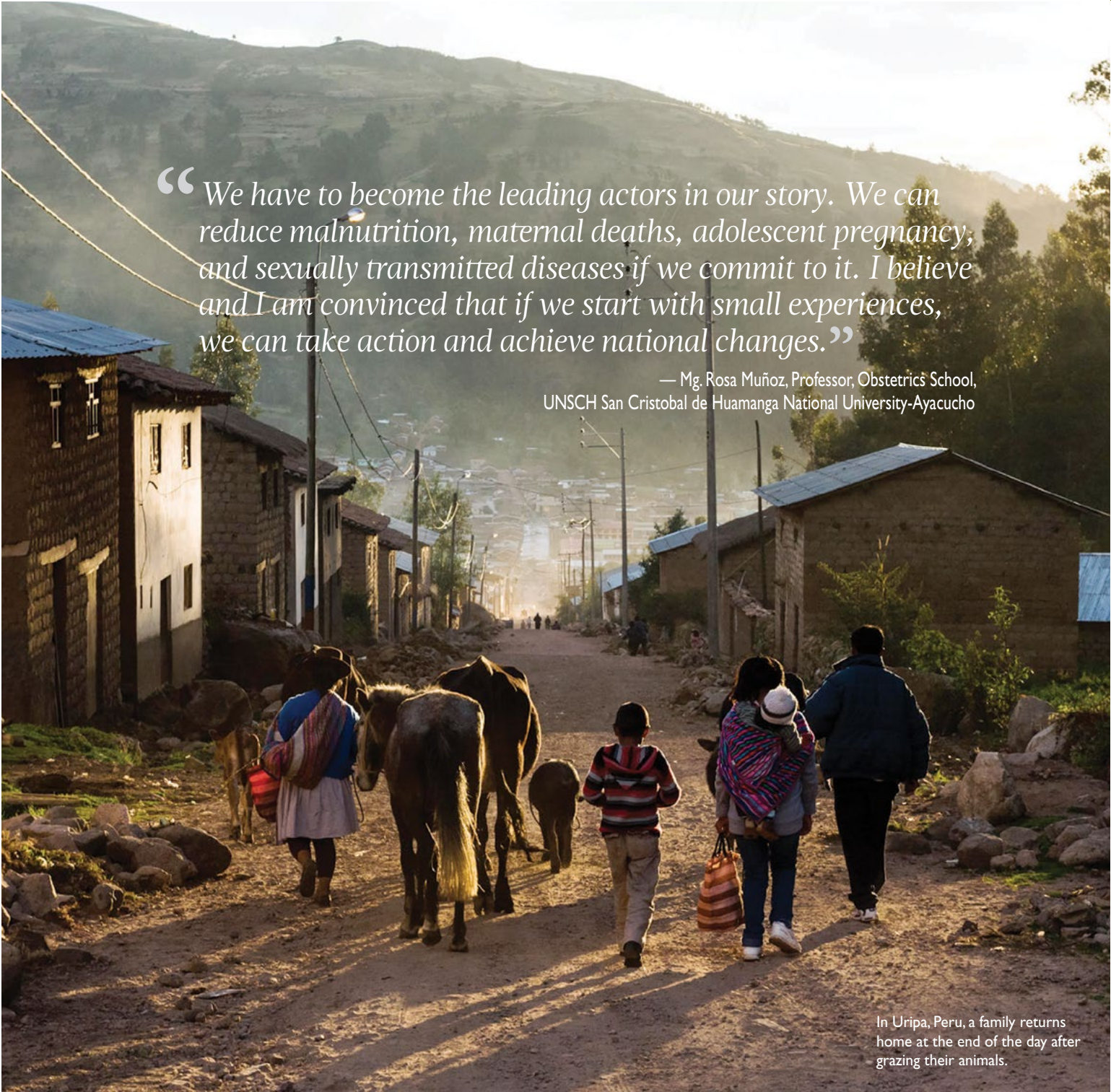
Perhaps the greatest testament to a country's economic and development progress is when other nations recognize it as a development leader. For this to occur, the country first needs to make the transition from donor recipient to self-sufficient development partner. Although development is a continuous process, social and economic trends and progress over the past decade demonstrate that as development indicators continue to improve, a gradual reduction in development programs is justified.

Over the past 55 years, USAID support to Peru in health evolved along the development continuum. It started with the direct provision of health services, and progressed to food for women and children, brick and mortar for clinics, health commodities for micronetworks, information gathering, health systems strengthening, and finally, to high level policy and technical support to save lives through a strong public health service delivery system. Along the way, the GOP made strides in incorporating and self-financing numerous USAID-supported improvements into the country's health

system, from the SINEACE medical certification process, to universal health insurance and dozens of health and medical information systems, including the continuous DHS.

With USAID support, Peru has improved subnational government capacity to plan and manage health activities through projects such as PAIMNI and Healthy Communities and Municipalities. Its ongoing efforts in this regard will increase social inclusion, and in turn, prevent and mitigate conflict as the country continues down its path as a development leader.

As the next phase of collaboration unfolds, it is clear that the partnership developed between the USG and GOP will strengthen, particularly as both countries work side-by-side as development leaders in the coming years. While USAID is phasing out health programming, the Agency is proud of the tremendous advances that have been achieved in Peru. Having worked together for decades, USAID is confident that the GOP has the knowledge, ability, and desire to further strengthen its own health systems. The Agency looks forward to Peru's continued development, to witnessing Peru's leadership on the global health stage, and to the improvements in health systems across the country that will positively impact millions of Peruvians in the coming years. ■

A photograph of a dirt road in a rural village in Peru. The road is lined with simple, rustic buildings made of stone and brick. In the foreground, a family is walking away from the camera. A woman is carrying a child on her back, and another woman is carrying a child on her back. A man is walking next to them. There are several donkeys and horses on the road. The background shows rolling hills and a sunset sky. The overall atmosphere is peaceful and rural.

“ We have to become the leading actors in our story. We can reduce malnutrition, maternal deaths, adolescent pregnancy, and sexually transmitted diseases if we commit to it. I believe and I am convinced that if we start with small experiences, we can take action and achieve national changes.”

— Mg. Rosa Muñoz, Professor, Obstetrics School,
UNSCH San Cristobal de Huamanga National University-Ayacucho

In Uripa, Peru, a family returns home at the end of the day after grazing their animals.

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Boats at Puerto Maldonado

Appendix: Methodology

This legacy report was created using a structured process of data collection which was discussed with and approved by USAID/Peru prior to implementation of the activity.

The K4Health Team used a five-step, mixed method approach for collecting qualitative and quantitative information and data:

- (1) desk review of documents and available data from secondary sources;
- (2) key informant focus groups of beneficiaries;
- (3) key informant interviews;
- (4) surveys; and
- (5) identification of agents of change.

Since the interviews required a representative group of beneficiaries and implementers, they were conducted in Washington, Lima and all of the country's regions. The challenge was to review the results and outcomes in the health areas, from Family Planning to Health System Strengthening. After reviewing the list of local and global projects, the process of data collection was organized by portfolio. Three regions were selected to capture most of the rich experiences: Ayacucho, Ucayali and San Martín. The research data for other region were extracted during the desk review from project's files.

Desk Review

USAID/Peru provided K4Health with a package of briefing materials, made up of relevant published and unpublished analysis reports, project implementation reports, and evaluation reports of practically all projects from the 1980s, 1990s, and 2000s. The research team also searched for studies on

health development written by local and international authors and verified quantitative data at the National Institute of Statistics (INEI).

Research Working Meetings

In addition to the continuous communication between USAID and R4Health research teams, there were three meetings in Lima to discuss and approve the approach and tools.

Key Informant Focus Groups

A small focus group was administered with beneficiaries of a behavioral change project in one region with participation of key women and health personnel. This experience provided an opportunity for collecting stories and lessons learned.

Formative Key Informant Workshop

The K4Health Team conducted a small workshop with a group of selected respondents in Peru who had substantial experience with the USAID/Peru health portfolio. Most of the respondents were implementers of one or more projects. The small group of respondents were selected from the key informant list provided by USAID/Peru. The purpose of the workshop was to construct a timeline, to orient the K4Health Team on the USAID/Peru health portfolio over the last 24 years, and to brainstorm additional key informants and background materials to highlight in the “Legacy Activity” and “Champions” sections.

Key Informant Interviews

The K4Health Team conducted qualitative, in-depth interviews with 14 key informants. The informants were based both in Peru and in the

US, and included current and retired USAID staff, implementing partners and government partners. Whenever possible, the K4Health Team conducted face-to-face interviews; however, when in-person contact was not possible, the K4Health Team conducted the interviews by phone or email.

Key Informant Survey

The K4Health Team developed an Internet-based survey, and used it to identify the areas of knowledge and expertise of all key informants. The survey was made available in both English and Spanish, and was administered online through the SurveyMonkey cloud-based software. Using email invitations, 84 key informants were invited to participate in the online survey. There were a total of 38 respondents (23 in English and 15 in Spanish), yielding a response rate of 45%. However, the exact number of respondents for each question was varied.

Identification of Development Champions (Agents of Change)

Through the discussions with the key informants, the K4Health team identified health development champions—that is individuals or organizations (including partners, government, civil society, or donors) who were key to advancing health improvements in Peru. These individuals were then interviewed and their stories highlighted in the report.



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Limitations

Given the size and complexity of USAID's support for health programs in Peru, many activities and interventions could not be explicitly covered in this legacy report. Even for those programs included in the document, much of the nuance and detail could not be captured due to the limited availability of health data, detailed project assessments and former USAID staff from the years prior to the 1990s. Although the authors attempted to incorporate a balance of examples and links across regions and throughout time, the projects and documents cited in this report reflect only a fraction of the work supported by USAID over the past 55 years. However, many additional project evaluations, assessments and reports are available in the Development Experience Clearinghouse at <https://dec.usaid.gov>. Descriptions of current USAID programs in Peru can be found at <https://usaid.gov>.

