

Empowering Communities to Strengthen Health Systems:
Lessons from Peru's CLAS Program

In the past decade, there has been “a renaissance of interest in health systems in academic discourse and policy dialogue within the development community...after 20 years of neglect in favor of vertical health programs, community-based small-scale projects, and donor-directed thematic health investments” (Kruk 264). However, community-based programs generally fall outside of the purview of systems efforts. Although the improvement of health care facilities is a central part of these efforts, the hidden logic is that the management and administration involved necessitate a top-down, government or donor-led effort. Community members simply become ‘end-users’ or ‘consumers’ whose sole involvement manifests in client satisfaction surveys.

However, the striking success of the CLAS program in Peru should call this logic into question. CLAS is the Spanish acronym for Local Health Administration Committees. The CLAS system increases community involvement and control of health services and holds public employees directly accountable to the communities that they serve (Altobelli 14). Its objectives include: improvement of public sector health services administration, decentralization, community participation, improving quality and coverage of health services, and increasing the funds available to local health services (15). While it has attained remarkable achievements in community empowerment, a closer examination of its short history can lend insight into the necessity of better institutional planning, the role of external partners in bolstering credibility, and help pave the way for future community-based health systems strengthening.

CLAS and the Shared Administration Program: A Brief Overview

CLAS began at the end of the Maoist Shining Path insurgency, a violent and turbulent period in Peru's recent history (Paredes 200). Community members in more remote areas of the Peruvian Andes were eager to exert greater control over local health services and improve

quality of care. In response, a progressive Minister of Health developed a proposal for what would become CLAS. Initially, communities with a history of community organization were approached and chose to participate (Altobelli 15). In July 1994, the first pilot projects were launched at 13 facilities in two different regions (12). CLAS committees expanded very rapidly, adding 250 in the first 6 months of the program (Paredes 201). At present, nearly a third of health posts in Peru are administered by a CLAS (Altobelli 21; see Appendix, Graph 1).

CLAS falls under two government programs: the Shared Administration Program (PAC) and the Integrated Health Insurance (SIS) program, which is the major health financing mechanism in the country (Altobelli 3). Contractual obligations between CLAS and government are defined at the national level, while contracts are executed via Regional Health Offices (13). Public funds are transferred to private bank accounts opened by the individual associations. The CLAS committee or association itself is composed of six elected community members as well as the local Health Center Manager. Both the Manager and the committee treasurer can disburse funds. Health planning also takes place at the local level, led by the CLAS association. The Local Health Plan includes and helps determine budgeting allocations made by the state for each facility. The CLAS committee along with local health center personnel “conduct an annual household survey and set local priorities to create an annual community health plan” (Paredes 201). Community members identify problems, help plan solutions, and allocate funds to implement them (Altobelli 16).

Example decisions that members can make as part of their oversight of local health services include increasing staffing, changing facility hours, and purchasing equipment and supplies. Many committees have also instituted a sliding scale of fees-for-services for the poor (Altobelli 17). Community health agents under the supervision of the CLAS associations act as

liaisons between community members and a more skilled health worker (generally a nurse) who provides health services as part of outreach efforts (18).

Independent evaluations of the CLAS system have demonstrated significant positive impact. CLAS-run health centers are more likely to serve people from lower income quintiles, and women and children under five are the primary beneficiaries. CLAS communities are more likely to receive free, subsidized consultations as well (Altobelli 25). CLAS associations also help develop community leaders and motivate them to participate through recognition and increased responsibilities. The impact on women is of note as 1/3 of CLAS associations had majority female membership (19). Other auxiliary benefits included other community development projects such as basketball courts and youth soccer leagues (Paredes 203). A complete assessment of the health impact of CLAS is beyond the scope of this paper.

Political and Administrative Challenges in Institutional Development

CLAS' rapid expansion was not without problems. Its very survival has been threatened several times over the past decade. While the "enabling framework" that was initially created has allowed CLAS to survive, it still faces the key challenge of developing an institutional structure that can withstand political vicissitudes and changing priorities among competing stakeholders at the national level (Paredes 205). This first "legal and institutional" framework was built in part on previous models for community-based administration of public services that had existed in Peru (Altobelli 11). Most notable among them was the Program for Revitalization of Peripheral Health Services (PRORESEP), a community-based drug fund for primary health care that was launched by the Ministry of Health as well as UNICEF. It had a similar structure of a community committee, which was given the authority to manage funds by the Ministry of Health (12).

However, while these experiences helped create the “basic program regulatory guidelines” for CLAS, they were fundamentally insufficient:

“[m]any operational and administrative issues had not been considered when first creating the program, and there was no institutional process in place for monitoring evidence of program implementation and updating regulatory guidelines on a continual basis. For example, the PAC program had no norms on how to conduct democratic elections of community members to the CLAS Associations, nor did PAC define clearly the new roles and relationships between the government, health personnel, and the community for co-management. When small problems were unsolved and then festered, anecdotal evidence was accumulated by those who were already against the program to demand its closure” (Altobelli 28).

While nearly all institutions evolve organically from their beginnings, this context helped amplify much of the resistance and conflict that CLAS faced, which perhaps could have been prevented.

Two parties in particular adversely impacted CLAS as a result of their opposition and the ambiguities generated by its structure: regional health directorates and physicians’ associations. Regional health offices have continually expressed opposition to CLAS. Points of contention are several, but all revolve around control of funds and devolution of authority. For example, before CLAS, pharmaceutical supplies were distributed by regional offices to local health facilities. Under CLAS, individual association could handle procurement and generated funds from local sales of drugs, “a major source of financing” diverted from the regional offices. Although some regional offices encouraged the expansion of CLAS, many were actively opposed to it (Paredes 202). Additionally, the flow of funds from the central government to CLAS bank accounts bypassed regional directorates, representing a loss of control (Altobelli 28). Initially, half of the CLAS association was selected by the health center physician and represented the Regional Health Directorate (13). This was changed to all democratically elected members, again a loss of control. Ministry of Health planners should have anticipated this tension, especially given that

the PRORESEP program served as a template for CLAS and involved similar issues. These conflicts were particularly important as quality of care was found to be sensitive to the nature of the local CLAS-government relationship and level of community of participation (Paredes 203). To some extent, the presentation of positive evaluations, particularly those conducted by external actors, helped convince Ministry officials and regional health directors to support CLAS and diffuse this tension (205). This phenomenon highlights the role of external actors in mediating internal conflicts and validating community members who are likely to be disadvantaged in the relations between community and government, a theme which will be expanded upon later.

Physicians unions have also expressed strong resistance to CLAS. The national Medical Federation views CLAS as a form of privatization, threatening physicians who have government jobs and benefits (Altobelli 28). CLAS can hire and fire some personnel directly, removing a layer of government bureaucracy. In non-CLAS facilities, this would require formally petitioning regional authorities and rarely occurs. However, public sector employees who also hold (i.e. are "named") a government position are not as accountable to communities. They are guaranteed certain benefits by the government including vacation, health insurance and a pension. Thus, they are able to use their status as "shields" to avoid evaluation by the committee (14). A physicians' strike in 2003 posed a significant threat to CLAS. Among the demands made was to appoint all physicians working in public sector health services as official government employees with the resulting benefits and autonomy. A new Minister of Health acquiesced to this request, threatening the ability of CLAS committees to manage and evaluate employees at the local level (23).

The waning political commitment that CLAS was faced with was often linked to misunderstanding of program features and general mistrust. Uninformed claims about CLAS

were made including that it did not truly embody community participation, that essentially untrained community members would be unable to manage health services, and that the mismanagement and abuse of funds would take place (Paredes 204). As shown by evaluations, these claims were basically unfounded (Altobelli 29). Initial confusion about metrics for community participation stemmed from the fact that “regional Community Participation Units” were entrusted with administering the CLAS program, but were not trained to do so (Altobelli 17). Labor unions have also opposed CLAS, mostly due to confusion surrounding the implications of committees’ ability hire contract workers (29).

Within three years of its creation, CLAS also faced resistance from national planning officials. At several points in its, officials have put forth proposals for alternate or “parallel” systems, which would undermine or even displace it. By 1998, a freeze was placed upon the expansion of CLAS associations. Simultaneously, multiple international agencies, and importantly donors, issued positive evaluations and assessments of CLAS. By 1999, the program was again expanding (Altobelli 21). However, the threat against CLAS again intensified in subsequent years when a conservative Minister of Health and his deputy took actions to diminish the independence of CLAS and shift the balance of power back to regional directorates (23). This arose in spite of yet another very positive evaluation of CLAS by a Ministry of Health official. A subsequent Ministerial Resolution constituted “a veiled threat” as it included mechanisms to terminate CLAS associations (30). During the next 2-3 years, the PAC experienced a substantial decline in funding and staffing at the Ministry of Health (24). A change in national administration was the only way that CLAS survived.

Legal Stability, Administrative Conflicts, and the Role of External Partners

This lack of a strong institutional and administrative framework at its inception along with a rapidly fluctuating political context was responsible for many of CLAS' woes. The role of non-Peruvian external partners, who carried less political baggage and were able to stand outside of conflicts related to power-sharing, was and continues to be essential to CLAS' success, especially its political survival. As CLAS officials were unable to communicate directly with outside parties and appropriately advocate for themselves, Future Generations and other parties (i.e. international NGOs and agencies) advocated for CLAS directly at the Congressional level. Efforts began to create a law to protect CLAS in the face of a changing Ministry of Health and national politics (Altobelli 23). Ministry of Health officials in turn responded with their own effort to create a CLAS law. Eventually, both proposals of a CLAS law were combined to produce the Law on Co-Management and Citizen Participation in the Primary Level of Care of the Ministry of Health and the Regions (24). The new law solves many of these difficulties. Most notably, it details the organizational structure of CLAS including the nationwide CLAS General Assembly, and the relationship between regional governments and CLAS associations. Overall, it paves the way for "legal stability" by creating better mechanisms for the development of regulations, but it remains to be seen as to how successful these reforms will be in dealing with as yet unknown political challenges (31).

While it is easy to argue that the new law that protects CLAS should have been instituted earlier with better planning, the foresight required for such a task is difficult to demand. Rather than centrally planning an institutional framework, which as was shown above is inevitably an evolving, organic process, the PAC program could have perfected its approach at the initial pilot program sites, creating Model CLAS associations and facilities. In fact, this effort is being

undertaken now through the creation of SCALE-squared centers to share lessons, improve weaker associations, and further expand CLAS (Altobelli 32). If this approach had been selected at the outset, it is likely that many of the disputes between national and regional Ministry of Health staff and committees could have been avoided in addition to other benefits.

As stated above, external assistance was also vital in the form of dissipating mistrust and skepticism about CLAS among Ministry officials, especially regional directors, via independent evaluations. Here, agencies such as UNICEF brought the international and national credibility and the technical know-how to conduct fair and rigorous assessments. Lastly, it appears that one of the factors that protected CLAS including its funding streams was a World Bank (International Bank for Reconstruction and Development – Spanish acronym BIRF) loan to the Ministry of Economy and Finances. The loan had attached conditions that forced the Ministry to implement specific policy reforms (i.e. decentralization) for public sector modernization, of which CLAS was seen as an example (Altobelli 22).

While these scenarios highlight the role of external partners in bolstering national programs, they also show their limitations. Though the aforementioned law addresses many deficiencies in the original administrative framework, it still leaves CLAS vulnerable to flux within the Ministry of Health. Earlier, for example, “repeated changes in the small supporting teams in the Ministry of Health and in most of the midlevel health-care centers” were a cause of disruption as well as waxing and waning interest (Paredes 206). While the law does strengthen the CLAS General Assembly, its ability to maneuver and resist political changes was not mentioned in the literature. What is the role of external partners in ensuring a constant state of support and optimum function in this regard? If Ministry appointments are tied to political

affiliations and party-based favoritism, what measures can be taken to stabilize human resources?

This level of involvement in national politics would bring with it concerns and connotations of meddling, favoritism, or at worst, neocolonialism. The case of the World Bank loan is illustrative. While in this case conditionalities favored the interests of the people at large and coincided with program goals, international donors too have changing agendas. The same form of conditionalities and guidelines attached to loans were part of the highly unpopular Structural Adjustment Programs of the 1980s, which principally involved severe cuts in public sector spending in developing countries to promote fiscal stability and economic growth (Goldman 89, Benson). Thus, the changing climate of international development aid further complicates reliance upon external partners to rescue national programs.

As was partly the case with CLAS, external partners should be consigned to a more limited role of technical assistance in planning, implementation, and independent evaluation. A particular area where they could have provided additional support was data collection, as this was another point of contention between communities and government. A new information management system was seen as too time consuming and burdensome (Paredes 204). Ministry of Health projections and estimates often differed from local census data, complicating agreement on local health plans (Altobelli 16). At present, this is particularly concerning as there is no system to feed data back into annual plans for revision purposes (Paredes 207). Given their expertise in evaluation, agencies such as UNICEF, which conducted an early evaluation of CLAS, could work with both CLAS associations and Ministry of Health to simplify, but also standardize an information system. This is particularly useful as standard indicators and metrics

for health programming allow better communication of results, both in-country and internationally.

Future Directions and Implications for Global Health Systems Initiatives

Globally, health systems initiatives are proliferating ; examples include the GAVI's system strengthening initiative launched in 2006 and the 2005 Montreux Challenge "Making Health Systems Work" a well-attended international conference where the Health Systems Action Network was launched (HSAN). While there is no official definition of the exact components of health system strengthening, it occurs "within the context of broader health sector reform" and includes "policy development and implementation, efficient financing mechanisms, increased information on health expenditures and costs, improved quality of health service delivery, surveillance and reporting of disease impact within communities, and implementation of sustainable health information systems" (Kolyada 1). However, it is dismaying to see that communities are somehow left out of this otherwise broad mandate.

Despite its relatively minor shortcomings, the CLAS program represents a fascinating case study of a community-based approach to strengthening health systems. Unique elements, besides the most important one of community empowerment and control, include scaling with flexibility, decentralization with community involvement, and a viable alternative to outright privatization of public sector services. I would also argue that it has vast implications for improved governance, democratic politics and increased citizen involvement beyond the health sector. While the literature does not dwell on this feature of CLAS, it certainly merits exploration. One can imagine a scenario in the future wherein community members from around the world receive training and support from CLAS associations and build an international network of empowered and active citizens from among the poorest members of society.

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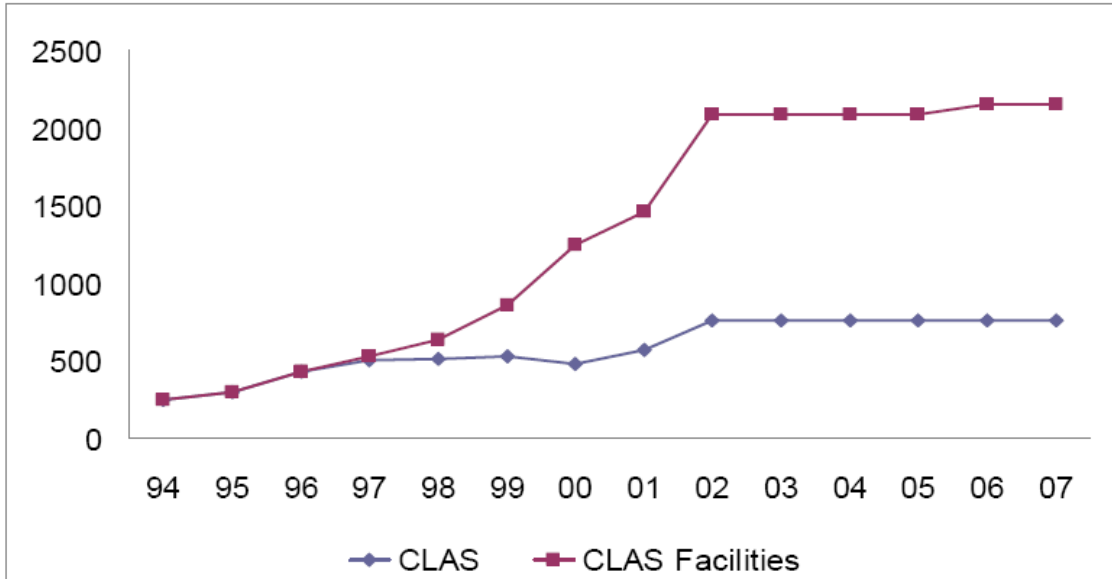
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Appendix

Graph 1: Growth of CLAS Associations and Number of Primary Health Care Facilities Administered by CLAS from 1994 to the present.



(Altobelli 22)