USAID | PERU | QUALITY HEALTHCARE

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USAID|Peru Quality Healthcare Program Strengthens the Healthcare System in Peru

The USAID|Peru Quality Healthcare Program's main objective is helping Peru's Ministry of Health and the Regional Health Directorates (DIRESA) develop locally appropriate solutions, with rapid and sustainable results, to improve maternal and child health, family planning and reproductive health, tuberculosis control and prevention, sexually transmitted infections (STI), the human immunodeficiency virus (HIV), auto-immune deficiency syndrome (AIDS), and intra-hospital infections (IHI). Therefore, the program has focused primarily within public health facilities and programs on practical and operational problems that impede effective and high-quality healthcare service delivery, working in close cooperation with the Ministry of Health and regional and local government health officials.

Strategies for strengthening leadership and ownership by the government of Peru at the national, regional, and local levels guide the program, as well as coordination, collaboration and communication among sectors to create inter-institutional synergies; and introduction of practical, innovative technical and managerial tools based on lessons learned from previous projects.

When USAID|Peru's Quality Healthcare Program (QHC) began, Peru needed to strengthen its healthcare system, integrating previous experience and lessons learned for improving quality of service to respond to the government of Peru's new healthcare sector policies.

The program focused on using standardized tools and methodologies for service provision, strengthening DIRESA and micro-network leadership, and solidifying partnerships with local governments, civil society organizations, universities, community organizations, and patient associations. Important changes in Peru's healthcare strategy shaped the context in which USAID|Peru implemented the Quality Healthcare Program. The Ministry of Health determined that their health objectives of reducing chronic infant malnutrition, infant mortality, and maternal mortality; infectious disease control; and chronic, degenerative disease control could be achieved through three strategies[1]:

- Universal health insurance coverage, promoting the use of the best national- and international-level scientific evidence to define the services provided in clinical practice
- Decentralization of healthcare services, seeking to transfer healthcare sector roles and responsibilities to regional governments
- Strengthening primary healthcare, using the Family- and Community-Based Integrated Service Model.

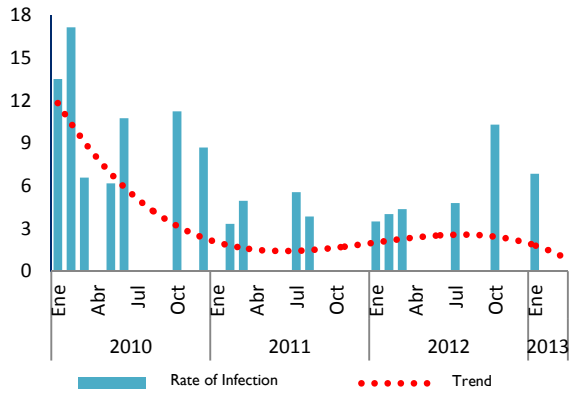
[1] Ugarte, Management Guidelines, 2007.

Strengthening Local Capacity in Technical and Management Skills

Program implementation centered on improving quality geared toward improving health outcomes, mainly through the Performance Improvement Methodology Based on Best Practices (PIM). PIM is a local management tool that healthcare teams use to identify performance gaps based on established, evidence-based standards in line with national technical norms. Next, they design and implement plans to close those gaps. Finally, QHC recognizes successful teams for their efforts, motivating them to continue to improve. Although recognition is the last step in the PIM cycle, the process is repeated every six months[2].

PIM's versatility allowed the program to support quality improvement in diverse technical areas, including tuberculosis treatment and control, STIs, HIV/AIDS, and IHI; maternal, newborn, and infant services; and family planning and reproductive health. QHC also covered the full range of service levels in Peru, from primary care in rural micro-networks to recognized healthcare centers, secondary and regional hospitals, and national hospitals and institutes. For example, at the National Institute of Child Health, the program trained 10 facilitators from each critical department within the institute to holistically manage and prevent IHI. This team demonstrated the ability and leadership to implement the PIM throughout the institute, which comprised 443 health workers actively utilizing the methodology to improve quality of service in all applicable processes, significantly reducing IHI[3].

Exhibit 1. Bloodstream Infection Rate: Intensive Care Unit, National Institute of Children's Health January 2010-March 2013



QHC used the strategy of investing resources in the micro-networks, networks, and DIRESA to build the technical capacity of personnel to identify common needs across healthcare facilities and to implement management processes to address those needs. This required ongoing dialogue and negotiation to ensure that program assistance responded to needs.

At the regional level, as a result of the six-month improvement cycles, the micro-network and health center teams began to implement the changes necessary to improve quality. Beyond its contribution to health outcomes, the Ucayali region's Campo Verde micro-network exemplifies a new way of generating and disseminating change: from the ground up and in harmony with Peru's healthcare decentralization principles and strategies.

As in many countries, high personnel turnover characterizes Peru's healthcare system; this also affected the PIM facilitators. To counteract the effects of the turnover, QHC conducted training-of-trainers with the highest-performing facilitators. In Ucayali and Ayacucho, the program trained lecturers from regional universities to take on the facilitator role.

Implementing the PIM provided evidence of the real training needs of healthcare workers. This enabled improved planning of training activities for micro-networks, networks, and DIRESA. Although QHC normally organized training around content that was pre-established at the national and regional level, using PIM allowed for a new approach to training management — from the ground up — based on the needs of a given healthcare team to close its performance gaps; implementing exchange and study visits was one successful strategy.

One strategy for institutionalizing the PIM consisted of incorporating it into the Ministry of Health's accreditation process for healthcare facilities to serve as training centers. The ministry incorporated accreditation requirements for carrying out a selected group of best practices associated with the training center's technical area. Under this system, the following centers achieved accreditation:

Campo Verde micro-network: preventing infection in primary care service centers:

- Campo Verde micro-network: peri-natal, primary care services
- Hospital Regional Pucallpa, Centro de Salud San Juan Health en Iquitos, Hospital Regional Loreto, and Hospital de Apoyo Iquitos: periodic medical services for MARPs and decentralized provision of anti-retroviral treatment

[2] USAID|Peru|Quality Healthcare.
[3] INSN — USAID|Peru|Quality Healthcare, 2011).

- Hospital Amazonico de Yarinacocha in Ucayali: Comprehensive Care for Diseases Prevalent in Infancy (AIEPI)

- Along the same lines, QHC strengthened the capacity of micro-networks, networks, and DIRESA to improve supply logistics for family planning through analysis of information provided by the Integrated System of Medicines and Medical Supplies (SISMED), reducing the number of stock-outs

Campo Verde: Change From the Ground Up

Very early in the program, the micro-networks identified an important and common gap: weak infection prevention and control practices in primary care facilities. QHC responded by training a group of facilitators in internationally-recommended, standard practices for healthcare facilities with limited resources. Participants then implemented those practices in their respective facilities as part of the quality improvement process; the Campo Verde micro-network in Ucayali was one of the high-performing teams. With the participation of management, administrative, and logistical personnel, the Campo Verde micro-network transformed its healthcare facilities, ensuring greater health safety for patients and workers alike.

This local-level change drew the attention of the DIRESA, which established Campo Verde as the center for hosting exchange visits from other micro-network teams who would learn what to do and how to do it. Months later, Campo Verde team members traveled to Yanaoca in Cusco to share their experience, becoming an excellent example of inter-regional collaboration. The Ministry of Health later recognized this experience, verifying that Yanaoca's performance scored high in infection prevention and control, having put into practice what was learned from Campo Verde colleagues. QHC also used these kinds of team-based learning experiences in training teaching centers and in regional government capacity-building plans. (USAID|Peru|Quality Healthcare, 2011).

In Loreto, QHC supported updating electronic mapping of the sex trade and social meeting points for men who have sex with men and sex workers. The sexually transmitted infections referral centers (CERITS) and periodic medical examination units (UAMP) in Iquitos, Alto Amazonas, and Datem de Marañón used this map to increase the number of clinical services consultations for men who have sex with men and sex workers. They also improved treatment efficiency and effectiveness, reducing personnel time in the field and transportation costs[4]. Exhibit 2 shows similar results in Ucayali.

Exhibit 2. HIV Treatment and Performance: Ucayali DIRESA, 2008-2011

The provincial municipality of Canas and the district municipality of Yanaoca made significant contributions to this process, hiring healthcare personnel, improving infrastructure, and purchasing equipment for training activities.

Another outstanding example of the strategy for strengthening micro-network team capacity was seen in the Llulluycucha micro-network in San Martin, which successfully implemented PIM with QHC's support. This micro-network's important health outcomes include maintaining zero maternal mortality since 2010 and improving other indicators between May 2009 and November 2012, such as births attended by trained personnel (from 52 percent to 90 percent), pre-natal check-ups (from 55 percent to 82 percent), infant immunization coverage (from 80 percent to 98 percent), reducing adolescent pregnancy (from 28 percent to 12 percent), reducing infant diarrhea (from 4 percent to 1 percent). Implementing best practices in community action represents a main pillar of the work, which contributed to increasing the demand for and improved quality of healthcare services[5].

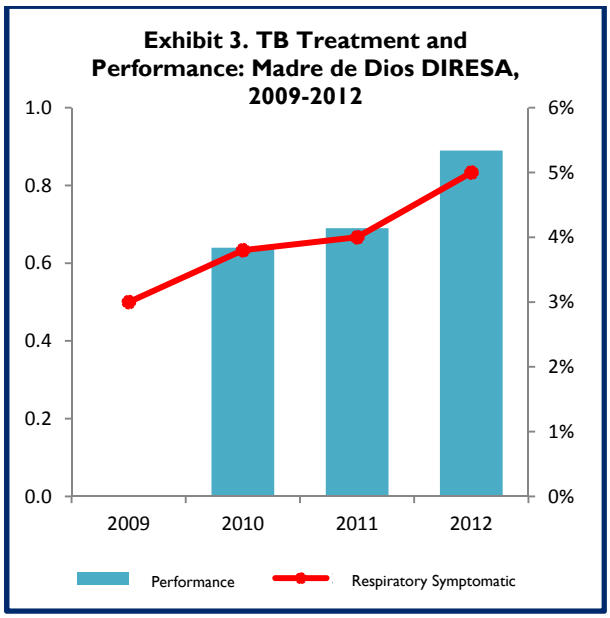
Another successful example of improved micro-network management capacity is Ucayali's San Francisco micro-network. The network identified as a gap sub-standard bio-safety conditions for tuberculosis treatment, due to inadequate ventilation in the treatment area.

Its action plan led to construction of a *maloka,* a type of room traditional for communities in the region

[4] USAID|Peru|Quality Healthcare, 2010.
[5] (INSN - USAID|Peru|Quality Healthcare, 2012.

that is inexpensive to install and maintain, and which has reduced transmission risk[6].

Exhibit 3 shows average results in the Madre de Dios DIRESA for simultaneous improvement in adherence to best practices in tuberculosis treatment and for identifying persons with respiratory symptoms.



Note: Respiratory symptomatic patients are defined as those complaining of cough and sputum for two or more weeks.

Strengthening Leaders and Building Alliances

Lessons learned during the movement for quality healthcare service improvement in Peru pointed to the need to build a network of champions at different levels within the system who are capable of advocating for, defending, and expanding the tools and methods developed during the program.

As a result of capacity-building, teams within the micro-network and healthcare facilities improved their ability to negotiate with institutions responsible for management and budget decisions. As a result, the priorities of the micro-network teams were incorporated inti the agendas of the larger networks and DIRESA, mobilizing resources necessary to close their performance gaps. This complex negotiation process between the participating micro-networks, regional government social development offices, and DIRESA led to PIM implementation in almost one hundred percent of primary care facilities.

For example, management in Cusco's Yanaoca micro-network, adopted the PIM, implementing monitoring visits, quarterly supervision, and monthly accountability reporting to the community on the part of healthcare facilities. This translated to dramatic performance and production improvements above the national average; Yanaoca became a successful micro-network within the framework of national initiatives, such as the Ministry of Health Program for Strengthening Primary Care[7].

Exhibit 4. Production of Healthcare Services, Yanaoca Micro-Network, 2010

Indicators	July	December
Percent of healthy newborns receiving care	33.1%	60.5%
Percent of children under five years of age receiving growth and development check-ups (CRED)	33.1%	82.3%
Percent of children under one year of age receiving a full set of immunizations	41.0%	85.4%
Percent of pregnant women receiving antenatal care from a skilled provider	59.8%	71.0%
Percent of deliveries attended by skilled providers	36.5%	66.5%
Percent of protected couples using modern contraceptive methods	9.3%	17.4%
Source: Yanaoca, Cusco Micro-network statistics, December 2010		

All these experiences formed a solid body of evidence that the PIM and other program tools and methods facilitated implementation of national policies to provide services with explicit guarantees of quality, build management capacity of decentralized entities, and strengthen primary care. This made it possible to build alliances from the bottom up between QHC and key offices within the Ministry of Health. The program collaborated closely with the ministry, responding to its needs and listening to its feedback, critiques, and suggestions, which resulted in the ministry adopting the program's proposals for achieving the respective health results in the national strategies for sexual and reproductive health, infant health, and tuberculosis and HIV/AIDS control.

QHC extended alliance building and leadership strengthening beyond the public sector, using a multi-sectoral approach. Collaboration with NGOs has been important, including Caritas and CARE in infant care; IDIPS from Northern La Libertad in tuberculosis; and multi-lateral donors, such as the Pan American Health Organization, which provided training materials for integrated management of childhood illnesses (IMCI). The NGO SOLARIS Peru took an active role in extending PIM in Andahauylas province and in Cusco and Puno, using lessons

[6] USAID|Peru|Quality Healthcare, 2011.

[7] Ibid.

learned by USAID|Peru's Quality Healthcare Program.

QHC also built alliances with civil society, establishing open dialogue with organizations such as the Roundtable for Fighting Poverty in Lima and Ayacucho and the Regional Institute of Ayacucho Women; decentralized public institutions such as EsSalud; and institutions from other sectors, such as the National Penitentiary Institute and the Madre de Dios Ombudsman.

These organizations played important roles in QHC implementation, advocating for implementation of performance improvement plans; signing agreements with regional governments outside the program's coverage area; and creating new alliances that allowed regional governments to allocate funds and issue regional resolutions, officially expanding the program's methodology to new areas.

QHC also worked with patient associations and community networks for populations vulnerable to HIV/AIDS (sex workers, lesbians, gays, transgender people, and bisexuals) and tuberculosis patient associations, which advocated tirelessly to technical and political officials at different levels of government to fulfill the obligations laid out in the performance improvement plans.

Universities also played key roles in training professors to serve as PIM facilitators, paving the way to incorporate the methodology within the undergraduate curriculum and improving teaching methodology. The Trujillo National University collaborated by reviewing and validating the performance measurement tools, helping to adapt them to the reality of the local healthcare facilities that would use them. The National Universities of Ucayali and San Cristobal de Huamanga re-activated agreements with the respective DIRESAs to implement a certificate course to strengthen local leadership development, with the participation of 47 leaders from the public sector, universities, local governments, NGOs, and civil society organizations. As a result, Ucayali achieved regional consensus on improving healthcare service provision with a multi-cultural perspective — such as implementation of standing or vertical-position births and elimination of non-essential gynecological exams that left indigenous women reluctant to seek health services — reducing barriers that make it difficult for indigenous community populations to access high-quality healthcare. In Ayacucho, a group of participants established a youth development center in the district of Santa Rosa, San Francisco, producing an unprecedented increase in treatment of the district's adolescents for sexual and reproductive health issues and a corresponding reduction in unplanned pregnancies among this population.

QHC also successfully promoted alliances with local governments, identifying funding mechanisms to implement some performance improvement plan activities through the DIRESA and networks, accessing the annual operating budget for the health sector and the municipal incentive budget. Thanks to these alliances, local governments also helped finance some costs associated with QHC activities, such as transportation and stipends for health workers to attend training, building or repairing clinic space, hiring personnel, paying for gasoline for transportation during supervision activities, and purchasing needed equipment or medicine. QHC also helped prepare small public investment projects through which local governments took charge of implementing activities to close some of the gaps that had been identified.

Integrating Program-Promoted Changes in Health Sector Systems

To support PIM implementation, QHC supported the Ministry of Health in revising and updating national norms and policies to ensure they are based on the latest scientific and technical progress. Ministry and DIRESA technical experts, university professors, members of professional associations, and other health professionals engaged in detailed discussions of best practices, technical documents, and norms in the program's priority technical areas, with the aim of ensuring that national norms, technical guidelines, and PIM instruments were aligned with the ministry policy framework.

Complementing this work with the legal framework, QHC leveraged funds as another strategy to institutionalize the tools, methodologies and changes it generated DIRESA, health networks, and local government budgets financed an estimated 75 to 80 percent of activities promoted by QHC. Over time, local governments made these commitments more formally: For example, by the end of 2012, Ayacucho, San Martin, and Ucayali DIRESA budgets explicitly allocated funds to PIM implementation.

Aside from its main purpose of improving healthcare performance and quality, the PIM can fulfill other roles. The Ucayali and San Martin DIRESAs conducted assessments of personnel capacity-building needs based on performance gaps identified through PIM, providing key material for developing regional capacity building plans. The Soritor (San Martin) and Santa Elena (Ayacucho) micro-networks used the performance measurement tools to train new personnel with emphasis on personnel from the Rural and Peri-Urban Health Service (SERUMS). The

Lluyllucucha (San Martin) micro-network uses PIM tools to promote peer learning to develop technical skills.

The DIRESAs have institutionalized PIM implementation in different ways. In San Martin, the regional government and the DIRESA lead the Comprehensive Program to Improve Infant Nutrition (PAIMNI), incorporating PIM as the methodology to implement evidence-based best practices, with a positive impact on infant nutrition. In Ayacucho, the DIRESA has included PIM implementation within regional priority goals as part of the Regional Strategic Health Plan (PERSA 2012-2017), as agreed upon with the health networks. The Loreto, Madre de Dios, and La Libertad DIRESAs incorporated PIM tools to supervise tuberculosis and STI/HIV/AIDS services.

With the Ministry of Health, QHC approached institutionalization through a participatory process from the bottom up. While the ministry has taken the lead in developing norms aimed to strengthen primary care, it recognized that improving primary care processes as an area needing work. Therefore, the ministry identified promising approaches tested at the local or regional level, including the PIM. Ministry officials took part in joint measurement exercises, determining that the PIM could complement other methodologies, which led to including the PIM within the National Plan for Strengthening Primary Care[8]. Finally, the ministry approved Administrative Directive 193-MINSA/DGSP-V0.1 of the General Directorate of People's Health, which makes PIM implementation mandatory for primary care facilities nationwide[9].

Demonstrating Effectiveness, Disseminating Results, and Strengthening Motivation

QHC designed and implemented mechanisms to incentivize support for PIM implementation from public officials, managers, facilitators, and healthcare workers. In the early years, the program used model sites as one strategy to combat the skepticism of DIRESA and network managers. Under this strategy, QHC concentrated efforts in few locations, allowing for intense, ongoing technical assistance. For the same reasons, improvement plans focused on low-cost activities that were easy to implement, leading to rapid results that would encourage institutions to adopt the PIM. The program facilitated implementation and observation of complete PIM cycles — identifying performance gaps, designing and implementing plans to close them, measuring progress, and recognition — generating interest and motivation among DIRESA and network officials and managers. As QHC promoted model centers that could host visits or provide technical assistance to other networks, replication was possible — micro-networks emulating best practices from other networks, and trying to equal or exceed their achievements.

Highlighting the link between implementing the PIM and achieving health outcomes proved another sound program strategy. This involved collecting information on implementing best practices, related interventions, and progress toward health outcomes as a result of those interventions.

QHC shared this information in user-friendly presentations, disseminating it quickly and widely to DIRESAs and networks alike. At the same time, by making visible the results achieved thanks to PIM implementation, QHC was able to include various stakeholders in civil society dialogue — for example, motivating mayors from Ayacucho, San Martin, and Ucayali to invest additional resources to support the performance improvement plans.

As a third strategy, QHC identified, documented, and disseminated success stories on an ongoing basis. This involved publishing recent news, success stories, and technical documents. QHC's final report incorporates many of these documents, which can be found in USAID's Development Experience Clearinghouse (http://dec.usaid.gov/).

Finally, QHC built recognition for teams of health workers in the micro-networks and healthcare facilities through dialogue and ongoing negotiation with networks and DIRESA. Some regional (Ucayali) and local (Cusco and Ucayali) governments also participated, as did universities (in La Libertad and Ucayali). The program worked with the DIRESA to jointly define the recognition criteria, in some cases with the participation of network and micro-network representatives. PIM facilitators reported that they valued most highly the incentives related to professional development, such as facilitator certificates issued by the network, DIRESA, municipalities, and universities.

Quality competitions open to micro-networks and health facilities represented another incentive used during PIM implementation, with the Ministry of Health and other institutions rewarding innovative and successful experiences. In 2011, competitions sponsored by the vice minister of health recognized the San Rafael (Huanuco), Campo Verde (Ucayali), Santa Elena (Ayacucho), and Yanaoca (Cusco) micro-networks and the National Institute for Children's Health.

[8] Ibid.
[9] Ministry of Health, 2012.

Conclusions and Recommendations

USAID|Peru's Quality Healthcare program implemented a successful strategy to improve the quality of healthcare in Peru. Among the key elements for success, the following stand out: alignment of the QHC strategy with national policies for universal health insurance with explicit quality guarantees; decentralization of healthcare through strengthening the technical and management capacity of decentralized institutions; and strengthening primary care.

The program has integrated the different elements created during almost 21 years of USAID support for the national health system. Learning from the experience of past projects, Quality Healthcare built a clear roadmap to institutionalize and make sustainable the methodologies and instruments designed to increase the effectiveness of reproductive health and family planning, maternal and child health, and control of tuberculosis, HIV/AIDS, and IHI.

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