SCALING UP HEALTH SYSTEMS BASED ON PRIMARY HEALTH CARE (PHC)

Analysis of the Integration of National Programs in the Health System of PERU

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CONTENTS

1. INTRODUCTION

The present study sought to analyze the ways in which selected National Programs (NP) are integrated in the Health Systems (HS) of Peru, as well as the influence of those programs on the strengthening (or weakening) of health systems.

2. METHODOLOGY

2.1 Survey for Heads of National Programs[1]

The principal activity of the study was the administration of a Survey for Heads of National Programs containing a structured questionnaire with 40 multiple-choice questions, a majority of them dichotomous (choice of YES or NO), with the possibility of adding observations if necessary. The survey also investigated respondents' perceptions of 30 sample actions or features of the National Programs and their influence in strengthening or weakening the health system.

2.2 Structured questionnaire[2]

In order to give greater objectivity to the qualitative information collected through this survey and in line with the study's objective, a point system was designed. Each possible response to a question on the questionnaire received one score for verticality and another for horizontality, depending on the response given.

The value assigned to each variable was defined in accordance with the importance of each question as a part of the whole, with the most important and relevant questions being worth more points and those less important and relevant being worth fewer.

The maximum score for each component is 10 points; therefore, the maximum score for the questionnaire is 60 points. This score is divided between two options: *horizontality* and *verticality*.

Therefore, when points for the responses are summed up, each questionnaire has a value X for horizontality (approach based on horizontal integration of the national program in the health system) and a value Y for verticality (approach based on vertical integration of the national program in the health system). The sum of both cannot be greater than 60. This score can also be disaggregated to show a value for each of the six components.

In order to classify and define the way in which the national program is integrated within the health system, an ordinal scale will be applied, as follows:

- When the score obtained for verticality or horizontality is equal to or greater than 80% of the total maximum score (48 points out of 60), it will be defined as a national program of purely vertical or horizontal integration.

[1] This text is based directly on the ToR of the study.
[2] This text was taken directly from the ToR of the study.

- When neither of the two approaches attains 80% of the maximum score, it will be defined as a national program of mixed integration, with predominance of the approach (vertical or horizontal) that received the higher score. There are three levels of predominance: weak, moderate and strong.

2.3 Classification

Horizontal: 80% to 100% of the total score for horizontality (48–60 points)
Vertical: 80% to 100% of the total score for verticality (48–60 points)
Mixed: 20% to 79% of the total score for each of the approaches (12–47 points)

In mixed systems, the approach with the higher score is considered predominant, as follows:

a. Weak predominance: when the higher score is between 51% and 59% of the maximum (31-35 points)
b. Moderate predominance: when the higher score is between 60% and 69% of the maximum (36-41 points)
c. Strong predominance: when the higher score is between 70% and 79% of the maximum (42-47 points)

2.4 Survey of perceptions[3]

Analysis of respondents' perceptions will be done directly, by calculating the percentage who believe that specific features of the national program:

- Totally strengthen the HS
- Partially strengthen the HS
- Neither strengthen nor weaken the HS
- Partially weaken the HS
- Totally weaken the HS

3. SELECTION CRITERIA

The National Health Programs of Peru have been developed and expanded in various ways, depending on their focus and on the priorities identified by different agencies in the sector, even within a single period of government.

Since 2004, the National Programs have been called National Health Strategies (NHS). The strategies were created during the term of Health Minister Pilar Mazzetti.[4]

On July 27, 2004, Ministerial Resolution No. 771-2004/MINSA (Annex 1) established ten National Health Strategies of the Ministry of Health. These are set within the framework of the Comprehensive Health Care Model and include actions geared to health promotion, prevention, and care, as well as access to information, aimed at avoiding the negative impact of disease on the development of the population and the society.

[3] This text was taken from the ToR of the study.
[4] Dr. Pilar Mazzetti Soler was Minister of Health of Peru from 2004 to 2006.

The original ten National Health Strategies include the NHS on Immunization, NHS on Prevention and Control of Metaxenic and Other Vector-borne Diseases, NHS on Prevention and Control of Sexually Transmitted Infections and HIV/AIDS, NHS on Prevention and Control of Tuberculosis, NHS on Sexual and Reproductive Health, NHS on Noncommunicable Diseases, NHS on Mental Health and a Culture of Peace, NHS on Healthy Food and Nutrition, NHS on Traffic Accidents, and NHS on Indigenous Populations. An additional strategy, the NHS on Oral Health, was approved recently.

With a view to ensuring the successful design, implementation, and application of the National Health Strategies, the Ministry of Health gave responsibility for the strategies to National Coordinators, who were nominated by ministerial resolution.[5]

Accordingly, the National Coordinators are responsible for designing, planning, programming, monitoring, supervising, and evaluating the implementation and execution of the National Health Strategies, as well as their intrasectoral and intersectoral integration. In addition, the management and execution of each of the National Health Strategies is overseen by a Standing Technical Committee[6] and an Advisory Committee,[7] an arrangement that reflects the political will to promote broad participation in the National Health Strategies. However, it is important to point out that not all the strategies are functioning with an optimal level of organic participation.

Each of the National Health Strategies operates according to an approved work plan. Plans for five of the strategies—those on Immunization, Vector-borne Diseases, Sexually Transmitted Infections and HIV/AIDS, Tuberculosis, and Noncommunicable Diseases—were adopted and authorized through Ministerial Resolution No. 721-2005,[8] which stipulates that the plans must be set within the framework of the Comprehensive Health Care Model.

The Ministry of Health, as one of its basic guidelines for the period 2002–2012, mandated the implementation of a Comprehensive Health Care Model. This implies, in general, "prioritizing and consolidating actions of comprehensive care, with emphasis on promotion and prevention, caring for health, and reducing risks and harm to the population, especially children, women, older adults, and disabled people."[9]

In line with what is set forth in the framework document of the Comprehensive Health Care Model, which takes a comprehensive approach to the needs of individuals, families, and communities, the National Health Strategies are intended to facilitate the management, control, reduction, eradication, or prevention of the priority diseases and risks and the achievement of priority objectives in health promotion, consistent with national policies and national commitments.

We can differentiate three categories of NHS according to their level of importance and the amount of resources made available to them in the Peruvian health system:

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[5] These provisions were approved by Ministerial Resolutions No. 771-2004/MINSA, No. 772-2004/MINSA, and No. 773-2004/MINSA, published on August 2, 2004, in the official daily newspaper *El Peruano*.

[6] Each Standing Technical Committee, according to the establishing ministerial resolution, includes the National Coordinator of the National Health Strategy along with representatives of the General Directorate of Health Promotion; the General Directorate of Medicines, Supplies, and Drugs; the General Bureau of Communications; the General Directorate of Epidemiology; the National Institute of Health; and the General Directorate of Environmental Health (the latter only for the national strategies on Vector-borne Diseases, Health of Indigenous Populations, and Healthy Food and Nutrition).

[7] Each Advisory Committee, according to the establishing ministerial resolution, will be made up of academic institutions, international cooperation agencies, nongovernmental organizations, and organizations of people affected within the framework of the particular National Health Strategy.

[8] Published on September, 28, 2005, in the official daily newspaper *El Peruano*.

[9] From http://www.minsa.gob.pe/portal/Servicios/SuSaludEsPrimero/MAIS/mais.asp, accessed September 9, 2007.

- Those given greatest emphasis are the NHS on Immunization, Vector-borne Diseases, HIV/AIDS, and Tuberculosis
- Those given intermediate emphasis are the NHS on Sexual and Reproductive Health, Noncommunicable Diseases, Mental Health and a Culture of Peace, and Healthy Food and Nutrition
- The most recent, and as a result the least developed, are the NHS on Traffic Accidents, Health of Indigenous Populations, and Oral Health (the latter was approved in 2007)

For the purpose of this study, all the NHS belonging to the first two categories were selected because of their comparability to programs analyzed in the other countries.

Of the three strategies in the third category, only the NHS on Oral Health was selected, for several reasons: In the first place, there existed a National Program on Oral Health (1986–1990) that carried out intensive decentralized activities over four years. Although that program was dismantled, a National Plan on Oral Health was formulated in 2005, and oral health is currently among the national public health priorities defined by the Ministry of Health.[10] Toward this end, the NHS on Oral Health was established recently.

4. BRIEF DESCRIPTION OF THE PROGRAMS EXAMINED

The following sections briefly summarize each of the NHS included in this study.

4.1 National Health Strategy on Immunization

The National Immunization Program existed in Peru from 1972 until 2001, when its activities were incorporated into the program of comprehensive children's health services. It was later converted into a National Health Strategy in order to affirm the political, technical, and administrative priority that the Peruvian people and government give to immunization.

For the Peruvian government, immunization has proven to be the most cost-effective public health activity of the last two centuries. Smallpox, measles, and poliomyelitis have been eradicated in the country, according to official documents of the Ministry of Health.

The NHS on Immunization has sought to develop a sustainable immunization program based on a single vaccination series, using a gender-sensitive and intercultural approach.

The commitment of public economic resources to immunization or vaccinations has been justified by the Ministry of Health on the basis of ethics and human rights. The sources of the investment are as follows: 70% of the budget from the Public Treasury, 5% from reimbursable external resources, 10% from non-reimbursable external resources, and 15% from other sources that include the private sector.

[10] Coordinated National Health Plan, Ministry of Health, August 2007

4.2 National Health Strategy on Prevention and Control of Metaxenic and Other Vector-borne Diseases

Vector-borne diseases have been one of the principal health problems in Peru in recent decades, affecting the poorer and more remote populations. These diseases are now classified as reemerging in the country as a whole, affecting large segments of the population and imposing a significant burden on national public health. The increase in transmission and in risk factors has made control of these diseases a priority for the Ministry of Health. Malaria, dengue, bartonellosis, leishmaniosis, and trypanosomiasis are the five health problems addressed by the NHS on Prevention and Control of Metaxenic and Other Vector-borne Diseases, according to information disseminated by the health sector.

These public health problems are conditioned by multiple factors. Their reemergence appears to have been triggered by imbalances among climatological variables (such as rainfall and temperature), migration flows, and planting and harvesting activities. The responsibility for controlling and/or maintaining these variables in balance involves diverse actors, most notably the Peruvian state and the various state agencies directly concerned with the livelihood of the population (agriculture, trade, labor, industry, and tourism).[11]

In the last 10 years, the Ministry of Health has reported between 150,000 and 200,000 cases of vector-borne diseases. The ones that affect the greatest proportion of the population are malaria, dengue, and bartonellosis. In the last five years, bartonellosis has become one of the principal problems facing the health services because of the high mortality and case-fatality rates it has recorded. It is estimated that about 20 million Peruvians reside in areas of risk for these diseases, in different eco-epidemiological strata and niches.[12]

Malaria and other vector-borne diseases constitute an especially serious problem for the indigenous population, but there is no precise information on their incidence and dispersion in these communities.

The response of the Ministry of Health (MINSA) to this alarming reemergence of vector-borne diseases has been successful in reducing the levels of transmission in the most affected areas. The organizational capacity of the services and the articulation with the work of volunteers has made it possible to control human reservoirs efficiently and within acceptable time periods. Multiple efforts carried out by the sector using strategies adapted to the least accessible populations have led to a reduction in complications and mortality.

The Plan[13] for this strategy aims to reduce transmission of malaria to less than 200 per 100,000 population, as well as to reduce the mucosal forms of leishmaniosis by 15% and the serious forms of bartonellosis by 30%, among other objectives. The plan emphasizes the timely and appropriate planning of drug therapy, according to therapeutic schemes and lines, to ensure the correct use of drugs and regulate their supply to the regions.

Ninety percent of the budget comes from the Public Treasury, with the remaining 10% from non-reimbursable and reimbursable external resources, among other sources.

[11] Taken from http://www.minsa.gob.pe/portal/03Estrategias-Nacionales
[12] http://www.minsa.gob.pe/portal/03Estrategias-Nacionales/02ESN-Metaxenicas/metaxenicas.asp
[13] ftp://ftp2.minsa.gob.pe/normaslegales/2005/RM721-2005IIparte.pdf

4.3 National Health Strategy on Prevention and Control of Sexually Transmitted Infections and HIV/AIDS

The first case of AIDS in the country was diagnosed in 1983. Three years later, the Ministry of Health took on the challenge of confronting this disease, creating various inter-institutional entities and programmatic lines. Beginning in 2001, a number of countries and international financial institutions forged the Global Fund to Fight AIDS, Tuberculosis and Malaria, with the intention to strengthen national responses to these epidemics.

Peru obtained funding for its proposal entitled "Strengthening the Prevention and Control of AIDS and Tuberculosis in Peru," for a total amount of $50 million, of which $23 million corresponds to the HIV/AIDS component. Later, in 2004, it established the National Health Strategy on Prevention and Control of Sexually Transmitted Infections and HIV/AIDS, which has continued the lines of previous work.[14]

The National Health Strategy on Prevention and Control of Sexually Transmitted Infections and HIV/AIDS designs and standardizes organizational processes to enhance institutional and sectoral management with a view to achieve functional objectives related to a culture of health and to prevent and control sexually transmitted infections (STI) and HIV/AIDS, using an approach based on equity, rights, and exercise of citizenship.

The principal target populations include persons living with HIV/AIDS; groups with high prevalence rates and at high risk of acquiring and transmitting STI and HIV, and their sexual contacts; newborn children of mothers with STI/HIV; and the general population.

The principal health activities to be carried out under this strategy focus on avoiding vertical transmission through administration of Highly Active Antiretroviral Therapy (HAART), and on preventing disease and promoting sexual and reproductive health by avoiding risky behaviors. Emphasis has also been given to information dissemination, use of condoms, control of STI, and work with vulnerable populations, among other things.

These activities seek to reduce the sexual and bloodborne transmission of STI, as well as vertical transmission of STI and HIV. Also, through HAART, efforts are being made to reduce the personal, social, and economic impacts of living with HIV/AIDS.

Investment in 2006 amounted to $10 million, representing a 250% increase over 2005.

4.4. National Health Strategy on Prevention and Control of Tuberculosis

In 1991 the Ministry of Health, through the National Tuberculosis Control Program, decided to implement the DOTS strategy recommended by the WHO.[15] Since 2004, under the renamed NHS on Prevention and Control of Tuberculosis, the DOTS strategy

[14] http://www.minsa.gob.pe/portal/03Estrategias-Nacionales/03ESN-ITS-SIDA/vih-sida.asp

[15] DOTS (Directly Observed Treatment, Short Course) has been evaluated by the WHO as a highly cost-effective treatment for tuberculosis. Its principal components are: (a) political commitment on the part of governments to guarantee the necessary resources for tuberculosis control by ensuring a regular supply of drugs and laboratory inputs to all the health services, (b) an organized approach to detection, diagnosis, and case management, (c) diagnosis through sputum examination in patients who present at the health services with respiratory symptoms (cough and expectoration for more than 15 days), (d) use of short-course treatment in which personnel of the health facilities directly observe the patients taking the drugs, (e) an up-to-date information system for the registry and monitoring of patients until they are cured, and (f) training, supervision, and evaluation, as described at http://www.minsa.gob.pe/portal/03Estrategias-Nacionales/03ESN-ITS-SIDA/esn-vihlinacc.asp.

has been implemented in all the services of the Ministry of Health network, which has helped to reduce the incidence of tuberculosis in all its forms.

In 1990, only 25% of the health services operated by the Ministry of Health offered tuberculosis diagnosis and treatment; in 2004, 100% of the services guaranteed access to tuberculosis diagnosis and treatment free of charge.[16]

Of the total cases diagnosed in 2005, 58.7% correspond to the Health Directorates of Lima and Callao, and the Health Directorates of La Libertad, Loreto, Arequipa, Ica, and Junín, which reported the highest number of cases. The figures reported indicate that tuberculosis must be considered a continuing public health problem and that we must maintain a sustained effort in the medium and long term until tuberculosis is no longer a health threat in our country.[17]

Peru has not been able to prevent the arrival of an emerging global threat, namely multidrug-resistant tuberculosis (MDR-TB). Starting in October 1997, a Standard Retreatment Regimen has been used for patients with multidrug-resistant tuberculosis in accordance with WHO recommendations to medium- and low-resource countries. Analysis of the period 1997–1999 shows that application of this retreatment regimen has obtained a cure rate of below 50%.

Following the recommendations of the WHO, Peru has incorporated the DOTS-Plus strategy. This calls for the use of second-line drugs in the management of patients with MDR-TB in low- and middle-income countries on condition that the DOTS strategy is implemented. For these cases, a new therapeutic regimen has been in use in Peru since March 3, 2005, pursuant to Ministerial Resolution No. 162-2005/MINSA.

HIV-TB co-infection represented 1.9% of general morbidity from tuberculosis in 2005. The case-fatality rate is high in co-infected patients, probably due to complications of AIDS or a late diagnosis of tuberculosis. In short, major efforts are being made to control tuberculosis in the country. However, it is indispensable to improve and strengthen the existing guidelines, incorporating broader health-related criteria.

Particular challenges to be confronted include drug resistance, HIV-TB co-infection, tuberculosis fatalities, and epidemiological patterns that put certain areas at high risk of transmission.

The distribution of investment shows 70% of the budget from the Public Treasury and 30% from reimbursable external resources (the Global Fund).

4.5 National Health Strategy on Sexual and Reproductive Health

In the context of the health sector reforms in Peru and after the International Conference on Population and Development (ICPD) held in Cairo in 1994, the concept of sexual and reproductive health was reframed as a right of every person. The 184 countries that signed the ICPD Program of Action, including Peru, committed to making the necessary efforts to adopt the measures proposed in that program.

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[16] Between 1993 and 2001 the coverage of case-finding increased nearly tenfold, although it should be noted that from 2002 to 2003 there was a 6% annual reduction in the capture of patients with respiratory symptoms due to the shortage of laboratory inputs for TB diagnosis; this situation was corrected in the second half of 2004. In 2005, diagnosis and treatment were provided free of charge to 35,541 tuberculosis patients throughout the country, a figure that translated into morbidity of 129.02 per 100,000 population; this represented a reduction of 50.4% compared to 1992 (the year with the highest rate). Of these patients, 18,490 were cases of untreated smear-positive pulmonary tuberculosis, an incidence rate of 67.12 per 100,000 population; this was a 58.3% reduction from 1993.

[17] http://www.minsa.gob.pe/portal/03Estrategias-Nacionales/03ESN-ITS-SIDA/vih-sida.asp

Sexual and reproductive health care comprises all the methods, techniques, and services—promotional, preventive, recuperative, and rehabilitative—that contribute to the sexual and reproductive health and well-being of persons in accordance with their changing needs at the different stages of life.[18]

Sexual health and reproductive health are intimately related and interdependent.[19] Reproductive health includes a person's capacity to enjoy a safe and satisfying sexual life with the freedom to decide when, how, and how often to procreate. This concept implies the exercise of a responsible sexuality based on a relationship of equality and equity between the sexes, full respect for the physical integrity of the human body, and the will to take responsibility for the consequences of sexual behavior.

The strategy on sexual and reproductive health within the framework of the comprehensive care model encompasses the entire human life cycle.[20] People's sexual and reproductive health is closely linked to their family and social environment. In order to attain and maintain an optimum state of health, comprehensive care should include specific actions of promotion, prevention, recovery, and rehabilitation tailored to the specific needs of each stage of the life cycle.

4.6 National Health Strategy on Mental Health and a Culture of Peace

The actions of the National Health Strategy on Mental Health and a Culture of Peace are based on the Guidelines for Action in Mental Health,[21] which provide direction for planning mental health actions in the country, and on the guidelines established in the framework document for the Comprehensive Health Care Model (MAIS). They seek to achieve functional objectives such as creating a culture of health that favors the physical, mental, and social development of the population; ensuring a healthy space for the entire population; and protection and recovery of health and rehabilitation of personal capabilities in conditions of equity and full access.

This strategy is regarded as a priority for the country, inasmuch as the mental health needs of the Peruvian population have been deferred and neglected. This problem was emphasized in the Final Report of the Truth and Reconciliation Commission,[22] which documented the causes and results of the internal armed conflict that gripped the country between 1980 and 2000. Among the major consequences of that conflict was a deterioration in people's mental health, hindering the process of human development.

Recognizing the importance of responding to this situation, the Ministry of Health has resolved to address the country's principal mental health problems. It has prioritized certain areas of work in the Mental Health Recovery Plan,[23] which has received technical and financial support from international cooperation.

The principal actions that have been carried out in recent years concern the preparation of national plans and policy documents,[24] the development of training

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[18] http://www.minsa.gob.pe/portal/03Estrategias-Nacionales/05ESN-SaludSexual/ss-sr.asp

[19] Sexuality and reproduction are intrinsic aspects of sexual and reproductive health. Sexuality is part of each person's life throughout his or her lifespan and develops through the years based on the knowledge, values, beliefs, and customs of the person's social environment.

[20] For the Peruvian health system, the life cycle is understood to include life in the womb, infancy, adolescence, adulthood, and older adulthood.

[21] National Mental Health Policy approved by Ministerial Resolution No. 075-2004/MINSA of January 29, 2004.

[22] www.cverdad.org.pe

[23] http://www.minsa.gob.pe/portal/03Estrategias-Nacionales/10ESN-SaludMental/Archivos/Informe%202004.pdf

[24] For example, the National Mental Health Plan 2005–2010 was approved by Ministerial Resolution No. 012-2006/MINSA, published on January 11, 2006, in the official daily newspaper *El Peruano*.

processes for health workers, and the implementation of pilot activities in community mental health in zones affected by the internal armed conflict, among other activities. However, much remains to be done in protecting, caring for, and improving the mental health of the Peruvian population.

4.7 National Health Strategy on Noncommunicable Diseases

The Ministry of Health, in its National Health Strategy on Prevention and Control of Noncommunicable Diseases, coordinates efforts for the rational and innovative management of noncommunicable diseases in the building of a healthy country. Toward this end it has undertaken to design and deploy sectorwide directives and to use basic tools such as education and citizen participation.

The strategy seeks to reduce morbidity and mortality, especially that caused by hypertension, diabetes mellitus type 2, cancer, and blindness. It promotes intersectoral cooperation and the participation of civil society in order to generate strategies to prevent and control these disorders.[25]

A goal of the strategy is for the regions to identify and carry out comprehensive care of noncommunicable diseases, with sufficient personnel to confront these problems. Documents will be prepared on the prevention of hypertension, type 2 diabetes, cancer, and blindness, among other actions.

The distribution of investment is as follows: 70% of the budget from the Public Treasury, 5% from reimbursable external resources, 10% from non-reimbursable external resources, and 15% from other sources that include the private sector. A rising trend can be seen due to the incorporation of this strategy in the Coordinated National Health Plan.

4.8 National Health Strategy on Healthy Food and Nutrition

The NHS on Healthy Food and Nutrition, one of the 10 strategies of the Ministry of Health, integrates priority interventions and actions aimed at reducing chronic childhood malnutrition, maternal malnutrition, obesity, maternal and child morbidity and mortality, and nutritional deficiencies. It serves to coordinate, supervise, and monitor the various activities related to food and nutrition carried out by the health services and to generate the necessary synergies for obtaining the intended results.

Its general objective is to improve the nutritional status of the Peruvian population through integrated health and nutrition actions, prioritizing vulnerable groups and those suffering from extreme poverty and exclusion. The specific objectives are to: (a) promote the development of healthy behavior in relation to food and nutrition as part of comprehensive health care, with the participation of public institutions, the private sector, grassroots organizations, and the community at large, (b) develop food and nutrition standards in line with the Comprehensive Health Care Model in order to protect the nutritional status of the population, (c) strengthen the competences in food and nutrition of human resources in the health sector, education, and local governments, and of community health workers, according to the Comprehensive Health Care Model, (d) help to strengthen the management of the Food Supplementation Programs geared to vulnerable groups at nutritional risk in extremely poor populations, (e) monitor and evaluate the food and nutrition interventions

[25] http://www.minsa.gob.pe/portal/03Estrategias-Nacionales/06ESN-NoTransmisibles/no-transmisibles.asp

developed in the context of the Comprehensive Health Care Model, (f) propose and develop research on food and nutrition geared to the different stages of life, at the local, regional, and national levels, according to nutritional priorities, and (g) create and strengthen opportunities for consensus building and for intra-, inter-, and multi-institutional collaboration in addressing priority nutritional problems.[26]

4.9 National Health Strategy on Oral Health

The National Health Strategy on Oral Health of the Ministry of Health was recently approved by Ministerial Resolution No. 649-2007/MINSA, dated August 8, 2007. A National Coordinator was named and given the responsibility to design, plan, program, monitor, supervise, and evaluate the implementation and execution of the NHS, as well as its intra- and inter-sectoral coordination.

This strategy, like the majority of the strategies mentioned above, comes under the General Directorate of People's Health and its management is overseen by a Standing Technical Committee and an Advisory Committee.[27]

5. PRINCIPAL FINDINGS/RESULTS

The presentation of the principal findings is organized according to the instruments that make up the Survey of Heads of National Programs.

The results of the administration of the **Questionnaires** are described below for each NHS.

The description of the questionnaire results is presented in two parts: first, a characterization of the degree of horizontality (H) or verticality (V) of each NHS, and second, the most salient information gleaned from the questionnaires.

5.1 The NHS on Immunization obtained a score of 50 for horizontality and 7 for verticality, corresponding to percentages of 88% and 12% respectively. It is therefore characterized as a national program that is integrated in the health system with a *purely horizontal approach.*

- This NHS was created through Ministerial Resolution No. 771-2004/MINSA in July 2004. Operationally, it depends on the General Directorate of People's Health in the Ministry of Health. It features an "Immunization Plan," approved in 2005, which is framed by the health policy guidelines of the Ministry of Health as well as by the national health priorities and the Millennium Development Goals.

- The NHS on Immunization coordinates with Social Security, the Ministry of Education, the Ministry of Women and Social Development, the Ministry of Defense, the Ministry of Labor, and all of the regional governments. In addition, it is closely linked to other NHS such as the strategies on Sexual and Reproductive Health, HIV/AIDS, and TB. It also coordinates periodically with CRECER.

[26] http://www.minsa.gob.pe/portal/03Estrategias-Nacionales/09ESN-NuticionSaludable/nut-saludable.asp
[27] http://www.minsa.gob.pe/portal/03esn/11sbucal/default.asp

- Financing for the NHS on Immunization comes from various sources, but the largest share (70%) is from the Public Treasury. Additional sources are as follows: 10% from grants, 5% from reimbursable external resources or loans, and the remaining 15% from various other sources including the private sector. It should be noted that the regional and local governments are currently providing various resources (human, economic, material, etc.) to the entities involved in this NHS.

- To develop its activities, the NHS on Immunization only maintains full-time personnel at the national level. It also makes use of personnel contracted with external resources.

- The actions of the NHS are carried out at the first, second, and third levels of care. They are part of the basic basket of services (Comprehensive Care for the Stages of Life), and include actions geared to prevention and promotion.

- The NHS does not have its own system of record keeping and information, but uses information generated by the General Bureau of Statistics and Informatics and the General Directorate of Epidemiology to prepare monthly reports at the regional level and quarterly reports at the national level.

NHS on Immunization:
Horizontality/Verticality by Component
Table 1

Component	NHS on Immunization	
	H	V
Steering Role	12	0
	100%	0%
Organization	6	2
	75%	25%
Financing	9	1
	90%	10%
Human Resources	6	4
	60%	40%
Service Delivery	7	0
	100%	0%
Information	10	0
	100%	0%
TOTAL	**50**	**7**
	88%	**12%**

Source. Author's calculations based on responses to the Survey for Heads of National Programs. PAHO/2007.

5.2 The NHS on Prevention and Control of Metaxenic and Other Vector-borne Diseases obtained a score of 51 for horizontality and 8 for verticality, with percentages of 86% and 14% respectively. It is therefore characterized as a national program that is integrated in the health system with a *purely horizontal approach.*

- This NHS was created through Ministerial Resolution No. 771-2004/MINSA in July 2004. Operationally, it depends on the General Directorate of People's Health in the Ministry of Health, specifically the Directorate of Comprehensive Health Care. The NHS coordinates closely with the Ministry of Agriculture and the Ministry of Education.

- At the interprogram level it coordinates with the NHS on Sexual and Reproductive Health and with line agencies of the Ministry, such as the General Directorate of Health Promotion, General Directorate of Environmental Health, General Directorate of Medicines, Supplies, and Drugs, and General Directorate of Epidemiology.

- Financing for the NHS comes mainly from the Public Treasury (90%), and the trend over the last few years points to a continuing increase. The remaining 10%, which comes from loans and grants, is administered separately. As in other NHS, the regional and local governments contribute various resources to the entities involved in the NHS.

- To develop its activities, the NHS maintains full-time personnel at the national and regional levels. It does not have personnel contracted with external resources. Health services personnel receive special training to implement the actions of the strategy; this is provided as part of a training package for the health services. The strategy offers some non-economic incentives such as enabling personnel to participate in training sessions and in international, national, and regional seminars.

- The actions of the strategy are carried out at the first, second, and third levels of care, with community-based activities forming the core of the strategy.

- The activities of the NHS are part of the basic basket of services (Comprehensive Care for the Stages of Life), and include actions geared to prevention and promotion.

- The NHS does not have its own system of record keeping and information, but uses information from the General Directorate of Epidemiology to prepare periodic reports that are used at all levels of management.

NHS on Vector-borne Diseases:
Horizontality/Verticality by Component
Table 2

Component	NHS on Vector-borne Diseases	
	H	V
Steering Role	12	0
	100%	0%
Organization	5	3
	62.5%	37.5%
Financing	6	4
	60%	40%
Human Resources	10	0
	100%	0%
Service Delivery	8	1
	89%	11%
Information	10	0
	100%	0%
TOTAL	**51**	**8**
	86%	**14%**

Source. Author's calculations based on responses to the Survey for Heads of National Programs. PAHO/2007.

5.3 The NHS on Prevention and Control of Sexually Transmitted Infections and HIV/AIDS obtained a score of 45 for horizontality and 12 for verticality, with percentages of 79% and 21% respectively. It is therefore characterized as a national program that is integrated to the health system with a *mixed approach,* but with *strong predominance of the horizontal approach.*

- This NHS has framed its actions within the Multisectoral Strategic Plan 2007–2011 for the Prevention and Control of HIV/AIDS in Peru prepared by the National Multisectoral Coordinator in Health (CONAMUSA). This is an intersectoral coordination agency chaired by the Ministry of Health; it is considered as the Country Coordinating Mechanism that monitors the HIV component financed by the Global Fund.

- In terms of coordination with the other NHS, the NHS on HIV/AIDS relates to the strategies on Sexual and Reproductive Health, TB, Oral Health, and Immunization.

- The principal source of financing for this NHS is the Global Fund, which creates commitments on the part of the Public Treasury that must be met. Exact percentages for the distribution of financing are not available, since some of the resources are channeled directly to the actions of the strategy; accordingly, it is recommended to conduct a study of national accounts. CONAMUSA administers the resources partially through a contracted Principal Recipient (CARE). Although the regional and local governments are providing resources, this process has started only recently.

- The NHS has personnel contracted with external resources at the national level and in the Regional Health Directorates (DIRESAS). The actions of the NHS are carried out at the first, second, and third levels of care. They are part of the basic basket of services (Comprehensive Care for the Stages of Life), and include actions geared to prevention and promotion.

NHS on HIV/AIDS:
Horizontality/Verticality by Component
Table 3

Component	**NHS on HIV/AIDS**	
	H	**V**
Steering Role	12	0
	100%	0%
Organization	6	2
	75%	25%
Financing	6	2
	75%	25%
Human Resources	6	4
	60%	40%
Service Delivery	7	2
	78%	22%
Information	8	2
	80%	20%
TOTAL	**45**	**12**
	79%	**21%**

Source. Author's calculations based on responses to the Survey for Heads of National Programs. PAHO/2007.

5.4 The NHS on Prevention and Control of Tuberculosis received a score of 40 for horizontality and 19 for verticality, with percentages of 68% and 32% respectively. It is therefore characterized as a national program that is integrated in the health system with a *mixed approach*, with *moderate predominance of the horizontal approach*, according to the methodology described.

- This NHS was created in 2005 through Ministerial Resolution No. 721-2005/MINSA, as a successor to the National Tuberculosis Control Program. It currently depends organically on the General Directorate of People's Health of the Ministry of Health.

- It coordinates with or relates to various agencies in other sectors, including the ministries of Labor, Housing and Construction, Education, Women and Social Development, and the Interior, and with the Office of the People's Defender. In terms of linkages to other health strategies, it relates in particular to the NHS on Sexually Transmitted Infections and HIV/AIDS.

- The standards arising from the strategy must be supported by Ministerial Resolution.
- The NHS has full-time personnel at the central and regional levels.

- Approximately 70% of the funds come from the Public Treasury; the remaining 30% are in the form of external grants, mainly from the Global Fund. Most of the external funds are administered by CONAMUSA. The resources of the Global Fund are administered in accordance with the Fund's own regulations, and a portion of the supplies are stored in its facilities.

- The Global Fund contracts personnel for the strategy on the basis of its own remuneration scale.

- The actions are widely incorporated at the different levels of the health services. The training activities are integrated with other training as part of the basket of benefits at the different levels of care. The interventions include actions geared to promotion and prevention.

- The distribution of supplies is done using the services and procedures of the Ministry of Health exclusively.

- The NHS has its own information system that generates reports used at the different levels of management.

NHS on Tuberculosis:
Horizontality/Verticality by Component
Table 4

Component	NHS on TB	
	H	V
Steering Role	12	0
	100%	0%
Organization	4	4
	50%	50%
Financing	6	4
	60%	40%
Human Resources	4	6

	40%	60%
Service Delivery	8	1
	89%	11%
Information	6	4
	60%	40%
TOTAL	**40**	**19**
	68%	**32%**

Source. Author's calculations based on responses to the Survey for Heads of National Programs. PAHO/2007.

5.5 The NHS on Sexual and Reproductive Health obtained a score of 41 for horizontality and 17 for verticality, with percentages of 71% and 29% respectively. It is therefore characterized as a national program that is integrated in the health system with a *mixed approach*, but with *strong predominance of the horizontal approach.*

- This NHS was created through Ministerial Resolution No. 771-2004/MINSA in July 2004. Operationally, it depends on the General Directorate of People's Health.

- The NHS coordinates with the Ministry of Education, Ministry of Women and Social Development, and Ministry of the Interior, and with the other members of its Advisory Committee: scientific societies, professional associations, nongovernmental organizations, Social Security, the Armed Forces, and Office of the People's Defender. It also maintains ties with other NHS including those on HIV/AIDS, Immunization, Noncommunicable Diseases, and TB.

- The NHS on Sexual and Reproductive Health has had various sources of external financing since its inception, and recently began receiving financing from the Public Treasury (starting in June 2007).

- To develop its activities, the NHS on Sexual and Reproductive Health maintains full-time personnel only at the national level; personnel responsible for the NHS in the DIRESAS and the Health Networks and Micronetworks are not dedicated exclusively to the strategy. The actions of the NHS are carried out at the first, second, and third levels of care. They are part of the basic basket of services (Comprehensive Care for the Stages of Life), and include actions geared to prevention and promotion.

- The team in charge of the NHS at the national level provides training in implementation of the strategy only to the DIRESAS, which are then responsible for training the Health Networks and Micronetworks in their respective regions.

NHS on Sexual and Reproductive Health:
Horizontality/Verticality by Component
Table 5

Component	**NHS on Sexual/Reproductive Health**	
	H	**V**
Steering Role	12	0
	100%	0%
Organization	4	4
	50%	50%
Financing	5	4

	56%	44%
Human Resources	6	4
	60%	40%
Service Delivery	8	1
	89%	11%
Information	6	4
	60%	40%
TOTAL	**41**	**17**
	71%	**29%**

Source. Author's calculations based on responses to the Survey for Heads of National Programs. PAHO/2007.

5.6 The NHS on Noncommunicable Diseases obtained a score of 43 for horizontality and 13 for verticality, with percentages of 77% and 23% respectively. It is therefore characterized as a national program that is integrated in the health system with a *mixed approach*, but with *strong predominance of the horizontal approach.*

- This NHS has a national plan for 2001–2012 that is framed by the health policy guidelines of the Ministry of Health and by the national health priorities and the Millennium Development Goals. The NHS depends on the General Directorate of People's Health and specifically on the Directorate of Health Services.

- The NHS coordinates in particular with the Ministry of Education and the Ministry of Women and Social Development, and at the interprogram level with the NHS on Sexual and Reproductive Health.

- Financing for the NHS comes exclusively from the Public Treasury, and although financing is still limited there is an upward trend.

- To develop its activities, the NHS maintains full-time personnel at the national level and also at the regional level, but not in all the DIRESAS. In the Health Networks and Micronetworks the personnel in charge of carrying out the actions of the strategy are the coordinators of the NHS, who also promote the actions of all the other strategies.

- The actions of the NHS are carried out at the first, second, and third levels of care. They are part of the basic basket of services (Comprehensive Care for the Stages of Life), and include actions geared to prevention and promotion.

- The NHS does not have its own system of record keeping and information, but uses information generated by the General Directorate of Epidemiology.

NHS on Noncommunicable Diseases: Horizontality/Verticality by Component
Table 6

Component	**NHS on Noncommunicable Diseases**	
	H	**V**
Steering Role	12	0
	100%	0%
Organization	5	3
	62.5%	37.5%

Financing	9	0
	100%	0%
Human Resources	6	2
	75%	25%
Service Delivery	7	2
	78%	22%
Information	4	6
	40%	60%
TOTAL	**43**	**13**
	77%	**23%**

Source. Author's calculations based on responses to the Survey for Heads of National Programs. PAHO/2007.

5.7 The NHS on Mental Health and a Culture of Peace obtained a score of 44 for horizontality and 15 for verticality, with percentages of 75% and 25% respectively. It is therefore characterized as a national program that is integrated in the health system with a *mixed approach*, but with *strong predominance of the horizontal approach.*

- Operationally, this NHS depends on the General Directorate of People's Health of the Ministry of Health.

- In 2004 the General Plan of the NHS on Mental Health and a Culture of Peace 2005–2010 was approved, and in October 2006 the National Mental Health Plan was approved. This plan describes specific problems, but also relates the central problem to dimensions such as poverty and access to services and identifies broad issues associated with mental health interventions.

- The NHS coordinates with the Ministry of Education and the Ministry of Women and Social Development, as well as with other agencies.

- To develop its activities, the NHS maintains full-time personnel at the regional and intermediate levels; however, the subnational levels do not require the approval of the national level for decision-making on NHS actions.

- Financing for the NHS is mixed, with approximately 40% of the resources coming from the Public Treasury. Most of the additional resources are in the form of grants from the European Union through the PASA Project; these resources are administered by the Ministry of Health.

- The supplies required by the NHS are managed through the Ministry of Health's own system. There is no use of personnel contracted with external resources.

- Actions are carried out at the first and second levels of care. The personal who carry out these actions require and receive direct training from the NHS. The activities of the NHS are part of the basic basket of services and include actions geared to prevention and promotion.

- The NHS has its own system of record keeping and information, which is used to produce periodic reports that are used at all levels of management.

NHS on Mental Health:
Horizontality/Verticality by Component
Table 7

Component	NHS on Mental Health	
	H	V
Steering Role	12	0
	100%	0%
Organization	6	2
	75%	25%
Financing	8	2
	80%	20%
Human Resources	8	2
	80%	20%
Service Delivery	6	3
	67%	33%
Information	4	6
	40%	60%
TOTAL	**44**	**15**
	75%	**25%**

Source. Author's calculations based on responses to the Survey for Heads of National Programs. PAHO/2007.

5.8 The NHS on Healthy Food and Nutrition obtained a score of 38 for horizontality and 21 for verticality, with percentages of 64% and 36% respectively. It is therefore characterized as a national program that is integrated in the health system with a *mixed approach*, with *moderate predominance of the horizontal approach*.

- The NHS on Healthy Food and Nutrition operated under the National Food and Nutrition Center (CENAN), which is part of the National Institute of Health. CENAN is also the National Coordinator of the strategy.

- The Strategic Plan 2007–2011 of the NHS is framed by the overarching intersectoral guideline known as the CRECER strategy and also by the health policy guidelines of the Ministry of Health, the National Accord, the National Action Plan for Children and Adolescents, and the Law on Results-based Budgeting.

- The NHS on Healthy Food and Nutrition coordinates with the Ministry of Women and Social Development (through PRONAA, the National Food Assistance Program) and with the Ministry of Production and the Ministry of Agriculture. It also relates closely to other NHS, especially the NHS on Sexual and Reproductive Health. Its Technical Committee comprises six divisions of the Ministry of Health: General Directorate of Health Promotion, General Directorate of Epidemiology, General Directorate of Environmental Health, General Directorate of People's Health, General Bureau of Communications, and General Directorate of Medicines, Supplies, and Drugs.

- The NHS uses instruments such as management agreements to set goals with the subnational levels, but this procedure is not standardized.

- The NHS has full-time personnel only at the national level, not at the subnational levels. At these levels the approval of the NHS is not required for decision-making on program actions.

- Operationally, the laboratory network at the national level depends on the Ministry of Health, but in the case of the NHS on Food and Nutrition there exist two laboratory networks at the regional level: the public health laboratories and the food laboratories, which depend on the Regional Health Directorates. The network of food laboratories depends specifically on the Executive Directorates of Environmental Health of the regions.

- The actions of the NHS are financed mainly by contributions from the Public Treasury, which account for more than 70%. For this strategy, as for several others, no detailed analysis is available showing the percentages of resources that come from international cooperation. Even though there is no record of the direct participation of regional and local governments in financing the actions of the strategy, the DIRESAS forge direct ties with international cooperation for the purpose of developing other actions on food and nutrition.

- To develop its activities, the NHS maintains full-time personnel only at the national level. It uses personnel contracted with external resources. The actions of the NHS are carried out at the first, second, and third levels of care. They are part of the basic basket of services (Comprehensive Care for the Stages of Life), and include actions geared to prevention and promotion.

- The NHS does not have its own system of record keeping and information, but uses information generated by the General Bureau of Statistics and Informatics and the General Directorate of Epidemiology to prepare monthly reports at the regional level and quarterly reports at the national level.

NHS on Food and Nutrition:
Horizontality/Verticality by Component
Table 8

Component	**NHS on Food and Nutrition**	
	H	**V**
Steering Role	9	3
	75%	25%
Organization	8	0
	100%	0%
Financing	8	2
	80%	20%
Human Resources	6	4
	60%	40%
Service Delivery	7	2
	78%	22%
Information	0	10
	0%	100%
TOTAL	**38**	**21**
	64%	**36%**

Source. Author's calculations based on responses to the Survey for Heads of National Programs. PAHO/2007.

5.9 The NHS on Oral Health obtained a score of 38 for horizontality and 17 for verticality, with percentages of 69% and 31% respectively. It is therefore characterized as a national program that is integrated in the health system with a *mixed approach*, with *moderate predominance of the horizontal approach.*

- The NHS on Oral Health was created through Ministerial Resolution No. 649-2007/MINSA of August 8, 2007.

- It coordinates with Social Security, the Ministry of Education, and the Ministry of Women and Social Development, and also with universities and professional schools.

- Interprogrammatic coordination includes relations with the NHS on Healthy Food and Nutrition, TB, HIV/AIDS, and Mental Health. It should be noted that this NHS also carries out coordinated actions with the National Institute of Health, including the issuance of standards (e.g., on fluoridation) and studies (e.g., on mycosis).

- The NHS on Oral Health receives resources only from the Public Treasury, with a trend toward increase.

- In addition to its team at the national level the strategy has coordinators in the DIRESAS and in the Health Networks, and in some cases in the Micronetworks.

- The NHS does not have its own system of record keeping and information, but uses information generated by the General Bureau of Statistics and Informatics.

NHS on Oral Health:
Horizontality/Verticality by Component
Table 9

Component	NHS on Oral Health	
	H	V
Steering Role	8	4
	67%	33%
Organization	5	3
	62.5%	37.5%
Financing	6	2
	75%	25%
Human Resources	10	0
	100%	0%
Service Delivery	7	2
	78%	22%
Information	2	6
	25%	75%
TOTAL	**38**	**17**
	69%	**31%**

Source. Author's calculations based on responses to the Survey for Heads of National Programs. PAHO/2007.

Survey on perceptions

Table 10 summarizes the results of the surveys on perceptions in global terms, separating the responses into two broad categories: those that say that a given feature of the national program *strengthens* the health system (combining the responses "strengthens totally" and "strengthens partially"), and those that say that the feature *weakens* the health system (combining the responses "weakens partially" and "weakens totally").

Peru: Total percentages for each feature
Table 10

Feature	Strengthens	Weakens
Interprogrammatic coordination of the Program	100%	0%
Development of a surveillance and information system proper to the Program	67%	33%
Exclusive training on the Program for health services personnel	67%	33%
Direct administration of all financial resources by the Program	50%	38%
Conducting of surveillance studies for the Program	100%	0%
Utilization of quality standards in the laboratories	89%	0%
Hierarchization and verticalization of decisions and actions in the Program	33%	56%
Achievement of political commitment for the implementation and expansion of Program objectives	100%	0%
Implementation of actions coordinated with other sectors (education, prisons, etc.)	100%	0%
Implementation of prevention and promotion activities as part of the Program	100%	0%
Inclusion of services of other health providers in the public sector (e.g., Social Security)	100%	0%
Inclusion of health services of private providers	78%	0%
Presence of cooperation projects involved in the same activities as the Program	25%	75%
Implementation of the regional/national strategy of the Program	100%	0%
Introduction of international norms and standards for care provided by the Program	100%	0%
Mobilization of activists and community representatives in Program activities	100%	0%
Cooperative projects with global initiatives focused on specific diseases (e.g., the Global Fund)	78%	0%
Knowledge transfer to the community	100%	0%
Implementation of behavioral change campaigns for the Program	88%	13%
Conducting of research at different levels of the Health System	100%	0%
Separate administrative systems for management of funds disbursed for the Program (different administrative entities due to different sources of financing)	22%	56%
Contracting or designation of personnel responsible for the Program at all levels of management	100%	0%
Supervision by the central level of the intermediate levels	100%	0%
Supervision by the central level of the regional and local levels	75%	25%
Approval by the central level of all decisions made by the intermediate and local levels	22%	78%
Financing by international cooperation of initiatives that are not priorities of the sector	0%	100%
Establishment of incentives for health services personnel who meet Program goals	100%	0%
Guarantee of job security for personnel of the Program and of the health services	89%	11%
Implementation of actions related to the Program	100%	0%
Community participation in Program actions	100%	0%

Source. Author's calculations based on responses to the Survey for Heads of National Programs. PAHO 2007 (Peru).

100% of the respondents held that the following features *strengthen* the health system (with responses ranging from "strengthen totally" to "strengthen partially"):

- *Interprogrammatic coordination of the Program*
- *Conducting of surveillance studies for the Program*

- *Achievement of political commitment for the implementation and expansion of Program objectives*
- *Implementation of actions coordinated with other sectors (education, prisons, etc.)*
- *Implementation of prevention and promotion activities as part of the Program*
- *Inclusion of services of other health providers in the public sector (e.g., Social Security)*
- *Implementation of the regional/national strategy of the Program*
- *Introduction of international norms and standards for care provided by the Program*
- *Mobilization of activists and community representatives in Program activities*
- *Knowledge transfer to the community*
- *Contracting or designation of personnel responsible for the Program at all levels of management*
- *Supervision by the central level of the intermediate levels*
- *Establishment of incentives for health services personnel who meet Program goals*
- *Community participation in Program actions*

In addition, 88% to 89% of the respondents stated that the following three features *strengthen* the health system:

- *Guarantee of job security for personnel of the Program and of the health services*
- *Implementation of specific behavioral change campaigns for the Program*
- *Utilization of quality standards in the laboratories*

We find 10 features for which the responses range from *strengthen totally* to *weaken totally*. These responses are very interesting because they show the doubts and differences of opinion that exist on some key issues in the development of the National Health Strategies and the health sector as a whole.

With respect to the following two features, 78% of the respondents said that they *strengthen* the health system, and the remainder, 22%, said that they *neither weaken nor strengthen it*:

- *Inclusion of health services of private providers*
- *Cooperative projects with global initiatives focused on specific diseases*

In considering "*Supervision by the central level of the regional and local levels*," 75% of respondents agreed that this type of supervision *strengthens* the system and the remaining 25% said that it *weakens* it.

With respect to "*Development of a surveillance and information system proper to the Program*," two-thirds of the respondents, 67%, stated that this feature strengthens the system; the remainder, 33%, said that it weakens it partially. This result is contradictory and reflects differences of opinion on the part of the National Coordinators with respect to the *information* component. It is also worth noting that the majority of the NHS do not have their own information system, but rather obtain data from the General Directorate of Epidemiology and the General Bureau of Statistics and Informatics.

Similar results were found in the responses for the feature "*Exclusive training on the Program for health services personnel*": 67% responded that this type of training *strengthens* the system and 33% said that it *weakens* it.

Regarding "*Direct administration of all financial resources by the Program*," only 50% said that this feature *strengthens* the system; the remaining 38% said *the opposite.*

For each of the following five features, a majority of respondents stated that the feature *weakens* the health system (the different percentages are noted):

100% of the respondents said that "*Financing by international cooperation of initiatives that are not priorities of the sector" weakens* the health system, either *totally* or *partially*.

"*Hierarchization and verticalization of decisions and actions in the Program*" was considered by 56% of the respondents to be a feature that *weakens* the system, but 33% said that it *partially strengthens* it.

There was greater agreement regarding the "*Presence of cooperation projects involved in the same activities as the Program*": 75% held that this feature *weakens* the system and 25% that it *partially strengthens* it.

"*Separate administrative systems for management of funds disbursed for the Program*" has to do with the *financing* component, which at the global level still presents a certain degree of verticality (25%). When asked about this feature, 56% said that it *weakens* the system and 22% that it *strengthens* it, while 11% said that it *neither weakens nor strengthens* it.

Regarding the "*Approval by the central level of all decisions made by the intermediate and local levels*," the majority of respondents believe that this feature *weakens* the system but 22% said that it *partially strengthens* it, reflecting the doubts that persist on the current process of decentralization.

6. CONCLUSIONS

Tables 11 and 12 summarize the results for each National Health Strategy.

Peru: Results for Each NHS

Table 11

NHS	Horizontality	Verticality
Immunization	88%	12%
Vector-borne Diseases	86%	14%
HIV/AIDS	79%	21%
TB	68%	32%
Sexual and Reproductive Health	71%	29%
Noncommunicable Diseases	77%	23%
Mental Health	75%	25%
Food and Nutrition	64%	36%
Oral Health	69%	31%

Source. Author's calculations based on responses to the Survey for Heads of National Programs. PAHO/2007.

Peru: Characterization of Each NHS

Table 12

NHS	Approach
Immunization	**Horizontal**
Vector-borne Diseases	**Horizontal**
HIV/AIDS	**Mixed,** strongly horizontal predominance
TB	**Mixed,** moderately horizontal predominance
Sexual and Reproductive Health	**Mixed,** strongly horizontal predominance
Noncommunicable Diseases	**Mixed,** strongly horizontal predominance
Mental Health	**Mixed,** strongly horizontal predominance
Food and Nutrition	**Mixed,** moderately horizontal predominance
Oral Health	**Mixed,** moderately horizontal predominance

Source. Author's calculations based on responses to the Survey for Heads of National Programs. PAHO/2007.

Of the nine National Health Strategies analyzed, two were described as strategies of purely horizontal integration. The remaining seven are integrated in the health system with a mixed approach that varies from moderately horizontal (three) to strongly horizontal (four).

Table 13

Peru: Horizontality/Verticality of All the National Health Strategies, by Component (%)

Component	TB		HIV/AIDS		Vector-borne Diseases		Immunization		Noncommunicable Diseases		Sexual/Reproductive Health		Food and Nutrition		Mental Health		Oral Health		Total	
	H	V	H	V	H	V	H	V	H	V	H	V	H	V	H	V	H	V	H	V
Steering Role	100	0	100	0	100	0	100	0	100	0	100	0	75	25	100	0	67	33	**94**	**6**
Organization	50	50	75	25	62.5	37.5	75	25	62.5	37.5	50	50	100	0	75	25	62.5	37.5	**68**	**32**
Financing	60	40	75	25	60	40	90	10	100	0	56	44	80	20	80	20	75	25	**75**	**25**
Human Resources	40	60	60	40	100	0	60	40	75	25	60	40	60	40	80	20	100	0	**70**	**30**
Service Delivery	89	11	78	22	89	11	100	0	78	22	89	11	78	22	67	33	78	22	**82**	**18**
Information	60	40	80	20	100	0	100	0	40	60	60	40	0	100	40	60	25	75	**57**	**43**
Total	**68**	**32**	**79**	**21**	**86**	**14**	**88**	**12**	**77**	**23**	**71**	**29**	**64**	**36**	**75**	**25**	**69**	**31**	**75**	**25**

Source. Author's calculations based on responses to the Survey for Heads of National Programs. PAHO/2007 (Peru).

Table 13 summarizes the results by component from the evaluations of the nine NHS participating in the present study; however, it should be noted that the methodology used was designed to evaluate each NHS, and not the specific components.

Of the six components analyzed, *steering role* and *service delivery* showed the strongest evidence of the horizontal approach. All the NHS evaluated depend organically and administratively on the Ministry of Health, permit the use of contracts or letters of intent at the subnational levels of management, carry out coordinated actions with other NHS, and require issuance of an explicit ministerial resolution for the approval of their standards. Furthermore, all the NHS included in the study carry out activities at the first and second levels of care, but do not provide these services exclusively; the actions of the NHS are in all cases part of the basic basket of services, including actions geared to prevention and promotion.

The other components analyzed showed mixed results, with the components of *organization* and *information* having a slightly greater tendency than the others toward verticality. For example, with respect to *organization,* seven of the nine NHS evaluated maintain full-time personnel at the subnational levels; with respect to *information*, six NHS reported having their own systems of record keeping and information.

Several of the interviewees pointed out that a particular NHS provided inducements or incentives for health services personnel, but in all cases these consisted of capacity-building activities such as formal training or internships; in no case did the incentives involve bonuses or any other type of economic incentive.

The facilities of the Ministry of Health have been transferred to the regional governments as a part of the decentralization process, except for those that operate in the Lima metropolitan area. These services depend organically and administratively on their regional governments but maintain a technical dependence on the Ministry of Health.

This aspect is important for the interpretation of the responses. For example, a reference laboratory at the regional level does not depend organically or administratively on the Ministry of Health, but depends instead on the Regional Health Directorate, which in turn depends on the regional government. The respondents did not have uniform views regarding the dependence of the Dependent Public Agencies of the Ministry of Health.

7. ANNEXES

- Annex 1 List of interviewees, timeline of interviews
- Annex 2 Glossary
- Annex 3 Ministerial Resolution No. 771-2004/MINSA
- Annex 4 Completed questionnaires

ANNEX 1: Timeline of interviews and names and affiliations of interviewees

NAME	MINISTRY OF HEALTH	PROGRAM	POSITION	INTERVIEW
Ms. María Ana Mendoza Araujo	DGSP	NHS on Immunization	**National Coordinator**	21/8/07
Dr. Luís Miguel León	DGSP	NHS on Metaxenic and Other Vector-borne Diseases	**National Coordinator**	14/8/07
Dr. Cesar Antonio Bonilla	DGSP	NHS on Tuberculosis	**National Coordinator**	3/9/07
Dr. José Luís Sebastián Mesones	DGSP	NHS on Prevention and Control of Sexually Transmitted Infections and HIV/AIDS	**National Coordinator**	13/8/07
Dr. Lucy del Carpio	DGSP	NHS on Sexual and Reproductive Health	**National Coordinator**	10/8/07
Dr. Héctor Eduardo Shimabuku	DGSP	NHS on Noncommunicable Diseases	**National Coordinator**	14/8/07
Dr. Maria Inés Sánchez	INS	NHS on Healthy Food and Nutrition	**National Coordinator**	10/9/07
Ms. Rita Uribe Obando	DGSP	NHS on Mental Health and a Culture of Peace	**Director**	11/9/07
Dr. Luís Villavicencio	DGSP	NHS on Oral Health	**Coordinator of the Directorate**	13/8/07

ANNEX 2: Glossary of Operational Definitions

1. Health System: Organization, relations, and coordination of the set of elements or components of a social system designated (formally or informally) as responsible for carrying out health care activities.
2. National Programs: Public health entities within the Health System in charge of standardizing, planning, implementing, and monitoring actions in a specific area (for example, maternal health, TB control, HIV/AIDS).
3. Integration of the NP with the HS: Situation or position, degree of dependency, and coordination of the NP within the HS, as well as relations with its environment.
4. Strengthening the HS through the NP: Building capacity in the elements or components of the HS through specific actions of the national program.
5. Weakening the HS through the NP: Reducing capacity in the elements or components of the HS through specific actions of the national program.
6. Levels of management: Corresponding to the management structure of the Health System, these include:

    - The central or national level, which carries out the steering role and sets standards
    - The intermediate, departmental, provincial, or state level, which is in charge of supervision, surveillance, and evaluation of the network of services corresponding to the geographic area
    - The local level, which is the operating level of the health services
7. Levels of care: Corresponding to the structure of the service delivery system, these include:

    - First level: offers basic health services through health posts, health centers, outpatient consultation, home care, community-based care, etc.
    - Second level: offers outpatient and inpatient health services in the basic specialties of internal medicine, surgery, obstetrics, and pediatrics, through clinics and intermediate hospitals
    - Third level: offers outpatient and inpatient services in all the specialties as well as high-complexity diagnostic and therapeutic support services, through general hospitals
    - Fourth level: consists of specialized centers, national institutes, research institutes, etc.

8. Primary health care (PHC): Strategy for organization and management of the Health System aimed at guaranteeing universal access to a minimum level of health services through an equitable distribution of resources, community participation, and policy coordination with other sectors.
9. Intersectoral coordination: Joint efforts by the health sector and one or more other social sectors with respect to resources, methods, and operations, for the achievement of a common objective.
10. Interprogrammatic coordination: Joint efforts by one or more programs of the Health System with respect to resources, methods, and operations, for the achievement of a common objective.

ANNEX 3: Ministerial Resolution No. 771-2004/MINSA

MINISTERIAL RESOLUTION NO. 771-2004/MINSA
Lima, July 27, 2004

WHEREAS:

Article 5 of Law No. 27657 - Law on the Ministry of Health, establishes that the Ministry of Health designs and sets standards for the organizational processes in the area of its institutional and sectoral management, in order to achieve functional objectives such as a culture of health that favors the physical, mental, and social development of the population; a healthy space for the entire population; the protection and recovery of health and the rehabilitation of capacities for all people in conditions of equity and full access; and the prevention and control of epidemics, among others;
Article 10 of the Regulation of the aforementioned Law, approved by Supreme Decree No. 013-2002-SA, stipulates that the process of protection, recovery, and rehabilitation of health has as a general functional objective to prevent risks and harm as well as to recover the health of the individual and of the population; this process in turn comprises various subprocesses, among them that of regulation and supervision of individual and population health, whose functional objective is to achieve the normalization, standardization, and fulfillment of comprehensive and universal health care for the population;
Paragraph (c) of Article 50 of the Regulation on Organization and Functions of the Ministry of Health, approved by Supreme Decree No. 014-2002-SA, stipulates that standardization and supervision of the development of health strategies and of programs on people's health are broad functional objectives of the General Directorate of People's Health;
Moreover, paragraph (e) of the aforementioned article stipulates that it is a responsibility of the General Directorate of People's Health to propose the policies, priorities, and strategies for people's health care and the model of care, with sectoral and institutional scope, among other broad functional objectives;
In accordance with its indicated functions, the General Directorate of People's Health has called for institutionalization of the National Health Strategies, described in the document entitled "Comprehensive Health: A Commitment of All - The Comprehensive Health Care Model," adopted by Ministerial Resolution No. 729-2003-SA/DM, of June 20, 2003, as mechanisms necessary for improving the management of the health sector;
In order to guarantee that the aforementioned National Health Strategies can be designed, implemented, and applied successfully, it is necessary to establish entities for coordination, supervision, and monitoring;
As provided in section (1) of Article 8 of Law No. 27657 - Law on the Ministry of Health;

BE IT RESOLVED:

Article 1 - Establishes the National Health Strategies of the Ministry of Health, and their respective responsible agencies:

National Health Strategy	Responsible agencies
Immunization	General Directorate of People's Health
Prevention and Control of Metaxenic and Other Vector-borne Diseases	General Directorate of People's Health

Prevention and Control of Sexually Transmitted Infections and HIV/AIDS	General Directorate of People's Health
Prevention and Control of Tuberculosis	General Directorate of People's Health
Sexual and Reproductive Health	General Directorate of People's Health
Prevention and Control of Noncommunicable Diseases	General Directorate of People's Health
Traffic Accidents	General Bureau of National Defense
Health of Indigenous Populations	National Intercultural Health Center National Institute of Health
Healthy Food and Nutrition	National Food and Nutrition Center National Institute of Health
Mental Health and Culture of Peace	General Directorate of Health Promotion

Article 2 - The National Health Strategies will be the responsibility of National Coordinators who will be nominated by ministerial resolution.

Article 3 - The National Coordinators will design, plan, program, monitor, supervise, and evaluate the implementation and execution of the National Health Strategies, as well as their intrasectoral and intersectoral coordination.

Article 4 - The management and execution of each National Health Strategy will be the responsibility of a Standing Technical Committee and an Advisory Committee, which will have the following functions:

1. Standing Technical Committee:

    a. Prepare the Plan of the National Health Strategy;
    b. Support the development and execution of the National Health Strategy;
    c. Carry out monitoring and periodic evaluation of the results;
    d. Mobilize financial resources for the execution of the National Health Strategy;
    e. Integrate the activities of the different General Directorates and Decentralized Public Agencies for the achievement of the objectives of the National Health Strategy.

2. Advisory Committee:

    a. Provide technical assistance for the development and execution of the National Health Strategy;
    b. Support the integration of actions of the public sector and of civil society within the framework of the National Health Strategy.

Article 5 - The makeup of the Committees will be as follows:

1. Standing Technical Committee:
    a. The National Coordinator of the National Health Strategy, who will chair the committee;
    b. A representative of the General Directorate of Health Promotion;

c. A representative of the General Bureau of Communications;
d. A representative of the Directorate of Medicines, Supplies, and Drugs;
e. A representative of the General Directorate of Epidemiology;
f. A representative of the National Institute of Health; and
g. A representative of the General Directorate of Environmental Health only for the National Health Strategies on Prevention and Control of Metaxenic and Other Vector-borne Diseases, Health of Indigenous Populations, and Healthy Food and Nutrition.

2. Advisory Committee:
   a. Academic institutions;
   b. International cooperation agencies;
   c. Nongovernmental organizations related to the National Health Strategy; and
   d. Organizations of people affected within the framework of the National Health Strategy.

Article 6 - For the formation of the Standing Technical Committee, each General Directorate or Decentralized Public Agency will name an incumbent and a substitute. For the formation of the Advisory Committee, the National Coordinator of the National Health Strategy will invite one member, at a minimum, of each institution. Both Committees should be constituted and prepare their regulation within thirty (30) calendar days of publication of the present resolution.

Article 7 - The structural organs and entities in the health field, at the national level, will implement the National Health Strategies and will give the necessary support to ensure the achievement of the objectives set forth in the present ministerial resolution.

Article 8 - At the regional level, the Regional Health Directors will be responsible for implementation of the National Health Strategies.

Article 9 - By a Resolution of the Minister of Health, the General Plan of the National Health Strategies will be adopted.

Article 10 - The plans to be developed and carried out within the framework of the National Health Strategies should be compatible with the Comprehensive Health Care Model, of which they are part.

Article 11 - The National Health Strategies are part of the Comprehensive Health Care Model, and the plans should be developed and carried out within the framework of that model.

To be recorded, transmitted, and published.
PILLAR MAZZETTI SOLER
Minister of Health