# USAID|Peru — 21 Years Supporting Efforts to Improve the Quality of Healthcare Delivery

In Peru, USAID has supported efforts to improve the quality of healthcare through a strategy focused on closing gaps between the healthcare needs of the population and health system performance. This movement went through three distinguishable phases: standardization of care processes, formulation of national policies and strategies, and formulation of a comprehensive proposal that was sustainable and viable in a decentralized governance environment. This paper discusses the strengths and weaknesses of the movement for improved quality healthcare in Peru, presents achievements and progress, and provides recommendations for the future development of quality improvement in the country's health system.

## The Years of Standardization

Healthcare in the early 1990s was in a state of disorganization: Annual health sector spending declined by 87 percent per capita; facilities lacked basic supplies to provide care (hospitalized patients had to bring their own food and bedding); surgical services were reduced, with only emergencies treated; and the leadership of the Ministry of Health was very weak[1].

In this context, without clear direction or a long-term vision, the movement to improve the quality of healthcare in Peru began. The first objective was to introduce the use of scientific evidence as the basis for effective healthcare delivery into the health sector. Among the first efforts, in 1996, was adoption of the Hospital Accreditation System based on management standards for institutions providing health services[2].

In this early stage of the movement to improve healthcare quality, important progress was made in developing technical standards of care, highlighting those relevant to family planning, immunizations, and child health. These standards were helpful in starting the standardization process, but they lacked complementary instruments to facilitate daily use by health workers during the organization and implementation of care processes.

In the mid-1990s, a new generation of public health professionals began to display growing leadership in the ministry. Ten new projects[3] restored the capacity to provide basic services and introduced the concepts of health services focused on meeting the needs and expectations of users and providing adequate services to address the cultural and ethnic diversity of the country. At the same time, quality improvement committees were formed at the health facility level.

Early versions of performance standards translated care standards into practical guidelines for everyday use by healthcare providers.

The projects introduced a new culture of accountability and recognition, implemented through the practice of self-evaluation and ranking of "model facilities."

During this period, local management processes to improve the quality of reproductive health programs were also strengthened. These included

[1] Chaw and Spelucin, 2012.
[2] Ministry of Health, 1996.

[3] Strengthening Health Services, Basic Health and Nutrition, Project 2000, Basic Health for All, Reprosalud, Reproductive Health Support Project, Max Salud, Primary Healthcare and Sanitation Project in Cajamarca, Administration of Management Agreements, Health Sector Modernization and Implementation in a Region in Peru.

the use of monitoring and evaluation systems and employee recognition systems, training of local facilitators, client feedback mechanisms, teamwork, and the inclusion of stakeholders beyond the confines of the health sector as key actors in the healthcare quality improvement process[4].

Not all these advances found conditions that were conducive for their development. The projects did not have not have a clear roadmap to achieve national reach; nor were mechanisms developed to support changes and improvements once the projects ended. Factors that impeded successful institutionalization included the lack of national policy and regulatory frameworks for managing quality improvement and highly centralized, hierarchical governance that was isolated from civil society.

## The Standardization Years

The first five years of the new millennium were marked by the beginning of a transition to a decentralized system of government that was more open to communities, local governments, and civil society. Decentralization in the health sector required strong and explicit structuring of government sector functions and the transfer of some of those functions from the national to the regional level[5].

In this context, development of local and regional initiatives continued to improve the quality of reproductive and maternal health services, giving priority to the development of policy and managerial support to allow for sectoral management of quality improvement processes that were comprehensive, effective and sustainable.

The main achievement during these years was strengthened leadership skills within the health system and improved management skills for the design and implementation of health strategies that address the needs and demands of health equity, effectiveness, efficiency, and quality in the context of decentralization. The National Policy on Quality in Health and the Quality Management Program were developed, incorporating quality in the Ministry of Health and regional health directorates (DIRESAs)[6].

Human resources management was strengthened, building the skills necessary to lead and implement quality improvement activities. In 2005, the ministry formalized the National Policy Guidelines for Human Resources[7]. In this context, USAID projects strengthened regional capacity to develop human resource potential by creating development competency centers. Also with the participation of the projects, systems to accredit colleges and schools of medicine, nursing, and midwifery were strengthened; a separate national autonomous entity for evaluation, accreditation and certification of higher education was created[8]; the organization and implementation of certification and periodic recertification of professional nursing, medicine, and obstetrics were supported; and sectoral capacity for the accreditation of health facilities was strengthened[9].

The various elements needed for quality improvement were integrated progressively into the DIRESA and Ministry of Health regulatory systems, leading to the formulation of a national policy on health quality[10]. Also, the development of standardization processes, with emphasis on surveillance, prevention, and control of hospital infections was strengthened; regional government investments contributed to the health sector; and regional systems were implemented to develop quality rules and methods.

Despite the efforts to strengthen management systems and quality improvement, discontinuation of the development and use of operational standards in the provision of health services presented a weakness. The ministry lacked the instruments to translate the new policies and management tools into daily practice for the provision of health services, particularly at the primary care level.

## The Years of Integration

In 2008, the Ministry of Health began implementing universal health insurance. The technical design of the policy considered three elements that shifted attention from management systems to processes of care: prioritization based on the burden of disease, use of standardized instruments of care, and inclusion of explicit quality guarantees, defined as the use of the best national and international scientific evidence in clinical practice management[11].

At the same time, Primary Healthcare was relaunched globally with the goals of achieving universal healthcare coverage, improving service delivery, establishing healthy public policies, and strengthening inclusive and participatory leadership

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4 Chaw and Spelucin, 2012.
5 USAID|Peru|Health Policy, 2011.
6 Chaw and Spelucin, 2012.
7 Ministry of Health, 2005.
8 Ministry of Health, 2001.
9 Ministry of Health, 2007.
10 Ministry of Health, 2009.
11 Ugarte, 2007.

that encourages dialogue — key elements for achieving better health for all[12]. Simultaneously, the global movement for the development of patient safety, led by the World Health Organization, focused on improving practices and standardization of care processes[13].

As the old saying goes, "To everything there is a season, and a time to every purpose under the heaven." The context for the third stage of the movement for improved quality was conducive for proposing the integration of all elements developed in the previous stages. A proposal was created to continue the progress and achievements of the previous stages, ensuring the implementation of best practices for healthcare, engaging the policy and quality management elements, strengthening state decentralization, incorporating various regional civil society and community actors, and ensuring institutionalization and sustainability.

## Recommendations

This review of experiences identified key policy and management recommendations to ensure the success and sustainability of quality improvement.

### Policy

- Favor locally appropriate and sustainable solutions within a decentralized context
- Incorporate quality improvement into healthcare planning systems and healthcare financing
- Continue the institutionalization process and retain the policy for quality on the advocacy agendas of organizations such as the Health Forum (Foro Salud) and the Council to Fight Poverty (Mesa de Lucha Contra la Pobreza) as mechanisms for civil society participation and oversight
- Monitor implementation of the Quality in Health Policy from the Coordinated National Health Plan as part of the shared goal of health governance in all sectors of government
- Align quality management objectives with the strategic direction of the sector, especially with the provisions of the Universal Insurance Law

### Methodologies for Quality Improvement

- Encourage diversified and complementary use of different approaches for improving the quality of care according to the particular situation. For example:
  - Improved performance based on best practices to establish minimum standards of care
  - Continuous quality improvement for processes that have reached a basic level of standardization
  - Quality collaborations to encourage cooperation and benchmarking of continuous quality improvement experiences
  - Building a body of evidence based on monitoring of interventions in improving care quality, regularly discussing their progress and results, and incorporating successful models and best international practices to address circumstances in Peru
- Promote joint interventions by different projects, especially if they share common goals, to generate synergy in continuous quality improvement

### Management of Quality Improvement

- Promote sustained leadership on improving the quality of care at the strategic, tactical, and operational levels
- Link quality improvement with systems for planning, financing, insurance, information, and human resource management, such as monitoring and supervision
- Strengthen regional government institutions' ability to monitor quality by improving the performance of health facilities, with emphasis on primary care
- Strengthen the technical capacity of new regional authorities to accelerate the learning process and implementation of quality management
- Scale up regional successes to the rest of the country

[12] World Health Organization, 2012.
[13] World Alliance for Patient Safety, 2008.

### Human Resources in Health

- Strengthen in-service training for new and existing personnel, including the use of tools to improve quality of care
- Implement five-year capacity development plans that include quality improvement tools
- Ensure that staff share information about how to use quality improvement tools selected by the institution
- Strengthen mechanisms for staff motivation and recognition based on performance and achievement of objectives
- Continue to train local development leaders capable of contributing, to improving healthcare quality from a social perspective

### Sectoral Partnerships

- Promote citizen and local government participation in implementation of improved quality of care, both to expand its social base and resources and to promote accountability
- Include regional health professionals in monitoring plans for improvement projects as part of the regional health governance exercise
- Coordinate with regional universities to incorporate performance improvement methodology in the curricula of health professionals
- Influence training organizations and promote recertification as a mechanism for the continuous improvement of health professionals' technical skills
- Include universities and human resource training institutions in the recruitment and orientation of new staff at health institutions

## Conclusions

During the past 21 years, the movement for improved quality of care in Peru has come a long way — from the first steps in the standardization of care processes and development of policies and quality management systems to the integration of all the elements in a proposal built to strengthen the effectiveness of services within a framework of decentralization, universal insurance, the participation of citizens and civil society, and strengthening care at the primary level.

The projects that built this movement have effectively supported the progressive development of public policy in the health sector (see Exhibit 1). Although it was difficult at the time to fully assess the contributions of each project, hindsight allows us to see the strategic coherence of the elements that have adapted to the needs and demands of Peru's political and social processes.

Improving quality of care has contributed to improved key health indicators. For example, the rate of chronic malnutrition in children under five years of age in 2010 was less than half of that recorded in 1990 (18 percent versus 37 percent), and the maternal mortality ratio and infant mortality rate decreased by more than two-thirds over the same period (from 300 to 93 per thousand live births and from 57 to 18 per thousand live births, respectively).

This movement joined other efforts by the government of Peru to improve the living conditions and health of Peruvians — in particular, increased access to education; development of productive infrastructure, communication, and transport; and access to electrification and basic sanitation. Of equal importance were processes to strengthen local governance instruments in the sector, explicitly incorporate improving the quality of health as a strategic goal of the state, and social participation and citizens' oversight in health sector management. It is important to recognize the valuable contributions of the many partners of the Peruvian public sector, including USAID, the United Nations Population Fund, United Nations Children Fund, World Health Organization, Japan International Cooperation Agency, Gesellschaft für Internationale Zusammenarbeit (GIZ, formerly GTZ), and other international and national organizations that have supported and actively participated in the movement for improved quality of care.

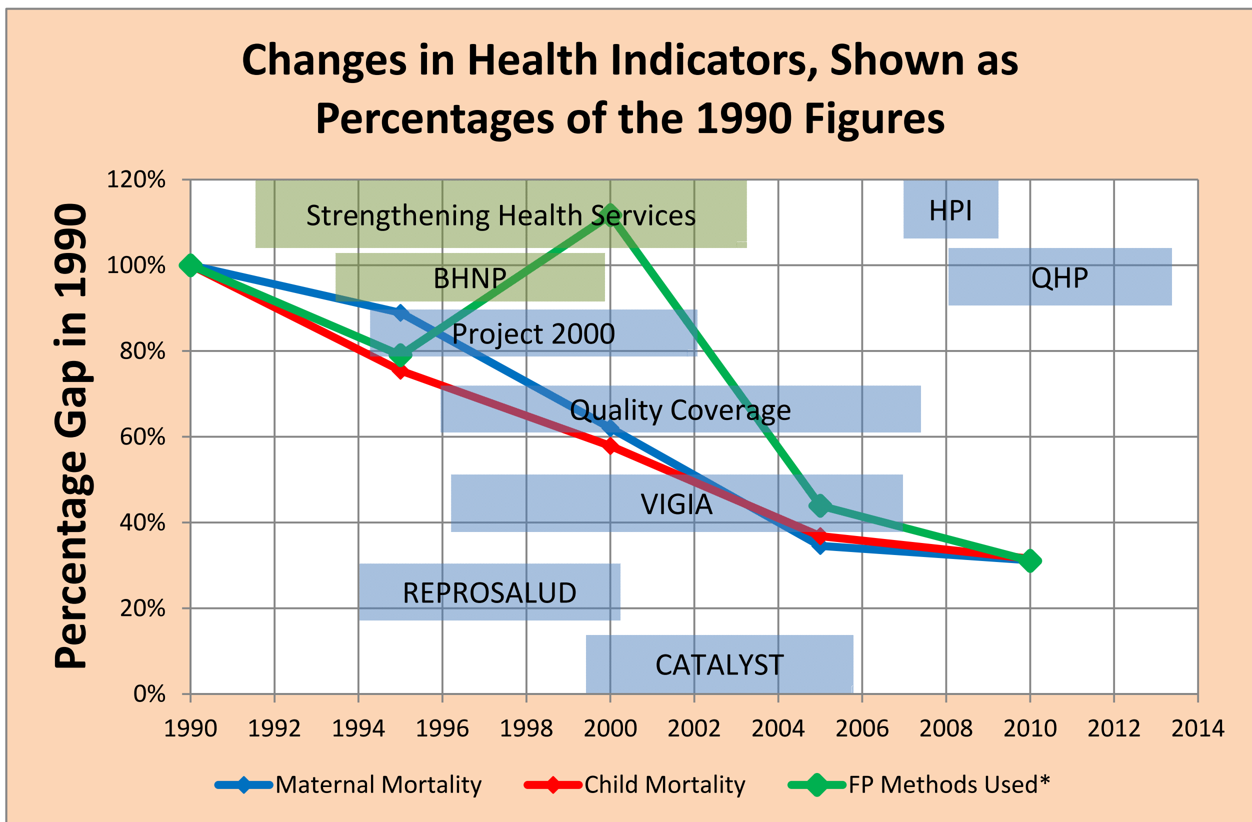
## Exhibit 1. Contributions of Projects and Programs Involved in Healthcare Quality Improvement

| APRISABAC<br>Primary Healthcare and Sanitation Project in Cajamarca | Strengthening Health Services Project | Basic Health and Nutrition Project (BHNP) |
|---|---|---|
| **Cajamarca (1993-2000)**<br>- 300 communities, 70 health posts, and 20 health centers<br>- Supported model design for organization and management of health services, community development, water, and sanitation<br>- Strengthened technical, managerial, and financial capacity of Cajamarca's health directorate (DISA), 7 provincial municipalities and 9 district municipalities<br>- 92 percent of establishments implemented internal and external planning systems; 74 percent implemented the health situation analysis<br>- Implemented quality improvement systems in 54 percent of health facilities | **National (1993-2000)**<br>- Re-equipped 2,655-health posts, 709 health centers, 117 hospitals, and 38 administrative units<br>- Trained 15,036 health officials<br>- Supported training of management teams in 33 DISAs, 114 intermediate administrative units, and 21 national hospitals<br>- Provided technical support for preparation of the General Health Law and the Law on Social Security Modernization<br>- Provided technical assistance in development of databases for the Ministry of Health's National Telecommunications and Information Network<br>- Resized five service networks and five hospitals<br>- Rebuilt and rehabilitated 19 facilities affected by natural disasters | **Cajamarca, Cusco, Lima Norte, and Piura (1994-2000)**<br>- 237 first-level facilities implemented an integrated model of management and patient care<br>- Supported production of 42 reference manuals<br>- Provided financial support for the renovation of 184 health facilities and equipment for 15 DISAs<br>- Trained 125 staff for diplomas in social marketing<br>- Trained 289 staff for diplomas in health services management<br>- Trained 500 technicians in health promotion services<br>- Trained 94 Cusco officials in Quechua and Andean culture<br>- Trained 77 staff in empathic communication and interpersonal relationships<br>- Supported implementation of a network management model<br>- 107 establishments implemented quality improvement projects |
| **Administration of Management Agreements Project** | **REPROSALUD Project** | **PROGRAM 2000** |
| **Lima Hospitals (1997-1998)**<br>- Supported improvements in production indicators<br>- Achieved improvements in commitments and institutional ownership<br>- Promoted improvements in quality of care and resource use optimization<br>- Obtained increases in income and fundraising<br>- Supported training of management support units<br>- Designed care systems and production indicators | **Ancash, Ayacucho, Huancavelica, La Libertad, Lima Este, Puno, San Martin, Ucayali (1995-2000)**<br>- Created 240 partnerships with community organizations<br>- Coordinated the participation of 140,000 people in educational programs<br>- Increased healthcare coverage in 30 localities<br>- Increased community referrals to health facilities<br>- Supported 1,290 women to conduct 58 community-level needs assessments | **Ancash, Andahuaylas, Ayacucho, Huancavelica, Ica, La Libertad, East Lima, Moquegua, Puno, San Martin, Tacna, and Ucayali (1995-2002)**<br>- Basic quality standards in maternal and child health achieved in 18 departmental hospitals and 78 rural hospitals or health referral centers<br>- Built capacity of 130 regional tutors and facilitators to conduct interventions<br>- 10,000 providers participated in training activities<br>- 107 operating units from 34 DISAs increased capacity to develop and support budgets<br>- 8 hospital cost units remained open<br>- Developed tools to improve the financial management of hospitals |

| Max Salud Project | PASARE<br>Reproductive Health Support Project | Quality Coverage Project |
|---|---|---|
| **Lambayeque and Cajamarca (1995-2011)**<br>- Achieved quality improvement in care<br>- 100 percent of clinics received 100 percent of inputs and equipment needed<br>- Increased partogram use from 40 percent to 100 percent<br>- Reduced rate of caesarean sections in the Balta Max Health Clinic from 64 percent to 11 percent<br>- Improved the quality of newborn care from zero-26 percent to 90 percent<br>- More than 90 percent of clients expressed satisfaction | **Ancash, Ayacucho, Huanuco, and Puno (1998-2000)**<br>- Incorporated a culture of quality at various levels of reproductive health services management<br>- Improved managerial skills in response to customer feedback<br>- Trained 100 facilitators to improve service quality in maternal and child health and reproductive health in coordination with Project 2000 | **Ayacucho, Cusco, Huancavelica, Huanuco, Junin, San Martin, and Ucayali (1996-2007)**<br>- Institutionalized the Healthcare Quality Standard Audit and the Quality Improvement Manual in the General Directorate for People's Health within the Ministry of Health<br>- Improved management system for DIRESA as well as for participating networks and micro-networks<br>- Updated equipment for participating DIRESAs<br>- Trained more than 4,000 providers<br>- Promoted development of quality units in health facilities<br>- Supported creation of 300 maternity waiting homes |
| **VIGIA Project** | **CATALYST Project** | **AMARES Project<br>Health Sector Modernization and Implementation in a Region in Peru** |
| **National (1997-2007)**<br>- Implemented the Intra-hospital Infections Surveillance System in 63 hospitals<br>- 55 epidemiologists were trained through the Epidemiologist Field Training Program<br>- Implemented the Health Intelligence System in 10 DIRESAs<br>- Trained 2,714 providers in 70 hospitals in infection prevention and control<br>- Improved provision of equipment to 18 national hospitals<br>- Provided technical support in the development and dissemination of standards and manuals for the prevention and control of intra-hospital infections | **Ayacucho, Cusco, Huanuco, Junin, Pasco, San Martin, and Ucayali (2000-2006)**<br>- Trained teams in quality improvement for 108 micro-networks<br>- 472 health providers trained<br>- Developed projects to improve quality and obtained co-financing with local authorities, private companies, and NGOs<br>- Implemented improvements in quality of care and management of obstetric and neonatal emergencies<br>-Supported implementation of maternity waiting homes | **Andahuaylas, Ayacucho, and Huancavelica (2003-2007)**<br>- Provided technical support for updating and disseminating the National Quality Standard Management System and Accreditation of Health and Medical Services facilities<br>- Supported design of continuous quality improvement instruments<br>- Provided technical support for training of the Andean Commission on Intercultural Health<br>- Trained DIRESA officials, networks, and micro-networks<br>- Systematized and disseminated the quality improvement model<br>- Supported development and implementation of quality improvement projects for 82 projects in 54 health centers and three regional hospitals<br>- Designed citizen oversight mechanisms in four micro-networks and a hospital<br>- Supported implementation of 19 intercultural adaptation projects for 17 micro-networks and two hospitals |

| NEXOS Project | HPI<br>Health Policy Initiatives Program | USAID|PERU Quality Healthcare Program (QHP) |
|---|---|---|
| **Cusco (2005-2009)**<br>- Reduced malnutrition in children aged 6 to 23 months from 38 percent to 29.8 percent<br>- Reduced the incidence of low birth weight from 17.6 percent to 12 percent<br>- Increased exclusive breastfeeding from 78.9 percent to 87.9 percent<br>- Reduced maternal mortality by 50 percent<br>- The percentage of mothers who knew at least two warning signs during pregnancy increased from 10 percent to 59 percent | **Ayacucho, Cusco, Huanuco, Junin, Pasco, San Martin, and Ucayali (2007-2009)**<br>- Supported technical development and dissemination of national policies on healthcare quality<br>- Designed national standards of quality for cesarean care, sepsis, pregnancy-induced hypertension, and family planning<br>- Provided technical support for development of accreditation standards for specialized institutes<br>- Provided technical support in development of a proposal for a quality management program | **Ayacucho, Callao, Cusco, Lima, Loreto, Madre de Dios, Huanuco, Lambayeque, Tacna, Ancash, La Libertad, San Martin, Apurimac, Huancavelica, Ica, and Ucayali (2008-2013)**<br>- Provided technical support in implementing skills development centers on sexually transmitted infections (STIs), and HIV/AIDS in Ucayali and Loreto<br>- Provided assistance to review and update an intersectoral plan for prevention and control of STIs and HIV in Alto Amazonas and Datem del Marañón<br>- Supported decentralization of highly active anti-retroviral therapy (HAART) in Ucayali, Loreto, and Lima City<br>- Provided technical support in performance improvement management of tuberculosis that successfully addressed strategic indicators<br>- Provided technical assistance in the reviewing and updating of sectoral plans for prevention and control of tuberculosis in Lambayeque, Tacna, Ancash, La Libertad, Ica, Lima, and Madre de Dios<br>- Provided technical and financial support for implementing the ministry's Zero Infection Initiative (decreasing bloodstream infection in critical care units)<br>- Provided technical support to increase performance improvement in the provision of maternal and child health and reproductive health services<br>- Provided technical support for incorporating PIM in the National Plan for Strengthening the First Level of Care<br>- Supported incorporation of balanced counseling on family planning practice standards and reproductive health services<br>- Provided technical support for better use of information in the Perinatal Information System, which was revised and updated<br>- Provided technical support for better use of the Integrated Supply System for Medicines and Medical Supplies (SISMED) |

### Exhibit 2. Contributions of the Movement for Improved Quality of Care to Achieving Health Outcomes




Adapted from Chaw and Spelucin, 2012.

Projects shaded in green were funded through loans from the government of Peru with multilateral agencies and with technical assistance from USAID projects.

## Project Documentation Reviewed for This Publication

- Strengthening Health Services Project
- Basic Health and Nutrition Project (PSNB)
- Primary Healthcare and Sanitation Project in Cajamarca (APRISABAC)
- Reproductive Health Support Project (PASARE)
- Quality Coverage Project
- PROGRAM 2000
- Health Policy Initiatives Project (HPI)
- Max Salud Project
- Improving Health for High Risk Populations Project (CATALYST)
- REPROSALUD Project
- USAID|Peru|Quality Healthcare Program (CeS)
- VIGIA Project

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