USAID | PERU
FROM THE AMERICAN PEOPLE

PERU QUALITY HEALTHCARE

Final Report

JULY 2013
This publication was produced for review by the United States Agency for International Development.
It was prepared by Chemonics International Inc. with contributions from Jhpiego Corporation.

July 2013

PERU QUALITY HEALTHCARE

FINAL REPORT
JUNE 2013

Contract No. AID-GHS-I-02-07-00004

TABLE OF CONTENTS

Annexes

ACRONYMS

BCO	balanced counseling and orientation
CLABSI	central line associated blood stream infection
DIRESA	regional health directorate
DISA	health directorate
DOTS	directly observed therapy short-course
EsSalud	Social Security Health System
FP	family planning
HAART	highly active antiretroviral therapy
HCF	healthcare facility
IHI	intra-hospital infections
IMCI	integrated management of childhood illness
INSN	National Institute of Child Health
LLDP	Local Leadership Development Program
MARPS	most-at-risk populations
MCH	maternal and child health
MDR	multidrug-resistant
MOH	Ministry of Health
mPIP	minor public investment project
NEOP	New Employees Orientation Program
NSHIV	National Strategy for the Prevention and Control of Sexually Transmitted Diseases and HIV/AIDS
PIM	Performance Improvement Methodology
QHC	USAID|Peru|Quality Healthcare program
RH	reproductive health
SERUMS	Rural Civil Service in Health
SISMED	Integrated Supply System of Medicines and Medical Supplies
STI	sexually transmitted infection
TB	tuberculosis

EXECUTIVE SUMMARY

The USAID|Peru|Quality Healthcare program (QHC) provided expert technical assistance to the government of Peru's health sector from July 2008 through July 2013 to improve the quality of the delivery of health services in three programmatic areas: prevention and control of infectious diseases; maternal and child health (MCH); and family planning (FP) and reproductive health (RH). QHC focused on the operating problems that impeded effective delivery of public health programs. This assistance aligns with USAID|Peru's Development Objective 2, "Management and quality of public services improved in the Amazon Basin."

Peru's health sector had made several advances before the first phase of QHC began in 2008. Since 1950, the gross mortality rate has been on a downward trend, largely due to the reduction in infant mortality. Life expectancy had also increased over the last 30 years, reaching 71.2 years.[1] Furthermore, some of the operational indicators of the strategies for which QHC provided technical assistance were on an upward trend, including completed vaccination scheme of more than 85 percent; pre-natal coverage (four or more controls) at 87 percent; institutional deliveries at 70.4 percent; and use of modern contraception methods at 46.7 percent.[2] However, these indicators were hampered by structural deficiencies in the health sector, such as:

- insufficient health insurance
- incomplete decentralization
- insufficient quality of services
- inadequate supply of services
- unmet needs, especially in marginalized and disperse populations
- inadequate human resources development
- poor access to and availability of pharmaceutical drugs
- deficient health financing
- weak stewardship by the Ministry of Health (MOH)
- deficient information systems
- lack of citizen participation[3]

To meet the Peruvian government's technical requirements for renewed focus on primary healthcare by promoting a comprehensive healthcare model based on family and community, QHC proposed adapting and implementing a performance improvement methodology (PIM) based on best practices for primary healthcare. The PIM brought together in a single instrument an updated set of standards for quality for MCH, FP/RH, prevention and control of tuberculosis (TB) and HIV/AIDS, and the prevention of other public health threats.

At its inception, QHC implemented activities in 16 regions: Lima, Callao, Ica, Ancash, La Libertad, Lambayeque, Madre de Dios, Tacna, Ayacucho, San Martin, Huancavelica, Huanuco, Cusco, Loreto, Apurímac, and Ucayali. In April 2011, its geographic focus shifted to concentrate resources in line with USAID's focus on specific regions. In its final year, QHC worked primarily in San Martin, Ucayali, Ayacucho, and Madre de Dios. In August 2012, the scope shifted based on the results of USAID's periodic program reviews. During its final year, QHC prioritized two different tasks: 1) transferring and institutionalizing

[1] Analisis de la Situación de Salud del Peru. Ministerio de Salud. Dirección General de Epidemiología. Agosto 2010.
[2] Plan Nacional Concertado de Salud 2007 – 2020. Ministerio de Salud. Julio 2007.
[3] *Ibid*.

interventions and fully transferring the models to the rest of the country to institutionalize permanent quality improvement and adherence to the healthcare delivery standards; and 2) incorporating PIM to guarantee equitable quality of health services in different government-run healthcare facilities (HCFs) and regions in Peru.

From the outset, QHC's interventions were led by the HCF staff providing services at primary HCFs, which are part of the networks and micro-networks of Peru's public health system. HCFs incorporated into their work plans the tools and the set of practices set forth in Administrative Directive No. 193-MINSA/DGSP-V.01, "Performance Improvement Methodology Based on Best Practices for Healthcare Services Delivery at Primary Care" (available on the DVD included with this report), and made official by Ministerial Resolution No. 556-2012/MOH. Issued on July 4, 2012, the resolution mandated the use of PIM at the national level. With PIM, regional and local health teams now have a tool to improve the quality of healthcare service delivery and are skilled in how to use it. Over the past five years, QHC introduced permanent quality improvements used by more than 10,000 trained health workers in more than 1,000 government-run HCFs. Today, the quality of health service delivery is more equitable because facilities and regions have incorporated the methodology and improved care norms into their daily routine.

By project closeout and as requested by USAID, QHC had supported the six key health systems functions.[4] As to the first function related to health governance, QHC supported regions in strengthening their partnerships with key local actors such as national and private universities, NGOs, associations of patients affected by TB or HIV, and regional and local governments.

QHC also built partnerships outside the health sector, particularly with the regional governments' Social Development Offices,[5] which, when required, provided political support to further interventions. Other important partners included Ayacucho's San Cristobal National University of Huamanga; the National University of Ucayali; the Peruvian Amazonian University; Alas Peruanas University of Cusco; Madre de Dios National University; the Technological Institute of Moyobamba; San Martin National University; and the National Major University of San Marcos. These institutions were strengthened by incorporating QHC methodologies into pre-service education, participating in social and technical development dialogue, and functioning as strategic resources to support continuous in-service learning and development for health staff.

Partnerships with NGOs and civil society organizations were important for advocating for the incorporation of a multicultural perspective to the quality improvement processes. These organizations included Ayacucho's Council against Poverty; Solaris Peru; Manuela Ramos Movement; PRISMA; Ayacucho's Women's Regional Institute; the TB Affected Patient Associations of Lima, Madre de Dios, and Ucayali; and the indigenous community associations in Loreto and Madre de Dios.

With regard to the second key function, health financing, QHC was successful leveraging local and regional financial resources to fund quality improvements at HCF levels using different mechanisms from the public system. Local governments and health teams in

[4]USAID. Health systems strengthening: http://www.usaid.gov/what-we-do/global-health/health-systems.
[5]These offices in the Peruvian decentralized system of government include other sectors (e.g., education, native nations, and women) and organizations other than regional health directorates that work in health and social development.

Ucayali, San Martin, and Ayacucho filed 51 minor public investment projects (mPIPs) with Peru's National Public Investment System by the end of 2012, and had 13 more under development (at the end of QHC). Each proposal is worth up to 300,000 *nuevos soles* ($117,650); four of them have a total value of 789,425 *nuevos soles* ($309,580) and are either completed or being implemented. Through its mPIP, the Bajo Biavo health facility in San Martin acquired obstetric and neonatal equipment and trained staff to deliver high-quality MCH services. If the remaining mPIPs are approved, some 11.1 million *nuevos soles* ($4.35 million) could be leveraged from the public budget to improve the quality of health services delivery. USAID's support for this collaborative methodology is making more public funds available to improve the health of men, women, and children across Peru.

QHC produced five model guides on how to develop and present mPIPs for funding in improving maternal, neonatal, and infant care; preventing child malnutrition; preventing adolescent pregnancy; infection control and bio-security; and preventing sexually transmitted infections, HIV, and AIDS. With these reference materials, local governments and health teams will have the tools to formulate future projects.

QHC provided technical assistance to Ucayali, Madre de Dios, and Lima to revise and update their multisectoral plans for the prevention and control of HIV, and Madre de Dios and Ucayali for TB. The Coronel Portillo municipality achieved remarkable success as a result of QHC assistance: For the second consecutive year, it will allocate more than $100,000 to a communications campaign that disseminates educational messages about how to prevent TB and HIV/AIDS. QHC also promoted a strong response to HIV/AIDS in the Amazonian region, where HIV prevalence among men aged 18 to 29 was reported as 2 percent in Iquitos and Pucallpa, the capital cities of Loreto and Ucayali, respectively, since 2003.[6]

The third key health system function is quality of service delivery. To this end and in addition to supporting the PIM administrative directive, QHC supported the revision or issuance of 20 norms, guides and manuals. These revisions included discussions with technical experts about the most recent scientific evidence collected in every technical area to ensure that diagnostic procedures, treatment schemes, and prevention measures follow international standards. By following this approach, QHC contributed with the MOH and regional health directorates (DIRESAs) to reinforce efforts to provide high-quality services in the technical areas covered by the program. See Annex A for all norms, guidelines, and manuals that were revised and updated during the life of program.

Regarding the health workforce, the fourth key function, QHC trained 6,993 health workers on issues related to the PIM, obstetric and neonatal emergencies care, and prevention and control of TB. It also trained 76 trainers of trainers, and eight educational institution facilitators regarding PIM. With the objective of ensuring that the high turnover of staff did not inhibit or affect the processes of care, QHC designed an innovative approach to orient new personnel from the Rural Civil Service in Health (SERUMS). The New Employees Orientation Program (NEOP) was implemented in Ayacucho, Ucayali, and San Martin. Furthermore, six training centers for the decentralization of highly active anti-retroviral therapy (HAART) were created in Loreto and Ucayali, and one training center for the integrated management of childhood illness (IMCI) was established in Ucayali.

[6] Carcamo CP, Campos PE, García PJ, Hughes JP, Garnett GP, Holmes KK; Peru PREVEN study team. Prevelances of sexually transmitted infections in young adults and female sex workers in Peru: a national population-based survey. Lancet Infect Dis. 2012 Oct; 12(10):765-73.doi 10.1016/S147303099 (12)70144-5.

The fifth key function concerned drug management and the introduction of technology. QHC provided technical assistance to the DIRESAs in Ayacucho and San Martin to improve prescribing and dispensing contraceptives, as well as improve the available stock of the four methods of FP prioritized by the National Sexual and Reproductive Health Strategy. QHC supported conducting a pilot to introduce GenoType MDR-TB*plus*, a rapid test that was introduced successfully in the jungle regions of Madre de Dios and Ucayali, as well as in Lima, to improve access to tests to identify therapeutic susceptibility to first regimen TB drugs. It also supported the publication of the effect of the universal access to the microscopic-observation drug susceptibility (assay) of treatment outcomes in new primary multidrug-resistant tuberculosis (MDR-TB) patients and on the process of drug susceptibility testing.[7]

For the sixth core function of a health system — information management — QHC supported the development of two computer applications. The first focused on the entry, tabulation, and analysis of all the information related to the PIM. This application was distributed to focus regions in both office- and Internet-based versions. In San Martin and Ayacucho, 168 people were trained to use it. A Web application for the management of the Infection Zero Initiative[8] to prevent central line associated blood stream infections (CLABSIs) was also developed. In addition, QHC supported the revision, updating, and installation of version three of the Perinatal Information System (SIP 2000) and the production of semi-annual newsletters with TB or HIV/AIDS information in Lima, Madre de Dios, and Ucayali. As a result, technical staff of the HIV/AIDS and TB Strategies was able to show the level of progress their interventions obtained. QHC's work took into account all core functions of the health system, thereby leading to more effective and sustainable change and the results shown in the box on the next page.

QHC conducted technical assistance guided by two main principles to maximize the sustainability of the interventions: Peruvian leadership/ownership and institutionalization. These principles helped to keep progress on track and QHC reach its intended goals.

The journey is not over, and many challenges remain. But the institutions and its people are now equipped with the knowledge, skills, and tools to continually improve the quality of healthcare services. The results show the capacity and commitment of the Peruvian health workers community and their partners to make changes to provide quality care to those who have access and those most-at-risk. For further details of QHC's contribution to the institutionalization of its interventions, please see "Technical Brief: USAID|Peru's Quality Healthcare Program: Strengthening the Peruvian Health System" on the DVD.

[7] Mendoza-Ticona A, Alarcón E, Alarcón V, Bisell K, Castillo E, Sabogal I, Mora J, Moore D, Harries A; Effect of universal MODS access on pulmonary tuberculosis treatment outcomes in new patients in Peru. Public Health Action. 2012; 2 (4) : 162-167.

[8] The Infection Zero Initiative was a collaborative approach that adapted and implemented a series of guidelines in Peru's public hospitals with the purpose of eliminating CLABSIs in clinical areas of intensive care units. The approach followed a set of activities technically validated and supported by the Armstrong Institute for Patient Safety from The Johns Hopkins Hospital, the World Health Organization, the Centers for Disease Control, the Society of Critical Care Medicine, the Society of Healthcare Epidemiologists of America, the Infectious Disease Society of America, and several other societies. QHC provided technical and financial support for its adaptation and implementation. The approach supported systematic reviews of information and included the appropriate use of hand hygiene, chlorhexidine skin preparation, full-barrier precautions during central venous catheter insertion, avoiding the femoral site when possible, and maintaining a sterile field while inserting the line. The compliance with these evidence-based practices resulted in dramatic reductions in CLABSI rates in clinical areas of participating hospitals.

Results by the Numbers

Health Service Delivery

With technical assistance from QHC, the national programs for HIV/AIDS, TB, maternal and child health, and family planning and reproductive health updated or created 20 national norms and guidelines. Ten were approved and the remainder are in the approval process.

Human Resources

- 3,978 people from 16 regions trained in the PIM
- 2,661 people from 21 regions trained in TB prevention and control (including the nine targeted regions)
- 465 people from Ayacucho and San Martin trained in neonatal and obstetric emergencies

HCFs

- 1,090 HCFs in 7 regions completed at least two maternal and child health/family planning/reproductive health performance assessments between 2009 and 2013. Of all HCFs in San Martin, Ayacucho, and Ucayali respectively, 99.2 percent, 88.9 percent, and 67.3 percent completed at least one assessment.
- 113 HCFs in seven regions completed at least two TB performance assessments between 2009 and 2013.
- 55 HCFs in six regions completed at least two HIV/AIDS performance assessments between 2009 and 2013.

Micro Networks of HCF

- 126 micro-networks of HCFs in Ayacucho, Cusco, Huanuco, San Martin, Madre de Dios, and Ucayali implemented performance improvement plans.

CHAPTER 1. A SUCCESSFUL METHODOLOGY FOR IMPROVING QUALITY SERVICE

A. The Challenge

The greatest challenge QHC faced was to strengthen the capacities of health teams to deliver effective interventions to reduce health gaps affecting populations living in poverty and in rural areas (i.e., "groups of interest," including women, mothers, children, families, and populations at risk of TB and HIV/AIDS). Furthermore, the interventions had to be implemented on a scale large enough to reduce these gaps — even though resources were very limited.

Reducing variability when delivering health interventions is a key element for successful implementation. Standardized best practices ensure that the groups of interest receive the same quality interventions regardless of where they live or their socioeconomic status. The standardization of service delivery is an important contribution of the health sector toward equity and social inclusion. This foundational QHC intervention strengthened the capacity of primary healthcare teams to deliver consistently effective services.

B. The Response

Exhibit 1. PIM Implementation Moments

Suited to use with HCFs, the PIM is based on "Standards-Based Management and Recognition: A Practical Approach for Improving the Performance and Quality of Health Services," published by Jhpiego, a nonprofit health organization affiliated with The Johns Hopkins University. PIM implementation allows improvement of quality services provision by standardizing service delivery processes through five "implementation moments" (see Exhibit 1 and Subsection C, next page). Standardized processes are those contained in current official norms and guidelines, which are named best practices. It is worth noting that best practices should be evidence-based (e.g., exclusive breastfeeding during the first six months), linked to operational and sanitary results, and complementary to other MOH tools. QHC promoted the use of PIM using a bottom-up approach, demonstrating first its utility at the local and regional levels then official approval at the central level.

QHC provided technical assistance to the MOH to implement Administrative Directive No. 193. Results from performance assessments were used to identify needs in human resources capacity development, responding to them through regional capacity development plans. The

results were also used to follow up on management agreements between DIRESAs and the health networks (e.g., the Ayacucho Health Strategic Regional Plan 2012-2017).


Photo: Ivanna Narduzzi

A healthcare worker in Lima reviews a checklist at the National Institute of Child Health in October 2012.

The versatility of the PIM allowed QHC to work on quality improvement in very different technical areas, such as TB prevention and control, healthcare for HIV/AIDS patients, MCH, FP/RH, and intra-hospital infections focusing on patient safety control measures. The QHC working scheme included primary HCFs, regional hospitals, and institutes with highly specialized services such as the National Institute of Child Health (INSN).

The approval of AD 556-2012 was a critical step toward sustainability of the PIM, because the resolution mandated the use of PIM to improve quality of healthcare services provision and allocation of funds to implement it nationwide.

C. The Five Implementation Moments

There are five "implementation moments" in each PIM cycle:

1. *Social dialogue*. A wide social dialogue is promoted to establish alliances with different actors and institutions (i.e., actor mapping).

2. *Identification of best practices*. Active discussion with the quality implementation teams prioritizes which health services will use the PIM. A healthcare delivery process is prioritized and selected.

3. *Best practice implementation and performance measuring*. A quality assessment team is organized to perform a series of assessments of best practices. This involves training facilitators who can continue with the assessment cycle. A reflection is facilitated after the baseline assessment to identify the bottlenecks and solutions that can be more holistic to increase the efficiency of what resources are available. This reflection also includes a behavioral component identifying barriers linked to negative attitudes.

4. *Assessment progress.* After six months, a follow-up assessment is conducted to verify levels of improvement and identify new or recurring gaps. There will probably be a level of improvement or gap reduction, but not complete elimination of the gap. A new improvement plan/project, based on the performance assessment analysis, must then be designed to change/adjust the interventions as needed.

5. *Achievement and recognition*. The administrative directive includes a series of non-monetary incentives. There is a formal framework designed for the different types of

ministerial and DIRESA decrees. This phase is also used to generate social recognition by inviting representatives from the private sector and NGOs. During QHC, this was an excellent opportunity to recognize local governments for participation and support; throughout implementation, QHC promoted interesting incentives, including short-term learning visits, gift baskets donated by commercial companies, recognition diplomas, and congratulatory letters with copies to health worker personnel files.

D. The Results

Important results obtained with PIM during the life of the QHC program are:

- PIM has become the official, government-sanctioned tool for improving the quality of health services at the primary care level.
- Approximately 1,191 HCFs conducted assessments using PIM.
- The program helped improve the management of MCH, FP/RH services in 633 HCFs, 113 HCFs that provide TB services, and 55 HCFs that offer HIV/AIDS services in the targeted regions.[9]
- An effective model of prevention and control of nosocomial infections was introduced in seven tertiary care hospitals in Lima, including a highly specialized national institute. These hospitals significantly decreased the rates of CLABSIs in their intensive care units (ICUs) for many months. These seven hospitals represent the complete range of healthcare providers in Peru: the MOH (3), Social Security Health System (2), Army Forces and Police Health Services (1), and the private sector (1).
- The PIM was introduced at the INSN as a managerial tool to improve quality of healthcare by standardizing clinical procedures in several critical units, including neurosurgery, burn unit, and cardiology.
- QHC trained informatics technicians from the Social Security Health System (EsSalud[10]) who were interested in using the software application developed by the program to track best practices measures for CLABSIs.
- Training of 5,352 healthcare providers from seven regions in standardized best practices for the provision of quality maternal and child and sexual and reproductive health services, including FP.
- The San Cristobal National University of Huamanga in Ayacucho incorporated the PIM into the pre-service syllabus of 26 technical career tracks and in human medicine.
- The National Major University of San Marcos incorporated the PIM into the syllabus of the health management course of undergraduate medical students (see the DVD).

[9] In the HIV/AIDS component, the program focused its technical assistance only on specialized services, which were minimal in the targeted regions.

[10] EsSalud is a public national insurance coverage that provides health services to the working population, retirees, and their families through its own HCFs. Benefits are financed by employer contributions equivalent to 9 percent of the wages of active workers. In the case of retirees, the contribution comes from the insured and is 4 percent of insurable earnings. EsSalud covers approximately 20 percent of the Peruvian population.

CHAPTER 2. EFFECTIVENESS OF QHC STRATEGY BY PROGRAM ELEMENT: INFECTIOUS DISEASES PREVENTION AND CONTROL

A. HIV/AIDS

A1. The Challenge

In Peru, the burden of HIV/AIDS infection is primarily in Lima, the capital; Callao, the main port; the major cities along the coast; and in the capital cities of the Amazonian regions. The epidemic is still concentrated in men who have sex with men and in sex workers; however, although it is still insufficiently evaluated, increased rates of HIV infection are reported among TB patients and indigenous populations from the Amazonian region. [11]

There is limited access to HIV prevention and care services for most-at-risk populations (MARPS), which are habitually marginalized. Furthermore, availability of services is scarce and centralized, as in the Amazonian region. Limited access to therapy results in life-threatening complications and death.

During 2009 in Loreto

3:1
Male/female ratio of HIV/AIDS infections

9,128
Cumulative number of sexuality transmitted infections

9,642
Pregnant women screened for HIV during the first quarter

603
Cumulative number of HIV/AIDS cases

271
Number of patients receiving HAART

99
Percentage of HIV infections acquired through sexual activity

Source: Regional HIV/AIDS Strategy health information system records, 2009

At the national level, norms and guidelines were outdated, including the technical norm for HIV/AIDS treatment for adults, children, and adolescents; others, such as the clinical guideline to manage the HIV/TB co-infection, did not exist. At the regional level, management, analysis, and use of information collected periodically was limited and without sufficient dissemination to serve as an advocacy tool. Multisectoral participation in the regional response to HIV/AIDS, mainly promoted by the Global Fund, focused on planning and implementation without securing funding from the different actors.

Although the heterosexual transmission of HIV has increased, and the male-to-female infection ratio was 3:1 in 2009, with more women becoming infected with the corresponding increment in risk of vertical transmission, no new approaches to HIV prevention and control were evaluated at that time. In the Amazonian regions, several characteristics that fueled the epidemic, such as high rates of sexually transmitted infections (STIs), early initiation of sexual activity, a high number of sexual partners, and low rate of condom use, existed and raised concerns about the risk of epidemic generalization.

A2. The Response

QHC recognized that an effective response to HIV/AIDS requires strong leadership from the MOH, regional and local governments, and DIRESAs, and multisectoral involvement. It must

[11] Zavaleta C, Fernandez C, Konda K, Valderrama Y, Vermund SH, Gotuzzo E. High prevalence of HIV and syphilis in a remote native community of the Peruvian Amazon. Am J Trop Med Hyg. 2007Apr;76(4):703-5.

be comprehensive, targeting not only MARPS but also general populations in settings of potential risk for spreading the epidemic, and the provision of prevention quality services has to be increased and decentralized.

Strengthening the leading role of the MOH at the national level included selecting, planning, and implementing program activities, and assisting the ministry in updating current norms and guidelines and issuing new ones when necessary. QHC also examined acceptability of and preferences to receive information about male neonatal circumcision, and services in Iquitos and Pucallpa, where conditions increase the risk of a general epidemic.

Multisectoral Involvement

"We need to work one single idea, to convince people and to defeat this disease."
— TuripiYangura, native communities representative, Loreto

"Working in partnership with the citizenry is the only way to guarantee that the important decisions reach the poorest … . Once that occurs we can say that we are carrying out an inclusive process."
— Fernando Fernandez- Sub Regional Manager-Alto Amazonas

To foster a regional multisectoral response to HIV/AIDS, QHC promoted extensive participation of regional actors in planning, implementation, funding, and monitoring of regional multisectoral plans. In addition to the health sector representatives, participation of affected populations, including native communities, regional and local governments (i.e., municipalities), the church, and representatives from non-health sectors was critical. To assure the plan's implementation, QHC paid special attention to identifying funding sources and activity implementers, and including monitoring activities during the planning process. In the case of public funding,[12] planned activities were included in the respective budgets; in the case of the health sector, they were included in the results-based budget.

Photo: Beatriz Cobian

Healthcare workers in Iquitos, Loreto, elaborate improvement plans for HIV health services. September 2010.

To improve the quality of HIV prevention and care services, QHC prioritized prevention services targeting MARPS (e.g., periodic medical examinations[13] and provision of HAART) and general population groups, such as STI syndromic management, HIV and syphilis vertical transmission prevention, and HIV counseling. QHC enhanced existing educational materials aimed to train men who have sex with men and sex worker peer educators, implemented the PIM as a tool to improve the quality of HIV service delivery, and introduced the motivational interview as the strategy to provide HIV counseling to MARPS and TB and pre-natal care users.

[12]Public funds in this context refers to funds assigned directly from the Ministry of Economy and Finance to municipalities to execute mPIPS.
[13]"Periodic medical examination" is defined as part of a service package consisting of clinical exams, lab exams, counseling to promote the use of condoms, provision of condoms, and counseling for adherence to medical examinations. The intent is to provide this package periodically (i.e., once per month) to at-risk populations in order to prevent and control the spread of HIV/AIDS.

To increase the provision of decentralized quality HIV services, QHC tapped accredited HIV/AIDS regional training centers that had sustainable resources to train new teams and provide refresher training to established teams. Potential training centers selected by the DIRESAs were strengthened in relation to staff competencies to provide HIV services and competencies maps. Standards, evaluation tools, and training plans were also developed. At the same time, tutors were trained and ultimately received certification from a local university. An external committee evaluated candidate training centers before they could receive accreditation from the DIRESAs. After accreditation, training centers began to train teams to establish new Periodic Medical Examination Units and HAART delivery points accredited by the DIRESAs (see Exhibit 2). For more specific results related to this technical component, please see the performance monitoring and evaluation plan in Annex B.

Exhibit 2. Accredited Provision Centers in Ucayali and Loreto

HAI: Hospital de Apoyo Iquitos
HRL: Loreto Regional Hospital
HAY: Hospital de Apoyo Yarinacocha
HRP: Pucallpa Regional Hospital

Source: QHC, June 2013

The decentralization experience in Loreto and Ucayali was documented in a report entitled "Decentralization of the Integrated Care of HIV/AIDS Affected Patients through the Capacity Development of Personnel — Documentation of Experiences in Ucayali and Loreto," which can serve as a roadmap to conduct this implementation in other regions. The Madre de Dios region received the report and had five professionals participate in a study tour to Loreto to learn how to implement the decentralization process.

Improvement of capabilities to manage, analyze, and use information was achieved through training conducted with the National Strategy for the Prevention and Control of Sexually Transmitted Diseases and HIV/AIDS (NSHIV), DIRESAs, and a national university. Participants were required to prepare e-bulletins containing epidemiological and operational information to increase dissemination of locally produced information and to use it as an effective advocacy tool, contributing to increasing multisectoral involvement in the regional response to HIV (see "Brief Note: Desarrollo Provincial Concertado y Monitoreado" on the DVD).

A3. The Results

Deliverable HIV-1: *100 percent of NSHIV guidelines are current with generally accepted scientific knowledge, WHO recommendations and guidelines, and other relevant reference documents.*

The Technical Norm on High Activity Anti-Retroviral Treatment for Adults Infected with Human Immunodeficiency Virus was approved with Ministerial Resolution No. 607-2012/MOH, issued on July 21, 2012, and the Technical Norm for Prophylaxis of the Vertical Transmission of HIV and Syphilis was approved with Ministerial Resolution No. 946-2012/MOH, issued on November 28, 2012. Both were delivered to the MOH. Seven additional norms and guidelines were updated and are following the official approval process at the MOH.

Deliverable HIV-2: *NSHIV equivalents in all health directorates (DISAs)/DIRESAs approved by USAID effectively produce and utilize quality information relevant to HIV/AIDS and STIs control (e.g., incidence, prevalence, and program indicators, such as coverage, cure rates, etc.)*

Semiannual e-bulletins containing HIV/AIDS epidemiological and operations information from the Ucayali and Madre de Dios DIRESAs are available through their respective websites as evidence that NSHIV equivalents in DISAs/DIRESA as approved by USAID effectively produce and utilize quality information relevant to HIV/AIDS and STIs control (e.g., incidence, prevalence, and program indicators, such as coverage, cure rates, etc.).

Deliverable HIV-3: *NSHIV equivalents in all DISAs/DIRESAs approved by USAID using a multi-sector approach, plan and implement HIV prevention and control interventions addressing most- at- risk populations based on evidence and responding to local needs.*

The Madre de Dios 2013-2017 Multi-sector Strategic Plan for STI/HIV/AIDS Prevention and Control was approved by Directorial Decree No. 951-2012-GOREMAD-DRS/DG, issued on November 6, 2012; the Ucayali Multisectorial STI/HIV/AIDS Prevention and Control Plan was approved on November 11, 2012, under Directorial Decree 842-2012; and the Multisectoral Plan for HIV/AIDS Prevention and Control elaborated in Alto Amazonas and Datem del Marañón provinces was discussed with sectoral representatives in March and April 2012. The latter was included as part of the Loreto Multisectoral Plan for HIV/AIDS Prevention and Control.

- Representatives from affected populations, such as the Association of Lesbians, Gays, Transgender, and Bisexuals and the Association of Sex Workers from Loreto, participated in planning and implementing plans.

- “Alto Amazonas y Datem del Marañón,” a video about the QHC activities, is available on the DVD. It provides testimonies of the depth and breadth of the technical approach to secure funds for health promotion and prevention to control the HIV/AIDS epidemic. Representatives from more than seven sectors participated.

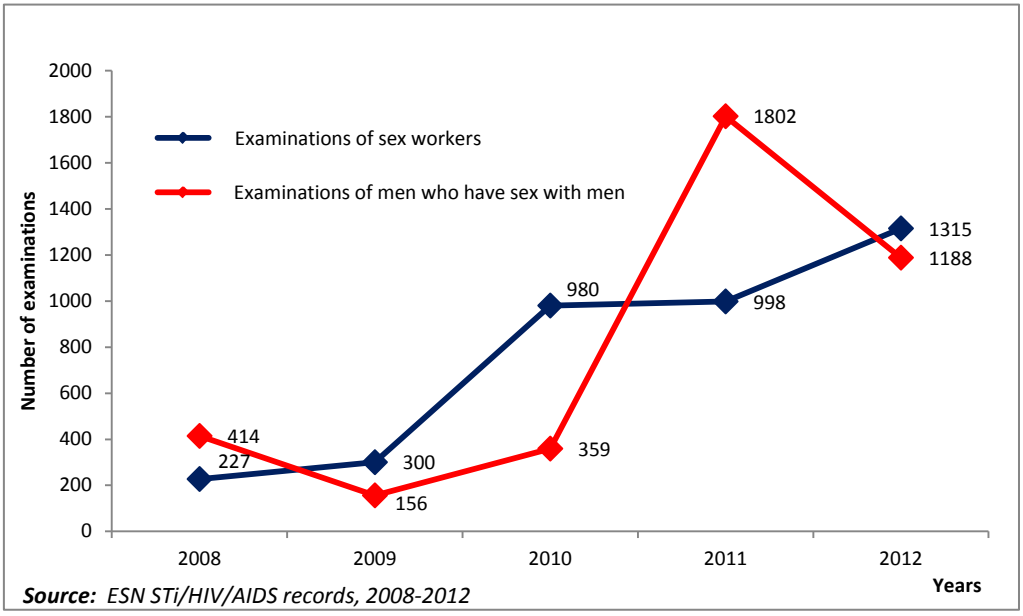
- Local governments are funding and implementing HIV prevention activities with the regional HIV/AIDS sanitary strategies. The municipality of Coronel Portillo in

Ucayali invested $78,000 during 2012 and had programmed $118,000 in its 2013 budget.

- HIV prevention and care services were extended when HCFs were accredited as regional HIV training centers in Loreto (the Regional Hospital of Loreto, Iquitos Hospital, and the STI Referral Center in San Juan) and Ucayali (the Regional Hospital of Pucallpa). Today, HAART or periodic medical examination services are provided in nine healthcare facilities in Loreto and seven in Ucayali (see Exhibit 2, p. 13).

- As a consequence of capacity development and decentralization of HIV prevention services provision, the number of periodic medical examinations provided to MARPS had increased substantially in Ucayali (see Exhibit 3) and Loreto. Please see Annex B for more details about the number of MARPS receiving services in each region.

Exhibit 3. Periodic Medical Examinations of Sex Workers and Men Who Have Sex with Men, Ucayali, 2008-2011



Source: *ESN STi/HIV/AIDS records, 2008-2012*

- The Madre de Dios region has five people knowledgeable about the implementation of HIV regional training centers. They received the "Decentralization of the Integrated Care of HIV/AIDS Affected Patients" report (see p. 13; available on the DVD) to use as a roadmap to conduct this implementation.

As a result of QHC's work in this component, by the end of the program, $98,515 from regional counterparts was leveraged to implement HIV/AIDS activities promoted by QHC.

A4. Exceeding Benefits

QHC met expected contractual agreements; however, benefits exceeded expectations. QHC not only contributed to updating current norms and guidelines, but also supported development of new ones, such as the first National Guideline for Diagnosis and Management of HIV/TB Co-infection in Adults, which was approved by the NSHIV and the National Strategy for the Prevention and Control of Tuberculosis (NSTB) and is under evaluation to obtain official approval.

A5. Shortfall

The acceptability and costing components of the "Feasibility Study of a Male Neonatal Circumcision Program in the Peruvian Amazon" were completed, but its economic impact evaluation sub-element was not. Using all resources at its disposal, QHC could not identify a suitable consultant. The first consultant produced a substandard product, which can be accessed at the USAID Development Experience Clearinghouse; a second consultant never delivered a product.

A number of norms and guidelines were not approved by the end of the program (see Annex A). QHC made efforts to expedite the approval, but the MOH approval process for documents of this nature is extensive, lengthy, and beyond the control of the program. QHC notified the USAID mission about these challenges well in advance of the suggested next steps to pursue the approval.

B. Tuberculosis: A Convener and Mobilizer Problem

B1. The Challenge

After Haiti, Peru has the highest rate of TB in the Americas. Peru and Brazil account for 50 percent of all TB cases in the Americas.[14] Peru also has the highest number of multidrug-resistant (MDR)-TB in the region. The capital, Lima, and the main port of Callao concentrate 60 percent of TB, 85 percent of MDR-TB, and 93 percent of extreme drug-resistant TB. The most recent national surveillance data indicate 5.3 percent of new TB cases and 24 percent of previously treated TB cases are MDR-TB.[15] TB in Peru, as everywhere, affects mostly straight, economically productive young adults. Fifty percent of cases are 20-44 years old, and the number of cases among basic and middle school students increased seven-fold between 2007 and 2010. In addition, hot spots with extremely high incident rates of TB occur in large urban areas such as Lima and in precarious human settlements such as informal miners' camps in Madre de Dios.

Even with the important contribution of the Global Fund, TB operational indicators, such as respiratory symptoms, and defaulters to treatment rates worsened around 2005-2006. The rise in the defaulters rate significantly affects the cure rate and delayed TB diagnosis favors transmission to household contacts and community members. Delayed TB diagnosis also worsens a patient's prognosis, with treatment beginning in a more extended stage of the disease. This is particularly important for MDR-TB patients, who undergo at least four to six months of additional delays before receiving the right treatment. Continuous community transmission of TB increases the number of TB, TB-MDR, and extreme drug-resistant TB cases. Beyond the human impact, there is a significant economic impact. For example, the cost of a drug regimen to treat TB, MDR-TB, or extreme drug-resistant TB case is $30, $2,500, and $120,000, respectively.

[14]Ministerio de Salud. Norma técnica de salud para el control de la tuberculosis.NTS No 041-/MINSA/DGSP-V.01. Lima, Peru: Ministerio de Salud, 2006.http://www.minsa.gob.pe/portada/esntbc_tbnormas.asp# Accessed November 2012. [Spanish].
[15] World Health Organization. TB country profile: Peru [cited 2010 Jun 5]. http://www.who.int/GlobalAtlas/predefi nedReports/TB/PDF_Files/per.pdf

B2. The Response

Multisectoral Involvement

"Tuberculosis is a problem that concerns the citizenry. [It requires] a multisectoral intervention through participation and socialization and an improvement on the patient attention process in the healthcare center.**"**

— Dr. Luis Tafur, former deputy director, DISA Lima, V – Ciudad

Programming and implementation of QHC-supported activities were coordinated with the NSTB for the TB case, but followed a similar approach for all technical components to assure they were in accordance with national policies and responded to MOH priorities. To strengthen the lead role of the MOH, QHC supported updating the National Norm for TB Prevention and Control and elaborating new guidelines such as the Clinical Guideline for Management of the TB-HIV Co-infection and the one for extreme drug-resistant TB management.

Because TB is a consequence of the combination of social determinants of health, it requires a comprehensive response that includes the following:

1. Strengthening multisectoral participation, incorporating participation of associations of affected persons to monitor, improve, and sustain quality service provision and guarantee fulfillment of all commitments acquired in regional multisectoral plans

2. Provision of quality health services that assure early diagnosis and treatment of cases to effectively stop TB transmission in the community and avoid disease progression

3. Adapting interventions to address social determinants and the context where interventions will be implemented (e.g., incorporating intercultural approaches existing at regional levels).

Along with secure funding through a results-based budget, multisectoral participation, especially in monitoring activities, is important for sustainable and sustained directly observed therapy short-course (DOTS) and DOTS-plus programs. Similar to what was done in HIV, strengthening of multisectoral participation relies on involvement of extensive numbers of regional actors, especially associations of affected persons; regional and local government leadership in the plan elaboration process; clear identification of funding sources and activity implementers; use of trace indicators when proposing monthly goals; and inclusion of monitoring activities to follow up on achievements and fulfillment of multisectoral plans.

Using the PIM in TB Prevention and Control

"[The PIM] is important to motivate our staff, which allows us to identify the problems and, at the same time, identify the solutions to those problems."

— Dra. Antonieta Alarcón, national coordinator, NSTB

QHC improved quality of service provision through implementation of the PIM in TB services. Improvement plans prioritized activities aimed to strengthen early diagnosis and treatment of TB and to lower the defaulters to treatment rate, such as active identification of suspicious cases of TB, enhancement of collection and handling of sputum samples, and improvement of quality of sputum slides reading through training of bacilloscopists. (In Ucayali, this was conducted by the Regional Reference Laboratory under a certification program.) Improvement of early diagnosis of MDR-TB was achieved by implementing universal access to rapid testing of Isoniazid and Rifampin drug susceptibility, using the

GenoType MDR-TB*plus* test. After promoting use of rapid testing in Lima, its use was extended to Ucayali and Madre de Dios, the regions with the highest TB rates.

Photo: Silvana Bolaños

Preparing tuberculosis educational materials at a primary HCF in Chimbote, Ancash. September 2010.

Improvement of quality of service provision also requires improving clinical skills identified as gaps in performance measurements and developing job aids and educational materials targeting the general population. QHC used different types of training to close performance gaps identified through performance measurements. Improvement plans also contained activities designed to lower the defaulters to treatment rate, including increasing the number of home visits; strengthening family support through telephone calls to patients' relatives; delivering medicine to a patient's home, if necessary; involving peer educators in patient follow up; and disseminating testimonies of positive experiences of cured TB patients, including those affected by MDR-TB. "Acción comunitaria de salud en Lluyllucucha – San Martin," a video about a patient who successfully finished her treatment against MDR-TB, is on the DVD.

Improved capabilities to manage, analyze, and use information was achieved through training conducted with the NSTB, DIRESAs, and a national university. Participants were required to prepare e-bulletins with epidemiological and operation information aimed to increase dissemination of locally produced information and to use it as an effective advocacy tool, contributing to increased multisectoral involvement in the regional response to TB. In addition, QHC helped micro-networks and HCFs to identify and map area with high-transmission cases and to share production information of TB services with users through informative panels. These panels were designed, elaborated, and validated in association with the NSTB, the International Union Against Tuberculosis and Lung Diseases, and the Pan American Health Organization.

QHC also supported two initiatives to address TB in special conditions. For example, it supported planning and systematization of a successful patient-centered approach for TB control in large urban areas such as the San Cosme district of Lima, which has the highest rates of TB and MDR-TB in Lima (see "A Comprehensive Approach to Tuberculosis Prevention and Control in the San Cosme Health Center" on the DVD). In Madre de Dios, QHC contributed to increased access to quality TB care for informal mining workers, who are dispersed across hard-to-reach areas.

B3. The Results

Deliverable TB-1: *NSTB and its regional equivalents in regions approved by USAID produce and utilize reliable information relevant to TB control (e.g., incidence, prevalence, and program indicators such as coverage and cure rates)*

Semiannual e-bulletins containing TB epidemiological and operations information from the Ucayali and Madre de Dios DIRESAs are available on their respective websites, showing that NSTB equivalents in DISAs/DIRESAs approved by USAID effectively produce and utilize quality information relevant to TB control (e.g., incidence, prevalence, and program indicators, such as coverage and cure rates). In addition, 30 HCFs in Madre de Dios and 30 in Ucayali — those with the higher numbers of TB patients — inform users about production of TB services using informative panels designed, elaborated and validated with the NSTB, the International Union Against Tuberculosis and Lung Disease, and the Pan American Health Organization.

Deliverable TB-2: *Sustainable and sustained DOTS programs in place in DISAs/DIRESAS, in regions approved by USAID, performing at or above 95 percent on the identification of expected number of suspicious TB cases, and cure rate at or above 95 percent.*

The identification rate of people with respiratory symptoms[16] improved from 3 percent in Madre de Dios during 2008 to 4.70 percent during 2012. These figures represent a 94 percent increase in the expected number of suspicious TB cases for 2012, which is very close to the 95 percent requested by the deliverable. Early closure of technical activities due to funding limitations and new geographic priority areas identified at the USAID mission was one factor that prevented QHC from achieving the goal (see Exhibit 4, next page).

The cure rate for the 2011 Scheme One (for susceptible TB) Cohort was 85.3 percent and 87.9 percent for Madre de Dios and Ucayali. Results from the 2012 Cohort will be available in the second half of 2013; further increases in the cure rate are expected as a consequence of early diagnosis and lower defaulters to treatment rates.

QHC focused not only on required results: It supported development of new products to strengthen the leading role of the NSTB. For example, it contributed to updating the National Norm for TB Prevention and Control, and the new Clinical Guidelines for TB-HIV Co-infection and for extreme drug-resistant TB Management. A video about the work of technical and administrative staff to improve the quality of services provided to TB patients at an HCF in Lima is on the DVD.

Deliverable TB-3: *Sustainable and sustained DOTSplus programs in place in DISAs/DIRESAs, in regions approved by USAID, achieving 90 percent or higher drug-susceptibility testing among people with approval to initiate MDR-TB treatment, and MDR TB cure rate of 60 percent or higher*.

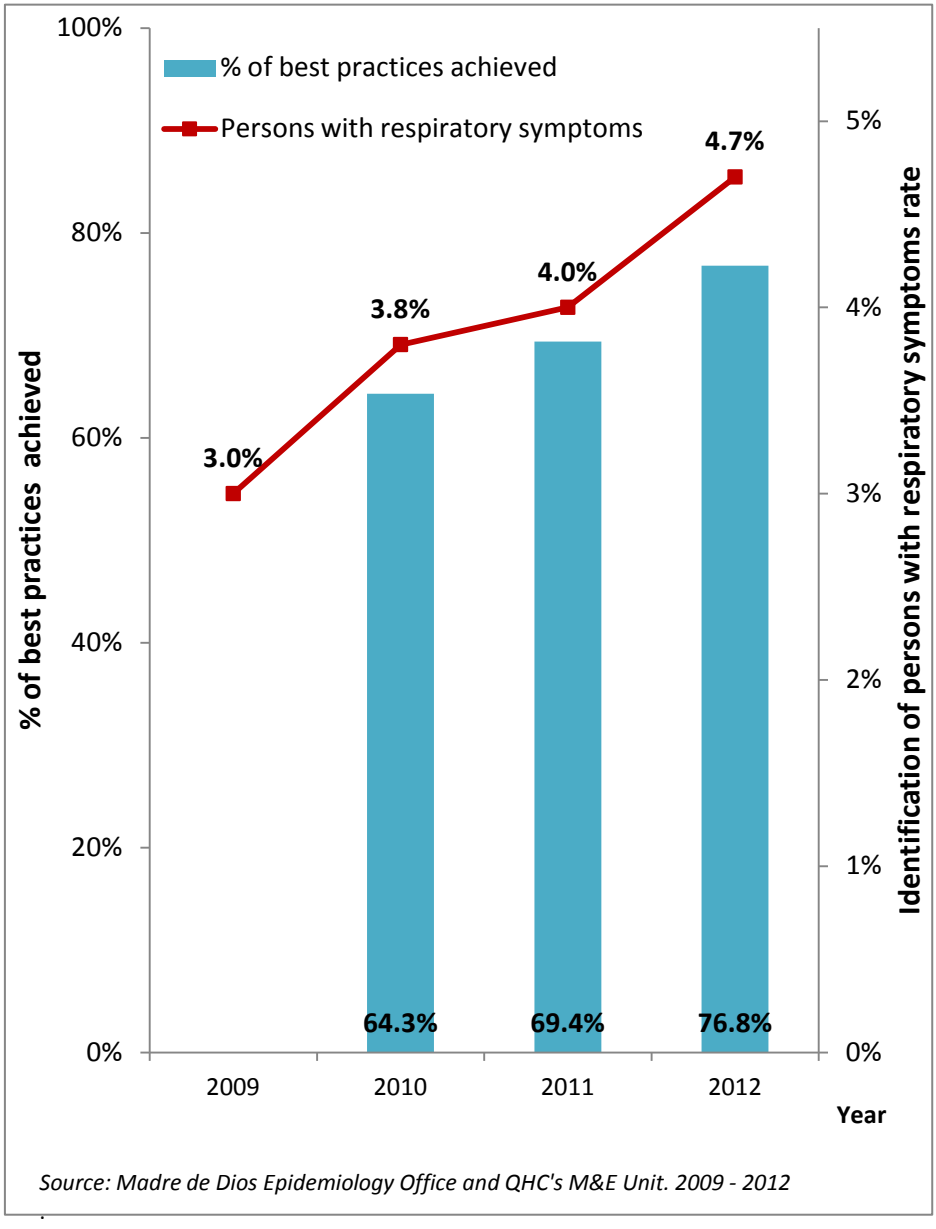
- Coverage of drug-susceptibility testing among people with approval to initiate MDR-TB treatment was 69 percent in Madre de Dios and 76 percent in Ucayali during the second half of 2012. Higher numbers could not be achieved because the current drug susceptibility testing strategy is based on isolation of the pathogen. Although coverage of cultures increased, a proportion of MDR-TB diagnoses still have to be performed on a clinical basis due to incorrect techniques to avoid culture contamination or absence of strains growing when performing primary isolation for drug susceptibility testing. For this reason, QHC introduced drug susceptibility testing based on rapid moleculater testing using GenoType MDRTB*plus* among new cases of sputum positive pulmonary TB, for which coverage is estimated at more than 95

[16]Respiratory symptomatic patients were defined as subjects complaining of cough and/or sputum for a period of two or more weeks.

percent in Madre de Dios and more than 70 percent in Ucayali at the end of 2012. Still, Madre de Dios was recently recognized nationally as the best DIRESA in terms of this indicator and other performance indicators considered by national authorities.

- Cure rates for the 2009 MDR-TB Cohort receiving individualized treatment is 83.3 percent for Madre de Dios and 66.7 percent for Ucayali. These are the last results available because treatment of these patients lasts an average of two years. Results from the 2010 Cohort are expected in the latter part of 2013.

Exhibit 4. Percentage of Best Practices Achieved and Identification of Persons with Respiratory Symptoms, Madre de Dios, 2009-2012



Source: Madre de Dios Epidemiology Office and QHC's M&E Unit. 2009 - 2012

- Multisectoral involvement was strengthened in Madre de Dios and Ucayali, obtaining enough political support to increase sustainability of established DOTS and DOTS*plus* programs. Each region developed and approved a multisectoral plan to prevent and control TB, and allocated resources for implementation. Three regional or municipal decrees were issued that prioritized TB as a public health problem; each requested funds

to be allocated to prevent, treat, and control the problem. Local governments, including the municipality of Coronel Portillo in Ucayali, the municipality of Laberinto in Madre de Dios, and the municipality of Lima, allocated funds to conduct TB prevention activities or improve infrastructure or equipment. In addition, associations of TB patients received technical assistance to strengthen participation in patients' support activities to decrease defaulters to treatment rates and implementation of the PIM, particularly of improvement plans introducing and advocating for the client perspective. These associations are actively involved in following up on surveillance activities. A photo album of TB patients is on the DVD.

As a result of QHC's work in this component, $141,169.00 from regional counterparts was leveraged to implement TB activities promoted by QHC.

B4. Shortfall

Two deliverables could not be achieved due to time constraints and lack of quality in the performance of laboratory techniques. For Deliverable TB-2, when this report was being finalized the Madre de Dios health region was able to perform at or above 95 percent on the identification of the expected number of suspicious TB cases, and had a cure rate at or above 95 percent. It received national recognition for that effort. In the second case, Deliverable TB-3, it is expected that with this level of recognition, that particular region could be able to correct the level of quality in the laboratory techniques. This would allow it to improve its indicator of drug susceptibility testing. Other regions from the jungle could also learn from that experience and follow a similar approach.

C. Other Public Health Threats

C1. The Challenge

Intra-hospital infections (IHI) are life-threatening complications of healthcare that affect patients and providers. They cause death, prolonged hospitalization, increased need for health services, and large expenses. Currently, patient safety is a global goal that reflects the quality of healthcare services provision.

In the INSN, 2008-2009

20.3
Blood stream infections per 1,000 catheter days were observed in the pediatric intensive care unit

20
Ventilator-associated pneumonia per 1000 days of mechanical ventilation in the pediatric intensive care unit

13
Ventriculitis associated to external ventricular drainage per 1,000 days of device usage

0
Protocols to reduce IHI

Source: MOH General Directorate of Quality Records, 2008

At the beginning of QHC, ICUs and other critical services did not use evidence-based protocols or have guidelines to prevent and control IHI. Procedures to implant or maintain invasive medical devices were not standardized, and IHI was not actively monitored with the devices. Rates of CLABSIs, ventilator-associated pneumonia, and ventriculitis associated to external ventricular drainage were high in a national referential institute of children health. In addition, space assigned to pediatric ICUs was inadequate. Similar conditions existed in other tertiary (i.e., specialized) level-of-care hospitals in Lima.

C2. The Response

As result of deadly outbreaks of IHI in the neonatal and pediatric ICU, the MOH and USAID|Peru agreed to promote patient safety initiatives in hospitals' critical areas. QHC promoted standardization of critical procedures, such as insertion and maintenance of central venous lines, through implementation of the Infection Zero Initiative and the PIM. The Infection Zero Initiative is designed to prevent CLABSIs in ICUs; the MOH Executive Directorate of Quality led its implementation with seven hospitals from Lima that covered the whole range of health service providers in Peru: MOH, EsSalud, the Armed Forces and National Police's health services, and the Ricardo Palma Clinic from the private sector.

Partners and Allies of the Infection Zero Initiative

- MOH
- EsSalud
- Peruvian Air Force
- Pan American Health Organization/World Health Organization
- The Johns Hopkins Armstrong Institute for Patient Safety and Quality
- Peruvian College of Physicians
- Hospital directors and management teams (head nurses, head physicians, epidemiologists, and others) at the ICUs from seven hospitals

Initial training of ICU teams participating in Infection Zero Initiative was conducted through seven video conferences facilitated by the Armstrong Institute members at The Johns Hopkins Hospital in Baltimore, Maryland. These conferences were simultaneously interpreted and broadcasted to all participating hospitals using the Elluminate platform provided by the Pan American Health Organization and the World Health Organization. In addition, a Web-based tool to facilitate reporting of CLABSIs and monitoring of adherence to best practices was developed.

QHC supported patient safety training workshops for ICU staff at 18 hospitals in Lima to prevent and control CLABSIs. Safety culture was assessed using a standard survey that explored the working relationships of the ICU working team members, described the flow of information, and provided information about the supervisory channels supporting the interventions to promote the safety of the procedures. Experiential exchanges and normalization of criteria among ICU staff were encouraged. The progress and performance in each hospital was monitored using indicators that measured the incidence of bloodstream infections.

At the INSN, the PIM was implemented as a managerial tool to standardize procedures in other critical care units (e.g., neurosurgery, cardiology, and burn units). The necessary changes began after several bottlenecks were identified during the process, and checklists and guidelines were developed. High-level INSN authorities (e.g., the director and the ICU chief) helped develop standards and checklists for all procedures and processes. Staff was empowered to carry out the best practices, such as a standardized procedure for medical devices placement and maintenance. Also, a series of team-building exercises were conducted to get everyone working together to reduce infection levels. One of the challenges was to address initial resistance, especially from physicians, to bring about the necessary changes.

Photo: Ivanna Naduzzi

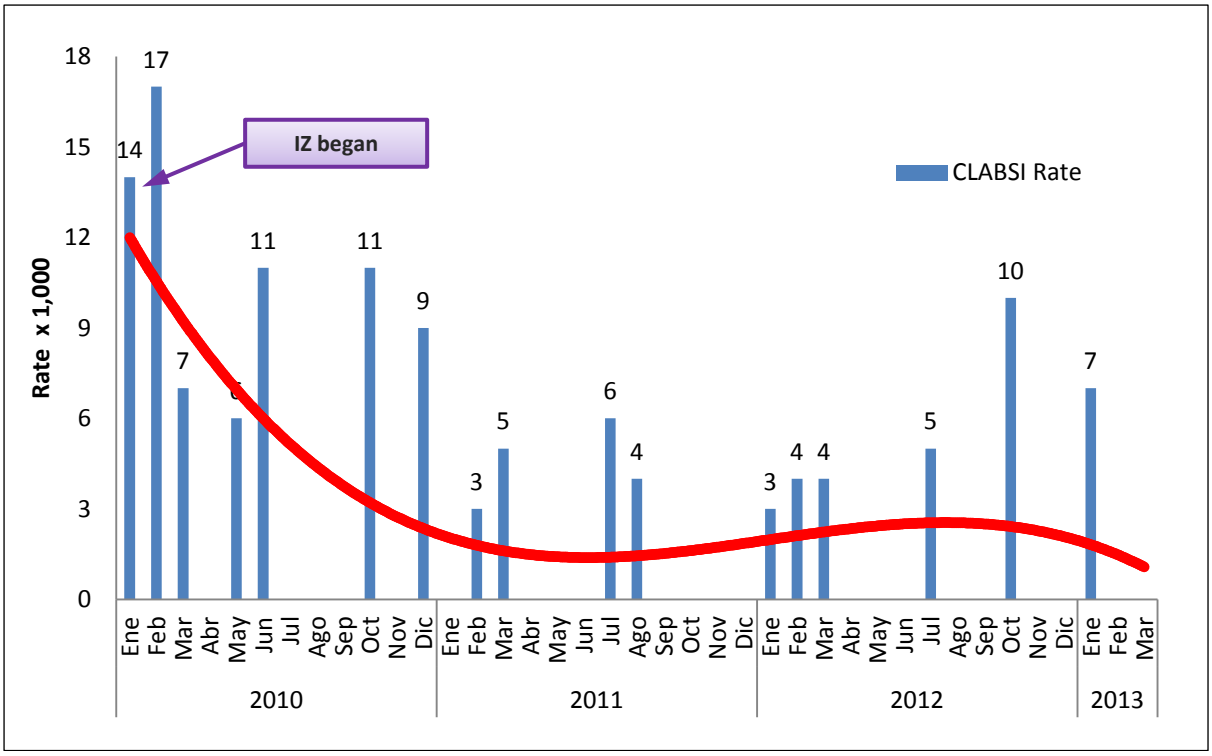
A health worker practices correct handwashing technique at the INSN in Lima. October 2012.

C3. The Results

Deliverable IHI-1:*A model for institutionalizing hospital infection prevention and control activities tested.*

A model for institutionalizing hospital infection prevention and control activities was successfully tested. On September 14, 2010, the vice-minister, on behalf of the National Committee of the National Quality Health Council, officially launched the Infection Zero Initiative. The protocols the ICU teams developed were implemented in each ICU. After two years of implementation, CLABSI rates in participating units significantly decreased (see Exhibit 5). At INSN, CLABSIs dropped from 10.01 per 1,000 in 2007 to 1.66 per 1,000 in 2012 among 1,314 patients using central lines. This is attributable to the implementation of simple, low-cost measures based on evidence, teamwork, and communication about safeguarding patients' lives and preventing IHI. These results were recognized at the 2012 International Society for Quality in Healthcare Conference in Geneva, Switzerland.

Exhibit 5. CLABSI[17]: National Institute of Child Health Pediatric Intensive Care, January 2010-March 2013



Source: National Institute of Child Health's Epidemiology Office records. 2010 - 2013

Deliverable IHI-2: *No less than 10 major hospitals in Lima/Callao are producing and utilizing local information on occurrence of hospital infections for designing, implementing, monitoring and evaluating prevention and control interventions, and with structures in place ensuring continuity of these activities*.

As a consequence of the Infection Zero Initiative design and implementation, including revision of the local CLABSI definition, design of monitoring tools, and establishment of a

[17] CLABSI rate is the percentage of blood stream infections occurring per 1,000 days of central lines use.

baseline for CLABSI and active surveillance, the seven participating major hospitals from Lima and Callao have improved the quality and use of the information of bloodstream infections surveillance. This information is analyzed every month and is used to advocate for extension of the experience to other ICUs inside the hospital and at other hospitals.

Deliverable IHI-3: *No less than 10 major hospitals in Lima/Callao monitor and evaluate hospital performance regarding hospital infection*.

At program closure, the seven hospitals that implemented the Infection Zero Initiative were monitoring and evaluating hospital performance regarding hospital infection. Two had begun using the Initiative's Web application and five had received this informatic tool. The application was developed with active participation of intended users, to assure it responded to their needs. It was also advantageous because the users were familiar with the application.

C4. Unintended Results

Using the PIM, the INSN also successfully standardized other critical procedures associated with life-threatening IHI, such as care of patients using ventilators, insertion and maintenance of central venous catheters in cardiology and external ventricular drainage devices, and treatment of wide burns. Today, 412 INSN staff has been trained in the PIM.

An unpublished cost study analysis conducted with support from Jhpiego estimates that the INSN saved $111,872 during 2011 and the Guillermo Almenara National Hospital saved $125,387 from October 2010 to March 2012[18]. The study also suggested that, in addition to saving lives and reducing complications due to nosocomial infections, implementation of the Infection Zero Initiative frees up hospital beds that, along with savings generated to hospitals, could be re-directed to provide services for more patients. The same study estimates that implementation costs an average of $20,466.50, meaning that approximately $143,265.50 was initially mobilized to control IHI in the seven participating hospitals. In addition, the INSN mobilized $150,000 from its institutional budget to refurbish the pediatric ICU, which now has 6,225 square feet and complies with international standards.

C5. Shortfall

QHC was able to implement the Infection Zero Initiative in just seven hospitals in Lima, which also have the Initiative's Web application. Although the expected MOH support to extend the Initiative into three more hospitals did not occur because of different political and technical priorities, the MOH Executive Directorate of Quality is now working to expand this successful experience in more hospitals in Lima and Callao. To date, 22 hospitals have officially expressed interest in implementing the Initiative; furthermore, EsSalud leadership has started a plan to expand it to all ICUs in its hospitals nationwide. EsSalud technicians were trained to manage the Infection Zero Initiative's Web application, the goal being to start implementing the interventions. They will be assisted by trained staff from Guillermo Almenara National Hospital who participated in the first phase of implementation.

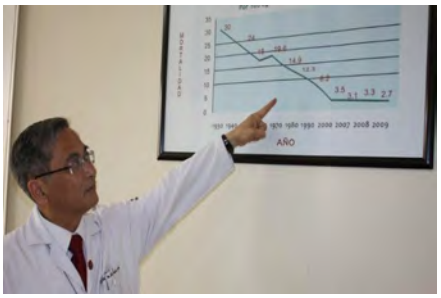
[18] Torres-Seoane, Maria. "Hospital Operation Costs Associated to a QI Intervention in Two Peruvian Hospital ICUs (2012).

USAID DEL PUEBLO DE LOS ESTADOS UNIDOS DE AMÉRICA | PERU | CALIDAD EN SALUD

SUCCESS STORY

INSN Working to Increase Patient Safety

Infection rates decreased and intensive care unit remodeled to meet international quality healthcare standards



Dr. Roberto Shimabuku, director of the National Institute of Child Health, Lima.

"As workers use the [performance improvement methodology], they begin to change their behavior."

— Dr. Danitza Fernández, director of INSN's Quality Management

"We have been able to share our experiences, to reach clear conclusions … the staff has been very involved and services are improving."

— Dr. Jaime Tasayco, medical staff at INSN

Improvements in clinical procedures and infrastructure contribute to improving patient safety, reducing the risk of contamination and facilitating quality healthcare services.

As part of the USAID|Peru|Quality Healthcare program's technical assistance to the National Institute of Child Health's (INSN), Dr. Peter Pronovost, an international leader on patient safety from the Johns Hopkins Hospital, visited in July of 2009. With Dr. Pronovost, INSN technical teams reviewed their responsive capacity and committed themselves to enhance surveillance, prevention, and control of hospital infections on critical units.

The INSN has been providing care to Peruvian children and adolescents for more than 80 years. It has 600 hospital beds and the capacity to attend to more than 1,000 outpatients daily. From 2009 to 2010, 10 facilitators at the INSN trained 337 professionals on performance improvement methodology, including 80 percent of cardiology, intensive care unit, neonatology, and neurosurgery services staff.

In each area of service, ad-hoc working groups created guidelines and checklists by videotaping and analyzing critical procedures. The groups also encouraged teamwork and better communication, and motivated staff to improve their clinical processes.

These efforts were intended to further reduce central line bloodstream infections in patients in intensive care. The dramatic results obtained after two years — from 5.5 infections per 1,000 patients/day during 2010 to 1.7 infections per 1,000 patients/day in 2012 — received verbal international recognition at the 2012 International Society for Quality in Health Care conference. In front of 1,200 delegates from 66 countries, Dr. Pronovost said, "results like these should inspire other countries to embark on experiences like Peru's in the pursuit of quality improvement in patient care."

Another major accomplishment was the remodeling of the intensive care unit. With an investment of $150,000, made by the INSN itself, the unit's space increased to 6,225 square feet; it now fulfills every international standard for intensive care services, placing the INSN at the level of first-class hospitals.

CHAPTER 3. EFFECTIVENESS OF THE QHC STRATEGY BY PROGRAM ELEMENT: MCH AND FP/RH

A. The Challenge

Despite advances, in 2007 Peru still faced high mortality rates among mothers and children under 5, particularly those living in rural areas and the poor. On average, the lifetime risk of maternal death was one out of 140 women — 30 times higher than in high-income countries — and 27 out of 1,000 children died before their fifth birthday. However, these averages hide large differences among Peruvians.[19]

There was a large disparity among different populations for delivering at a health facility, which is the most effective intervention to reduce maternal mortality. Although institutional delivery was almost universal in urban areas, only half of the deliveries in rural areas occurred in a health facility. This difference was even higher when comparing populations based on wealth: Practically all women in the richest quintile delivered in a health facility, but only two of five women from the poorest quintile did. In rural areas, mortality for children under 5 was 43 per 1,000 — more than double than in urban areas. Mortality among children from the poorest quintile was almost seven times higher than among the richest quintile.

In 2007 …

625
Women died from maternal causes

1 in 140
Woman died from maternal causes during reproductive life

59%
of coupled women living in rural areas did not use any modern contraceptive

45%
of deliveries in rural areas occurred outside a health facility

43
out of 1,000 children from rural areas died before their fifth birthday

44%
of children from rural areas between 18-23 months did not receive all the required vaccines

30%
of children from rural areas with acute respiratory infections were not attended by health providers

50%
of children from rural areas with acute diarrhea were not seen by health providers

Source: ENDES data from 2007-2008

The health sector was not properly equipped to cope with these challenges. None of the HCFs that should provide basic or essential emergency obstetric and neonatal care had all the required resources to guarantee quality services. On average, HCFs had 47 percent of the required resources for basic or essential emergency obstetric care and 56 percent of the required resources for providing neonatal care.[20] Shortages of human resources were very high in rural areas, where they were most needed. Health systems, particularly continuous in-service learning, were not prepared to deal with high staff turnover or to support recently graduated professionals, most of whom had never been exposed to working conditions at the primary care level or to the rural culture and characteristics of the demand.

The MOH helped develop health service delivery tools for applying universal health insurance and primary healthcare priority policies. The most vulnerable groups are mothers, their babies, and children under 5. In Peru, the most common obstetric complication,

[19]Encuestas Nacionales de Salud. 2007-2008.
[20]Encuesta a Establecimientos de Salud con Funciones Obstétricas y Neonatales. Instituto Nacional de Informaticá y Estadística. 2009.

hemorrhage or infection, is related to the post-partum period. A woman has less than three hours to look for assistance, and when she realizes something is not going well, the degree of infection has already compromised her vital systems. For newborns, mortality rates remain high because many events related to the mother's quality of healthcare at the time of delivery have a direct impact on their health. The numbers of low-birth-weight babies and children from 0-23 months with malnutrition have persisted in Peru.

The negative impact on brain growth could be irreversible for low-birth-weight babies and children under 2 if no early detection signs are identified. Low birth weight also increases chances of abnormal immune system function and growth and development retardation, particularly if an infection occurs, primarily pneumonia and diarrhea.

In terms of FP/RH, different operational studies reported the need to improve the quality of services by introducing the balanced counseling and orientation (BCO) strategy, developed by QHC, which focuses on identifying and satisfying the user's FP needs and improving the information delivered by the provider. It was also reported that providers introduced their own biases when offering contraceptive methods. The second most frequent gap reported was insufficient stock at the moment of the health appointment. These two conditions were reported as the most common causes of unmet needs for contraceptive methods.[21]

B. The Response

The effective interventions to improve MCH and reduce mortality are birth spacing; prevention of low birth weight; institutional delivery and adequate management of obstetric and neonatal emergencies; vaccines; management of diarrhea and pneumonia; and micronutrient supplement. For these interventions to produce expected health outcomes, human resources, equipment, supplies, and drugs must be available; health workers must follow best practices when delivering the effective interventions; and the production of effective interventions must reach the majority of families, especially those living in poverty and in rural areas.

Photo: Andrea Soto

A baby receives care at the INSN's Intermediate Care Unit in Lima. April 2012.

The reduction of variability when delivering effective health interventions is a key element for their successful implementation. In other words, standardized best practices ensure that women and children receive the same quality interventions regardless of where they live or their wealth. Standardization of service delivery is a contribution of the health sector toward equity and social inclusion. QHC's primary intervention has been to strengthen the capacity of primary healthcare teams to deliver effective, consistent interventions every time.

[21]Women with an unmet need for contraception in developing countries and their reasons for not using a method. Occasional report No. 37. Page 11-12. June 2007. Guttmatcher Institute.

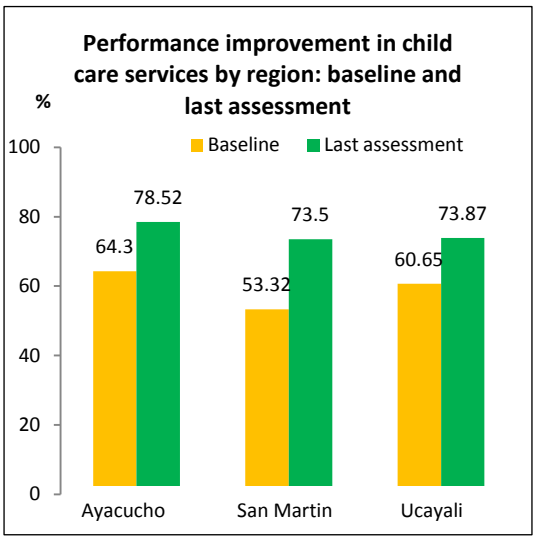
C. The Results

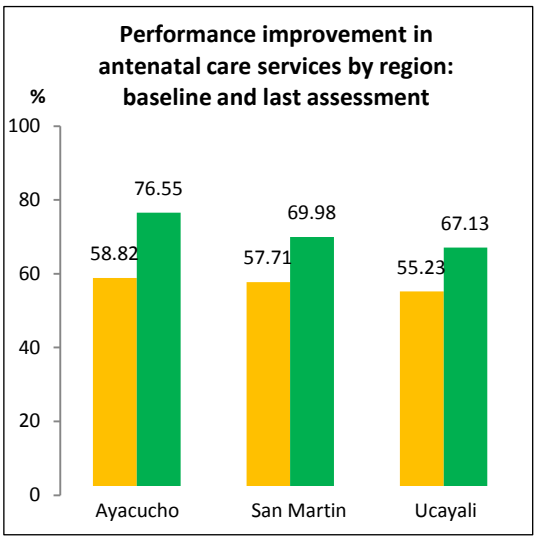
Deliverable MCH-1: *Institutionalized regional quality improvement programs (PIM) that address in-service training, supervision, and evaluation of staff on maternal and child health in regions approved by USAID as evidenced by: 90 percent of micro-health networks have an active human resources-quality improvement plan*.

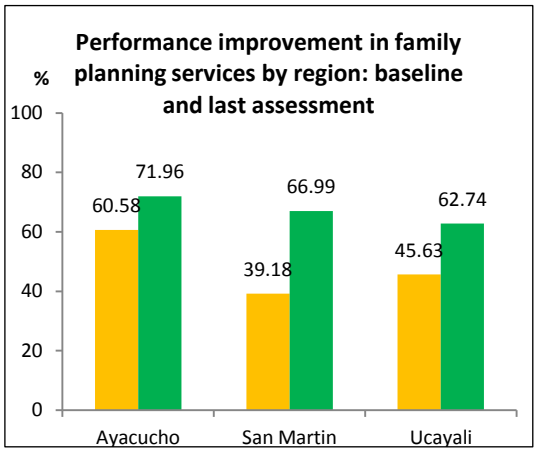
In 2012, every target micro-network in San Martin, Ayacucho, and Ucayali had performance improvement plans for MCH services; by the end of the first half of 2013, the same was true for 100 percent of target micro-networks in San Martin and Ayacucho.

QHC worked to strengthen the capacity of 84 micro-networks to provide in-service training, supervision, and evaluation in MCH and FP/RH. At the beginning of QHC in 2009, the percentage of adherence to best practices achieved was 62.5 percent in Ayacucho, 50.3 percent in San Martin, and 55.9 percent in Ucayali — an average of 56.2 percent. By the end of 2012, the average had increased to 70.7 percent: 72.8 percent in Ayacucho and San Martin, and 66.7 percent in Ucayali. Exhibit 6 provides a more detailed summary.

Exhibit 6. Progress of Micro-Networks in Implementing Best Practices







Source: QHC M&E Reports. 2009-2013

QHC implemented activities following intense negotiations with DIRESA Quality Management Units, the MOH's National Family Planning and Reproductive Health Strategy, and the Comprehensive Care Health Directorate, which is in charge of child health. There was also regular communication with DIRESA Human Resources Directorates, which are in charge of managing the processes for strengthening staff competencies and performance.

DIRESAs and micro-network officers played an important role in setting the pace of implementation. The three DIRESAs decided to start with 52 micro-networks during 2008, eventually incorporating at total of 84 priority micro-networks — including nine more than planned in San Martin. DIRESA officers used criteria such as regional priorities, accessibility to HCFs, and the volume of demand to start implementing the PIM and expanding its coverage based on the results gathered during the life of QHC.

Finally, the Local Leadership Development Program (LLDP) in Ayacucho and Ucayali increased the number of leaders at different levels inside and outside the health sector; they are expected to work collaboratively to champion sustaining quality improvement advances in MCH and FP/RH. Participants came from regional governments, DIRESAs, micro-networks, local governments, civil society organizations, universities, NGOs, and media. See Chapter 4 for more details.

Specific MCH interventions were strengthened in all approved regions: 505 health professionals were trained in child health and IMCI; 465 were trained in maternal health/obstetric complications; 85 percent (71 of 84) of micro-networks implemented improvement plans to reduce performance gaps; and 2,687 facilitators were trained to implement and manage the PIM.

Performance assessments were carried out and improvement plans were designed in 644 HCFs. To guarantee the institutionalization of regional quality improvement programs that included training needs in MCH, QHC provided technical assistance to Ucayali, Ayacucho, and San Martin to elaborate Five Year Regional Plans for Staff Development that included all MCH training needs from 2013-2017 for all staff that perform MCH and related activities. QHC also helped elaborate annual plans that included staff development activities in Ucayali and San Martin for 2013.

Pursuing the goal of establishing in-service training activities, in Ucayali, a national teaching site for IMCI and ICATT, a Web-based training module, and a regional teaching site for infection prevention and control in primary care were established to support the quality of MCH and FP/RH services delivery. Also, to comply with the AD 193-MINSA/DGSP-V01 criteria to recognize quality services provided, several regional, municipal, and district recognition resolutions were issued.

Deliverable MCH-2: *Institutionalized regional budgeting processes in support of quality improvement programs (PIM) that address in-service training, supervision, and evaluation of staff on maternal and child health in regions approved by USAID as evidenced by: health networks representing at least 90 percent of micro-health networks cover PIM activities in their annual budgets*.

QHC successfully mobilized regional and local public financial resources to fund quality improvement of MCH services. Health networks from San Martin, Ayacucho, and Ucayali, which represent at least 90 percent of micro-networks, have covered PIM activities with their

own funds since 2012. DIRESAs and micro-networks invested approximately $159, 538, including results-based budget funds, to support in-service training, supervision, and evaluation activities. This was equivalent to 80.7 percent of the total funding for these activities.

In coordination with micro-networks and local governments, QHC mobilized additional funds. Local governments provided venues for training activities, financed transport and other expenses (e.g., meals) for trainees, built or repaired HCFs, hired required health staff, provided fuel for supervision activities, and occasionally bought missing equipment, supplies, or drugs.

QHC also mobilized funds from mPIPs to finance activities included in the micro-networks' improvement plans. A full list of these budgets is on the DVD.

Deliverable MCH-3: *Technical assistance is provided to DIRESAs in regions approved by USAID to integrate best clinical and management practices into employee training systems, addressing the main causes of maternal and infant morbidity and mortality*.

QHC provided technical assistance to San Martin, Ayacucho, and Ucayali to incorporate the PIM into the regional quality management systems and in the formation of human resources. Performance assessment results of MCH services were used to develop Five-Year Staff Development Plans, which follow national standards established by the National Civil Service Authority. These plans address the main causes of maternal and infant morbidity and mortality, and help regional health authorities list the professional cadres that require training during the five-year period, increasing the efficiency of resources assigned to strengthen the capacities of employees. The PIM was also used to prepare the NEOP, especially recent graduates and those recruited by SERUMS (see Chapter 6 for more details). Furthermore, QHC helped strengthen the capacity to effectively manage and use SISMED.

QHC strengthened the regional capacity to implement and use its recommended approaches, methods, and tools for in-service training and to orient new employees and train facilitators. Progressively, DIRESA and micro-network officers took responsibility and implemented the approaches as part of their regular responsibilities.

QHC contributed to form regional facilitators for implementing the PIM and managing and using the Perinatal Information System (SIP 2000 v 3.0). This revised version captures previously neglected data such as use of waiting homes; vaccination history; number of prenatal stimulation sessions; results of rapid testing for syphilis, HIV, Human T Lymphocites Virus, and malaria during pre-natal care; alarm signs during labor; offering vertical delivery; and asking about the presence of a relative during labor. It also includes laboratory results for the newborn that will be key to assure that best practices managing babies are followed. In total, 217 facilitators were trained to use the Perinatal Information System. Today, 46 HCFs in Ayacucho and San Martin are using the system.

QHC also strengthened the capacity of select micro-networks and HCFs to become regional and national training facilities for preventing infections at the primary healthcare level, and for implementing the IMCI's ICATT module. It also helped develop and strengthen the core MCH and FP/RH competencies of 5,985professionals. These continuous learning activities responded to the gaps and weaknesses identified during the PIM process.

USAID | PERU | CALIDAD EN SALUD

DEL PUEBLO DE LOS ESTADOS UNIDOS DE AMÉRICA

SUCCESS STORY

Public Investments Improve Local Health

With USAID support, communities and local governments collaborate to gain access to public funds for health projects

Photo: Quality Healthcare Project

Participants designed mPIPs in a November 2011 workshop in Pucallpa, Ucayali province. Workshops like this one have enabled local governments and health teams to prepare proposals for needed health projects.

"I've worked with projects for two years, but this is the first time we've developed the project as a group effort: the citizens, the municipality, health teams, and local authorities. We've come up with a project that will benefit all, and that is an example to follow."

— Biller Delgado Montilla, social development manager for the district municipality of Bajo Biavo in San Martín

Local governments in Peru face a dilemma: Every year, public funds for health go unspent, likely due to limited capacity for project design and a complex approval process for the disbursement of available funds. Thanks to a recent collaboration between two USAID programs, however, local governments and health facilities are accessing funds for projects that will improve the health of Peru's people.

The USAID|Peru|Quality Healthcare program and the Healthy Communities and Municipalities (HCM) II program joined forces to provide local governments and health workers in Ucayali, San Martín, and Ayacucho with a practical methodology for developing minor public investment projects (mPIPs) and accessing funds to implement them.

Starting with a community-based methodology designed by the HCM II team, the Quality Healthcare team customized the methodology formulated for health projects and applied a Performance Improvement Methodology to identify gaps in health service provision. Beginning in mid-2011, the two project teams then jointly delivered three-day regional workshops to train community representatives, local governments, health teams, project designers, and evaluators to develop mPIPs quickly and collaboratively.

Applying the skills they learned in the workshops, local governments and health teams in the three regions filed 38 mPIPs with Peru's National Public Investment System by the end of 2012, and had 13 more under development. Each proposal is worth up to 300,000 *nuevos soles* (equivalent to about $117,650). Four of these 38 mPIPs, a total value of 789,425 *soles* ($309,580), have been implemented or are under implementation. In San Martín, the Bajo Biavo health facility team's mPIP was funded just one month after the workshop, and used the money to acquire obstetric and neonatal equipment and train staff to deliver high-quality maternal and child health services.

If the remaining mPIPs are approved, some 11.1 million *soles* ($4.35 million) could be leveraged from the public budget to improve the quality of health services delivery. USAID's support for this collaborative methodology is making more public funds available to improve the health of men, women, and children throughout Peru.

The program also contributed to strengthening the capacity of DIRESAs and micro-networks to improve MCH competencies by introducing the use of anatomic models for skills development for removing retained placenta.

QHC also supported the MOH to update and develop its technical norms. Please see Annex A for further details.

Deliverable MCH-4: *Existing and reliable data on child health, nutrition, and services is available in "friendly" formats to the public in regions approved by USAID.*

The program developed, tested, and disseminated information about the local child health situation using innovative, public-friendly posters illustrating the status of the primary child health program indicators: number of children who are seen for growth and development follow-up; number of mothers who provide exclusive breast feeding to their babies at least for six months; number of deliveries attended by skilled health workers; and number of pregnant women who receive pre-natal care. The posters were designed to be easily updated, extending their useful lifespan, and were distributed among HCFs in Ayacucho and San Martin. Dissemination of this information will help raise awareness about the main local plans and initiatives to improve child health, which could improve HCF management by introducing some level of accountability to the local community. This can also expand the opportunities for cooperation with local governments and other stakeholders.

Deliverable FP/RH-1: *Institutionalized regional quality improvement programs (PIM) that address in-service training, supervision, and evaluation of staff on FP/RH in regions approved by USAID as evidenced by: 90 percent of micro-health networks have an active human resources-quality improvement plan*.[22]

In 2012, every target micro-network in San Martin, Ayacucho, and Ucayali had performance improvement plans for FP/RH services; by the end of the first half of 2013, the same was true for 100 percent of target micro-networks in San Martin and Ayacucho.

The PIM enforced adherence to standards of care at the point of healthcare service delivery, improving processes and, as a consequence, the quality of healthcare. Implementation of an improvement plan was a milestone, because it was based on performance assessments and identification and analysis of gaps. The improvement plan addressed the root causes of problems, including technical skills gaps.

Photo: Calidad en Salud

Family planning BCO in San Martin. February 2011.

[22] The language in Deliverable FP/RH-1 and Deliverable MCH-1 is similar because they are related and complement each another.

USAID | PERU | CALIDAD EN SALUD

DEL PUEBLO DE LOS ESTADOS UNIDOS DE AMÉRICA

SUCCESS STORY

Achieving Patient-Oriented Healthcare

With strong leadership and a team committed to improving performance, Lluyllucucha has shown significant progress in health service delivery

Healthcare employees read a poster at the entrance to the Lluyllucucha health center that informs users and patients of their right to high-quality care.

"Performance improvement is now part of our work … we've progressed. The staff's energies are directed toward patients."

—Dr. Marcia Ríos Noriega, director of the Lluyllucucha MN

Ensuring high-quality maternal-child health services is a challenge faced by many rural health facilities in Peru. Poor quality of services for women and children is often blamed on a lack of human and financial resources.

However, the Lluyllucucha micro-network (MN) in San Martín has good reason to be proud. Since January 2010, the maternal mortality rate has been zero. It reported one death,in 2008-2009 and three deaths From May 2009 to November 2011, skilled birth attendants participating in delivery increased from 52 to 90 percent; prenatal care rates increased from 55 to 82 percent; child immunization coverage increased from 80 to 98 percent in the coverage area; teenage pregnancy went from 28 to 12 percent; and cases of infants with diarrhea fell from 4 to just 1 percent.

Since 2009, the USAID|Peru|Quality Healthcare program has provided technical assistance to the Lluyllucucha MN to implement a performance improvement methodology at its 11 health posts, two health centers, and one community pharmacy. It calls for periodic monitoring and measurement of best practices. This allows the MN's facilities to identify and implement improvements such as standardization of services, more organized patient visits, privacy guarantees, improved logistics, and regular facility sanitization procedures to provide quality health care to a local population of 25,000. The process has relied heavily on the commitment of healthcare workers, who have prioritized patient satisfaction. Staff institutionalized the use of best practice guides in day-to-day service provision and when training new employees. The methodology is now a daily activity. "It allows us to satisfy users, prevent illnesses, and improve our technical capabilities," said one employee.

A guide to community action, enriched with the support of the USAID|Healthy Communities and Municipalities II project, has helped health personnel interact with community leaders. The health post Flor de Primavera exemplifies excellent community coordination: It has strengthened support from local authorities, community leaders, and midwives, has contributed to increased demand for health services and improvement in the quality of services provided.

The final challenge is to promote the sustainability of these achievements and continue improving the quality of health services. The Lluyllucucha MN has proposed two investment projects to the provincial municipality of Moyobamba for financing: improving the response capability of health facilities in obstetric and neonatal services, and improving the capacity of family care for children under the age of five to reduce chronic malnutrition. Through continual work with municipal authorities to offer quality health service improvements, the Lluyllucucha MN can make these reforms sustainable.

U.S. Agency for International Development
www.usaid.gov

Performance assessments are an effective way to supervise and evaluate health personnel. Following this approach, QHC contributed with:

- 894 health professionals trained in FP/RH
- 267 health professionals trained in infection prevention and control at the primary care level
- 29 facilitators trained in intrauterine contraceptive devices and implant insertion using anatomic models
- 324 facilitators trained in the use of the Integrated Supply System of Medicines and Medical Supplies
- 79 regional facilitators trained in integrated care for adolescents during pregnancy, labor and delivery, and post-partum

The program also contributed to strengthening the capacity of DIRESAs and micro-networks to improve FP/RH competencies by introducing the use of anatomic models for skills development during insertion and removal of intrauterine contraceptive devices and implants.

Deliverable FP/RH-2: *Regional health authorities had capacity to manage and lead the implantation of evidence based quality standards compliance related to FP/RH counseling in USAID approved regions*.

San Martin, Ayacucho, and Ucayali regional health authorities implement the BCO strategy, which focuses on identifying and satisfying FP/RH quality standards to comply with counseling needs in USAID-approved regions, and improving the information providers deliver at that level. BCO is provided following an algorithm that systematically analyzes the client's options using graphic cards and complementary information. The international evidence shows that BCO significantly improves the quality of the service and client satisfaction.

After establishing a dialogue with the MOH's National Reproductive Health and Family Planning and Reproductive Health Strategy, QHC succeeded in incorporating BCO into the national norms and protocols. The process counted on participation and feedback from many FP/RH facilitators and professionals from the MOH, regions, and micro-networks, and supported the formation and capacity building of national and regional facilitators. By December 2012, QHC contributed to training 77 BCO regional providers in Ayacucho, 722 in San Martin, and 288 in Ucayali. It also contributed to the distribution of BCO materials in all regions targeted by USAID, and gave 500 copies to the MOH to be distributed in all health regions of the country. The entire micro-network system in Ayacucho, San Martin, and Ucayali has these materials.

Deliverable FP/RH-3: *Institutionalized regional capacity to manage and maintain FP/RH commodity security in regions approved by USAID as evidenced by: an adequate mix of commodities to meet clients' needs*.

At QHC closeout, DIRESAs in Ucayali, San Martin, and Ayacucho had enough supplies to satisfy two-month demands of oral combined contraceptives, progestin-only injectables, condoms, and intrauterine contraceptive devices, and had prepared plans to assure a minimum stock of contraceptives. QHC provided technical assistance to the regions and micro-networks to strengthen their competencies to better analyze and use the information regularly gathered by SISMED. Three indicators were used to determine if there were enough

commodities to respond to demand: months of supply on hand, stocks on hand, and average monthly consumption.

Deliverable FP/RH-4: *Ongoing basic and refresher training programs established in regions approved by USAID for SISMED and logistics management*.

QHC provided technical assistance to incorporate training activities for the use and analysis of SISMED data and logistics management into the Five-Year Plan for Staff Development in Ayacucho, San Martin, and Ucayali. Regional and micro-networks teams in charge of managing the logistics of FP/RH commodities were trained to identify deficiencies in commodities distribution, based on the analysis of the three indicators listed above. As a result, micro-networks experienced a significant improvement in the distribution of FP/RH commodities: The DIRESAs in Ayacucho, San Martin, and Ucayali ensured availability matched demand.

Deliverable FP/RH-5: *Institutionalized regional capacity to appropriately manage and use SISMED in regions approved by USAID as evidenced by: 90 percent of micro-networks reporting FP/RH data through SISMED*.

QHC incorporated training activities for the use and analysis of SISMED into the Five-Year Plan for Staff Development in Ayacucho, San Martin, and Ucayali. Every micro-network in these regions — 100 percent of the target — is reporting data through SISMED, allowing operational teams in districts to assure appropriate levels of commodities. It provides an easy-to-interpret graphic report that warns teams when stocks are approaching critical levels.

Deliverable FP/RH-6: *In regions approved by USAID, quality of reproductive healthcare improved as measured by compliance with MINSA standards. Year Five Goal: 50 percent increase in or 80 percent compliance among 90 percent of micro health networks in regions approved by USAID*.

During the life of QHC, in the regions approved by USAID, 54.8 percent of micro-networks increased the fulfilling of best practices in FP/RH and 31 percent complied with at least 80 percent of best practices in FP/RH or had increased compliance up to 50 percent of the baseline (see Exhibit 7, next page). Lack of accomplishment could be explained by the high turnover of health personnel at the primary care level. For example, in the FP users satisfaction survey, QHC could estimate that in the previous 12 months of the survey, 70 percent of all HCF in San Martin and 60 percent in Ayacucho had received new personnel to work in FP services. The negative impact occurred even though the NEOP targeting SERUMS was in place. This pointed out the need to extend the program to all new employees, including those working in FP services.

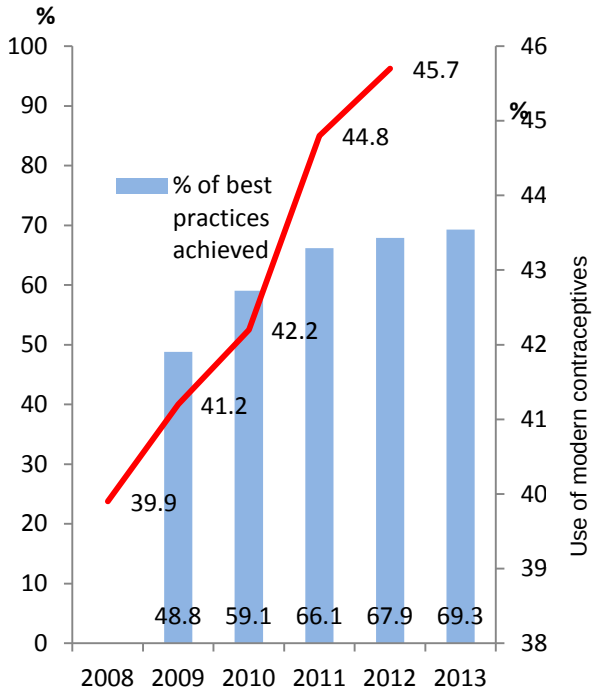
Deliverable FP/RH-7: *Institutionalized regional budgeting processes in support of quality improvement programs (PIM) that address counseling, commodity security, policymaking, information system, and logistics on FP/RH in regions approved by USAID as evidenced by: health networks representing at least 90 percent of micro-health networks cover PIM activities in their annual budgets*.[23]

QHC successfully mobilized regional and local public financial resources to fund quality improvement of FP/RH services. Health networks from San Martin, Ayacucho, and Ucayali,

[23] The language in the deliverable FP/RH-7 and MCH-2 is similar because they are related and complement each other.

which represent at least 90 percent of micro-networks, have covered PIM activities with their own funds since 2012. Funding included allocation of human resources, travel/transportation, materials, and other items necessary for implementing performance improvement plans. A total of $148,606 was leveraged from regional counterparts to implement FP/RH activities promoted by QHC. Furthermore, 49 minor public investment projects were formulated to reduce gaps in MCH and FP/RH for a total of $4.2 million.

Exhibit 7. Percentage of Best Practices Achieved in FP/RH Services and Use of Modern Contraceptives Among Women of Reproductive Age, Ayacucho 2008-2012



Source: QHC monitoring and evaluation reports. 2008-2013 for performance percentages and ENDES 2008-2012 for contraceptive use rate

Deliverable FP/RH-8: *Institutionalized regional capacity to assess and improve FP/RH service delivery in regions approved by USAID as evidenced by: no less than 70 percent of patients satisfied with FP/RH services and counseling*.

Patient satisfaction is affected by factors such as provider performance, availability of human and material resources, and administrative polices. The 2013 Family Planning User Satisfaction Survey conducted in Ayacucho and San Martin showed that, on average, users rated services with 73.5 out of 100 points. In Ayacucho and San Martin, 30.9 per cent qualified as “satisfied users” based on the MOH definition — those who rated the services with 80 or more points.

Deliverable FP/RH-9: *Improved capacity to provide health services for pregnant adolescents in regions approved by USAID, as evidenced by: 1) MOH Technical Norm for Services Among Pregnant Adolescents validated in regions approved by USAID and 2) training of trainers on the use of the technical norm*.

QHC introduced the BCO strategy to provide counseling in FP into the new Technical Norm on Comprehensive Care of Adolescents during Pregnancy, Delivery, and in the Puerperal

Period, assuring that pregnant adolescents will receive quality services oriented to avoid further undesired pregnancies. Content of the relevant section was validated with providers from the targeted regions, who were also trained in the use of this new strategy to provide FP counseling. Although the norm is undergoing the formal approval process in the MOH, QHC trained 27 from San Martin and 29 from Ayacucho on how to use the proposed norm.

D. Unintended Results

Since technical norms govern service provision nationwide, including the BCO strategy for providing FP counseling in the proposed FP and Pregnant Adolescent Services technical norms, they will foster quality improvement in FP services beyond the QHC target areas. Although the norms were not officially approved when this report was being finalized, the NSRH is currently promoting the use of BCO throughout the country.

E. Shortfall

E1. Deliverable FP/RH-8: *Institutionalized regional capacity to assess and improve FP/RH service delivery in regions approved by USAID as evidenced by: no less than 70 percent of patients satisfied with FP/RH services and counseling*.

On average and based on exit interviews, FP/RH and counseling users rated the services with 73.5 out of 100 points. However, only 30.9 percent qualified as "satisfied users" based on the MOH definition (i.e., giving a rating of 80 points or higher). This MOH standard is very demanding, as evidenced by these results. Other reasons to explain the shortfall are related to lack of compliance with two best practices: handwashing and use of educational materials to inform users. These two areas received low user ratings. The shortfall with use of educational materials is expected to be addressed once BCO materials are available to HCFs. Adherence to handwashing best practices will require continued attention.

Despite these shortcomings, technical teams from targeted regions are experienced with the use of this kind of survey. This is encouraging, because the Technical Norm of Family Planning going through the approval process at the MOH requires that a survey be conducted periodically in each region. Regions participating in future surveys are positioned well to implement the new family planning norm.

E2. Intermediate Result 5 Monthly Deliverable: Design and Publication of the Updated FP Technical Norm and Sexual Reproductive Health Manual

Updating of the FP Technical Norm and approval by the FP/RH National Program was completed in August 2012. The Counseling and Orientation in Sexual Reproductive Health Manual was completed in November 2012. After that, both documents underwent extensive revision by other technical offices at the General Directorate of People's Health, and were later submitted for official approval. For reasons beyond QHC's knowledge or understanding this process has not been completed. Despite numerous attempts to expedite the process — by interacting with administrative or technical authorities at the MOH, for example — QHC has not been able to control or influence the final step of the official approval process and could not proceed with the design and publishing of these documents. The USAID mission has been informed of the difficulties in obtaining official approval.

CHAPTER 4. CROSSCUTTING ACTIVITIES AND ACHIEVEMENTS

A. The Challenge

Within the decentralization context started by the Peruvian government over the past decade, the primary responsibility for health service delivery has shifted from the central MOH to local offices. This change places primary authority for service provision and financial responsibilities on DIRESAs and local governments. The resulting system lacks key personnel with basic managerial skills to guarantee effective execution of the service delivery processes. In this decentralized health system, regional and district health authorities are given power to allocate investment funds at the local level. This flexibility allows for some local priority-setting according to needs but also signifies that implementation plans to address performance gaps are dependent on local commitment and financing of said initiatives.

Another recurring problem has been the constant turnover in the workforce due in part to the lack of adequate training, an uneven geographic distribution of workers, and concerns over low compensation for qualified healthcare personnel. Processes and tools must be part of the formal orientation and training process to ensure early adoption and on-the-job application of tools and methods.

Insufficient leadership and weak inter-sectoral linkages in decentralized health regions had a negative impact on the status of the population's health. The lack of competencies, tools, instruments, manuals, guidelines, protocols, and recognition systems produced a vicious cycle in which poorly performing workers remained in HCFs to provide poor-quality services. Factors such as these demotivate people to visit facilities in a timely manner, producing high risks of clinical complications and, frequently, high mortality rates.

B. The Response

Local Leadership Development Program (LLDP)

Throughout the five years of QHC implementation, the MOH, DIRESAs, local HCFs and their health workforces were actively involved in defining program activities, setting targets, and continually monitoring desired results. One strategy QHC adopted to solve problems was to design an LLDP to strengthen the ability of recognized local leaders to formulate, implement, and evaluate strategic health interventions oriented to overcome the main regional health problems.

QHC focused on ensuring that Peruvian health institutions drove the process, which included planning, designing, implementing, and monitoring activities, and supports decentralization of the health sector.

LLDP was designed and implemented to link with local universities and include participation of institutions or representatives of the health and education sectors, local government, and civil society. QHC provided technical assistance with the Healthy Municipalities and Communities II project, counting on its financing with an innovative approach of inter-institutional collaboration, co-financing from DIRESAs, and a self-financing component from the participants.

USAID | PERU | CALIDAD EN SALUD

DEL PUEBLO DE LOS ESTADOS UNIDOS DE AMÉRICA

SUCCESS STORY

A Successful Model of Intersectoral Work to Develop Local Capacity

Intersectoral work has enabled participants to implement evidence-based action plans

Participants from Ucayali hold their post-graduate diplomas in local leadership development.

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

—Mg. Rosa Muñoz, professor at the Obstetrics School, UNSCH

"I want to thank USAID/Peru and the Regional Health Directorate because with this group of 26 leaders that represents different institutions, we will be able to prepare quality health programs. One hundred percent of participants graduated, which is something that rarely occurs."

—Ing. Edgar Díaz Zúñiga, Ucayali National University

U.S. Agency for International Development
www.usaid.gov

The lack of sustainability and institutionalization of successful health interventions in Ayacucho and Ucayali has a negative impact on people's health. In response, the USAID|Peru|Quality Healthcare program proposed the implementation of the Local Leadership Development Program (LLDP) with the aim of strengthening the capacity of local leaders to formulate, implement, and evaluate strategic health interventions to overcome the main health issues of Ayacucho and Ucayali.

LLDP was designed and implemented in partnership with a local university; institutions or representatives of the health and education sectors and local government and civil society also took part. USAID|Peru|Quality Healthcare program and the USAID|Peru|Healthy Communities and Municipalities II project provided technical assistance. LLDP had inter-institutional financing and self-financing from participants. Its approach was to build competencies on leadership for service, strategic planning from a regional perspective, intersectoral common vision and mission, coaching and community mobilization, and achieving specific outcomes (e.g., including reproductive health interventions to reduce teen pregnancies in the regional government agenda).

The cross-cutting themes of LLDP were service-based leadership, quality, interculturality, right to health, and gender and public health. The content of the program was divided into four modules and a mentoring phase in different public and private institutions in the country.

Every participant from Ucayali (26) and 91 percent from Ayacucho (21 of 23) received a "Post Graduate Diploma in Local Leadership Development" after fulfilling requirements established by Ucayali National University and San Cristobal de Huamanga National University-Ayacucho.

The graduates are now implementing action plans, such as the "Centro de Desarrollo Juvenil Santa Rosa," a youth development center that has increased access to balanced counseling and orientation in sexual and reproductive health for adolescents. In 2012, 321 adolescents sought counseling, compared with 281 in 2011.

The involvement of local leaders, health and education institutions, universities, local governments, and NGOs enabled the development of common regional aims that led to the creation of multisectoral action plans. This successful experience should be repeated under the leadership of local people and with regional funding. It also merits extension to other regions through horizontal collaboration.

The program was designed to strengthen the leadership skills of regional leaders in different public and private. It focused on competencies, and was based on results and developed with classroom and non-classroom modalities. Participants could use a virtual platform to join classes remotely. LLDP covered servant leadership, the model of challenges, quality definitions, interculturality, health rights, gender and public health; these topics were divided into four modules, and a final mentoring phase was implemented in different public and private institutions throughout the country.

Photo: Eva Miranda

LLDP graduates from the National University of San Cristobal of Huamanga, Ayacucho. May 2012.

C. The Results

The National University of Ucayali and the San Cristobal National University of Huamanga participated in identifying leaders in the regions; coordinated with the DIRESAs to increase communication and reactivate expired inter-institutional agreements; and designed a post-graduate diploma as academic incentive for participants who acquired the required competencies.

The universities also prepared four modules for the program. The first included a strategic analysis of the health situation, including a service component oriented to reflect the importance to develop a regional common vision and mission. The second module was based on facing challenges to generate results, and was accompanied by the formulation of action plans with timeframes that went beyond the academic program.

Local Leadership

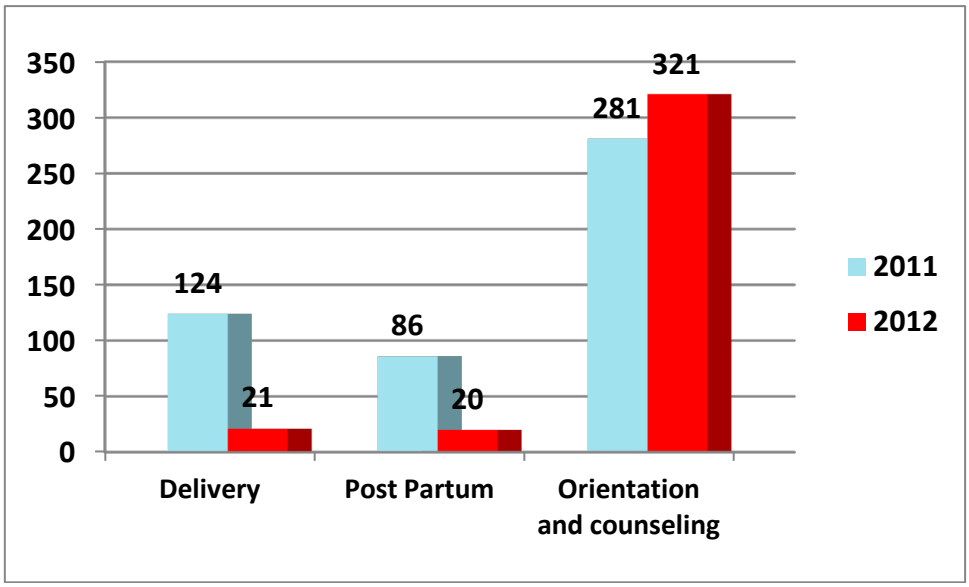
A total of 47 participants — 26 from Ucayali and 21 from Ayacucho — received a "Post-Graduate Diploma in Local Leadership" after attaining the competencies and complying with the requirements of the National University of Ucayali and the National University of San Cristobal of Huamanga.

LLDP generated many different positive results.[24] The first was implementation of a Youth Development Center in the Santa Rosa Health Center in Ayacucho. The center increased access to services for orientation and counseling in adolescent sexual and reproductive health, obtaining an important reduction in the number of adolescents assisting the health center for deliveries and post-partum services compared with the same period in 2011 (see Exhibit 8, next page).

The second result was the participation of leaders from different institutions and sectors, allowing them to develop a shared regional vision and generate multisectoral plans of action, with the idea that interventions such as the San Rosa Health Center should be copied and extended to other local and regional levels.

[24]The program contemplated a six-month period after graduation for participants to finalize their action plans. The results described in this section occurred during that timeframe and are attributable to QHC.

Exhibit 8. Adolescent Delivery Care Post-Partum Services and Adolescents Accessing Orientation and Counseling Reproductive Health Services, 2011-2012



Source: Health Information System. Santa Rosa Health Center. 2011 -2012

The third result was the successful preparation and submission of a local project in sexual and reproductive health to prevent teen pregnancies. This was prepared by an alumnus, who received $120,000 from the extractive industry tax earnings fund. Fifty proposals were submitted to this competition.

The fourth result in Ayacucho was that the San Cristobal National University of Huamanga adopted the PIM for a competency-based curriculum for use in all 26 of its disciplines, which include human medicine, nursing, obstetrics, veterinary medicine, pharmacology, social work, and biology. The university is now applying the PIM in its nursing, medicine, and midwifery programs, and using it as part of its continual improvement program for operations and management.

In the Ucayali region, an intercultural component was discussed to improve health service delivery, and an official decree was issued to mandate the follow-up of the PIM intercultural criteria in all performance assessments conducted in the region.

NEOP and SERUMS

QHC facilitated and validated the design and implementation of a new employee orientation program for people starting service in rural and marginal urban areas of San Martin, Ucayali, and Ayacucho. The previous orientation had been criticized for being too formal, relying on PowerPoint presentations instead of effective, one-on-one interaction among health authorities and officers and the new workers. The QHC orientation program included engaging activities and effective learning methods, including the “museum technique” or “mini-university,” demonstrations, case studies, simulations, and participatory learning exercises among peers. At the time this final report was being prepared, there had not been a quantitative study to determine why the new approach was better. However, technical teams in the regions have reported that, after the new orientation, 517 professionals had a better understanding of what is expected of them during the 12 months they will be at their posts.

QHC provided technical assistance to the San Martin DIRESA to adjust its NEOP and to organize the orientation program used with its second cadre of SERUMS in 2012. It also provided technical assistance to the Ayacucho DIRESA to design a NEOP, including an orientation on how to incorporate an intercultural approach during delivery of healthcare services. The MOH General Directorate of Human Resources participated in this design and in the approval of an orientation calendar for the incoming SERUMS cadre. The Ayacucho NEOP followed most of QHC's recommendations, and combined didactic and hands-on activities, as well as visits to HCFs.

Based on the practical application of the SERUMS orientation activities in the San Martin and Ucayali DIRESAs, the MOH decided to incorporate the "museum technique" into its national administrative directive for organizing SERUMS orientation activities across the country. This method includes the implementation of several work stations at which a facilitator presents and discusses a specific issue: Moving from station to station, small groups have ample opportunities to interact, ask questions, participate in hands-on exercises,, exchange experiences, and receive practical tips. This process increases the participants' understanding of the regional priorities and cultural context of the areas where they will be working. Also in Ucayali, QHC and INMED Andes, an NGO, conducted training for 65 SERUMS professionals from August 1-3, 2012. The courses focused on the intercultural aspects necessary to improve comprehensive healthcare.

Results-Based Budgeting Approach

Through technical assistance provided by QHC, $275,500 was identified — in addition to the amount leveraged in MCH and FP/RH — and officially allocated in the three regions' results-based budgeting and in their annual operational plans. Regional teams, working with financial software used by the Ministry of Economy and Finance, introduced justifications in line item budgets to include quality improvement activities that could be used in regional maternal and neonatal strategic work plans. To help HCFs reduce performance and quality gaps, 51 public investment projects valued at $4.4 million were formulated. Furthermore, five model guides were produced to explain how to present public sector projects to improve maternal, neonatal, and infant care; prevent child malnutrition, adolescent pregnancy, and sexually transmitted infections, including HIV/AIDS; and control infection and bio-security.

Photo: Eva Miranda

New personnel attend an orientation in Moyobamba, San Martin. May 2012.

D. Unintended Results

In April 2013, the MOH General Directorate of Human Resources formally requested that QHC deliver the plans to incorporate SERUMS professionals in the other health regions.

Based on feedback from the first group of professionals in 2012, the MOH decided this was the best way for the new people to assimilate into their working environments. This has decreased the number of adaptation problems and improved the quality of service provided.

CHAPTER 5. LESSONS LEARNED

Change takes time; people will not adopt new behaviors overnight. It is vital that implementers and donors recognize that the accomplishments detailed in this report occurred over a five-year period and some initiatives are still in progress. It is from this experience that we compiled our lessons learned — lessons that could be useful for future programs working in the sector. The hope is that by sharing this information, programs can use the QHC experience to continually improve health programming.

Leadership

Leaders make the difference. Effective leaders at the local, regional, and national levels have a tremendous impact on whether initiatives are successful. Gaining their buy-in from the outset is imperative if an initiative is going to be successful. In Lluyllucucha, for example, a strong local leader gave rise to a culture of quality, *Yo Soy Calidad en Salud* ("I am quality in health"), which is prevalent at every level of the regions' micro-network workforce. Intensive work in the initial stage of program implementation will help these leaders understand program initiatives and "sell them" to teams. Leadership at universities is also important: being open to participating in a pilot, taking an active role in its success, then promoting it by ensuring the development of a new curriculum and course offering. Leadership and personal initiative on other levels is equally as important. On QHC, an obstetrician went beyond her normal routine work and implemented an intercultural approach to increase health access for women to receive prenatal care.

Supervision

Supportive supervisory systems to encourage performance and continual improvement are vital when new procedures and processes have been introduced. Furthermore, reinforcing these new behaviors is critical to sustainability. The regional resolutions in Ucayali, Huanuco, Lima, Madre de Dios, and Cusco that formalized recognition mechanisms based on measured performance improvement offered incentives for employees to continue learning and improving. These types of recognition measures should be put in place as soon as possible to reinforce positive behaviors from LLDP inception.

Context

Success is more likely when goals and plans combine national, regional, and local needs. Ideas and approaches need to have bottom-up (local) and top-down (MOH) participation. For example, implementation of the Infection Zero Initiative in INSN's pediatric ICU to standardize central line placement and maintenance procedures led to a CLABSI rate of zero during several months in 2012. The MOH and EsSalud are now promoting this experience to other facilities. Similarly, because the PIM could be adapted to the realities and idiosyncrasies of different regions and, perhaps, different micro-networks, it (and other approaches) could be tailored each local context. This increased opportunities for success and minimized opportunities for failure. It is also important to note that such experiences are powerful incentives for stakeholders to participate.

USAID | PERU | CALIDAD EN SALUD

DEL PUEBLO DE LOS ESTADOS UNIDOS DE AMÉRICA

SUCCESS STORY

Modeling Culturally Responsive Services

With support from USAID, Peruvian health facilities are increasing indigenous women's access to culturally appropriate maternal health services

Photo: PSR Tacshitea

Obstetricians Jovany Acosta Flores and Nestor Fredhy Luyo Vallejos Vidal create a stool for vertical delivery as part of the Tacshitea referral health post's efforts to create a culturally appropriate birthing room.

"The work that has been achieved in Tacshitea is striking and is based on perseverance and continuity of the health staff, as well as their desire to offer caring, quality health care."

—Jovany Acosta, head of PSR Tacshitea from 2008 to 2011

Indigenous women in Peru traditionally have had much lower access to essential maternal health services. This gap is cultural and practical: indigenous women of childbearing age do not readily seek health services, and providers do not have the training or facilities to provide culturally appropriate care, despite their commitment to doing so.

To evaluate the quality of maternal and child health services in Ucayali, the USAID|Peru|Quality Healthcare program supported Ucayali's regional health directorate (DIRESA) in conducting the first assessment of maternal-infant health services. The July 2010 assessment revealed important gaps. Women lacked information and were not comfortable meeting with health providers. Also, staff at health facilities did not have experience with vertical delivery (birth in an upright position) and other culturally appropriate services. Perhaps the most significant finding was indigenous women's discomfort with procedures they found embarrassing, such as gynecological examinations, which kept them from seeking or accepting standard maternal health services.

Working with international donors, DIRESA used this information to develop a "Joint plan for vertical delivery with cultural adaptation" to help guarantee that maternal-infant services are attuned to users' cultures. As part of the plan, the United Nations Population Fund and Children's Fund provided training in intercultural dialogue and vertical delivery, and the USAID|Peru|Quality Healthcare program conducted guided visits to show how other health centers had integrated gender-sensitive and intercultural services. The program team also designed improvement plans to aid health facilities in closing gaps in care.

The referral health post in Tacshitea has distinguished itself in applying the initiative. Five of its nine health facilities serve communities of the Shipibo-Conibo ethnic group, and local health providers are committed to respecting the customs of those communities. With the technical training and support received under the joint plan, and a new birthing room that allows vertical delivery, the Tacshitea post now offers services that women feel more comfortable seeking.

The results are clear. Between 2010 and 2011, assisted vertical deliveries increased from one to nine, indigenous women's demand for sexual health services increased from 15 to 38 percent, and 269 pregnant women visited the post, up from 197. Recognizing the value of these results, DIRESA added ethnic variables to health service forms and, in a February 2012 regional directive, approved criteria for improving equality and inter-culturalism. These changes, coupled with an evidence-based policy to guide them in providing user-centered, culturally sensitive maternal health service delivery, have paved the way for other facilities to start replicating Tacshitea's success.

Collaboration

Encourage collaboration from the beginning. QHC found an NGO, Solaris Peru, that was outside of the prescribed scope of work but was willing to contribute its resources implementation, expanding reach to more communities. Sometimes, the most unlikely partnerships yield great results. QHC also collaborated with the Healthy Communities and Municipalities II Project and two local universities to create and implement a successful university-level diploma course which is now part of their curriculum. The partnership led to a better program, built on the special capabilities of all involved, and created a sustainable product. Furthermore, QHC helped train district health and municipality officers to formulate mPIPs for different kinds of health interventions, a collaboration that helped spread success in the regions.

Results-Based Decision-Making

A monitoring and evaluation system, results-based reporting, and decisions based on evidence are critical to assess performance, make adjustments, and continually improve. Partners such as INSN have data showing that improvements in the IHI rate have inspired other facilities to inquire about use and adoption of the PIM. Establish a way to collect data from the beginning so activities can quickly demonstrate results.

Photo: Silvana Bolaños

A PIM workshop for maternal-child health services in Huamanga, Ayacucho. April 2009.

The hospitals and HCFs that developed performance improvement plans based on gaps identified through the PIM made positive, beneficial decisions. They could then be successful by tapping available resources to buy supplies, refurbish clinical areas, provide equipment, motivate health workers, and appropriately inform users and patients.

Pre-Service Integration

The PIM must become incorporated into university pre-service curricula to ensure its continual diffusion and sustainability. New graduates will enter the healthcare system with these skills, and they will be reinforced on the job. This is a very cost-effective way to influence a culture of quality and an immediate opportunity to apply those new technologies, procedures, and tools. Rather than health workers having to “unlearn” something from their professional preparation, they are building on an established knowledge base.

Knowledge Management

Any program, regardless of technical area, should be designed to encourage continuous learning and intended results. This applies to health workers at the local, regional, and national levels who could benefit from professional knowledge exchanges to discuss

experiences that could increase the potential for sustainable improvements. The exchange visits that teams from Ucayali had to Cusco to implement infection prevention and control measures at primary care facilities were a clear example of this, as was the trip a team from Madre de Dios made to Loreto to learn from the HAART decentralization process.

Tutorial activities developed with the LLDP participants were another example. During the program, 7-10 days were allocated for participants to finish their action plans. Mentoring and coaching by professionals from different public and private organizations was provided to ensure participants had the support and assistance they needed.

Sustainable Training Systems

High turnover was noted as an issue over and over throughout implementation. Therefore, educational programs to teach health workers new and continuing skills must occur regularly. The inclusion of pre-service training can help ensure that new personnel have the requisite knowledge and skills to provide the highest standards of care from Day 1. A continuous training program will ensure that personnel receive refreshers and updates, and stay current with new and evolving healthcare practices.

Civil Society Engagement

Accountability for improvement plans is up to local HCFs, with follow up by civil society, which can plan for implementation as it was originally intended. Programs should encourage collaboration with civil society actors because they encourage third-party accountability and can be part of the solution. Getting civil society engaged and participating benefits all stakeholders.

Ownership

Assuming responsibility and accountability for improving the quality of healthcare services requires institutions and individuals to take ownership and lead the charge to bring about the desired changes. The commitment, participation, and collaboration that the MOH and DIRESAs had with QHC were very important. These organizations accepted and adjusted key interventions for their own purposes, creating an ownership culture that enabled participation and collaboration at all levels to find solutions to close gaps. QHC was successful in that process; it listened to their needs, responded quickly to demands for technical support, and considered feedback and suggestions. As a result, national strategies adopted QHC's technical interventions.

Another example of this was the active participation of affected patients associations and representatives from native and indigenous communities. These groups advocated strongly in favor of keeping best practices available to assure quality of services. Local NGOs (e.g., Solaris Peru, CARE, and IDIPS del Norte), watchdog organizations (e.g., the Regional Council to Fight Poverty in San Martin, Ayacucho, and Lima, the Regional Institute of Ayacuchan Women in Ayacucho, and the Regional Ombudsman Office in Madre de Dios), and public sector organizations such as the National Penitenciary Institute also allowed QHC to expand its interventions and a keep track record of its achievements in reducing the quality gaps found at the HCF level. Please see Annex C for detailed information on the number and type of organizations that partnered with QHC. Annex D contains a list of QHC team members.

CHAPTER 6: RECOMMENDATIONS FOR SUSTAINABILITY AND CONCLUSIONS

Sustainability was an important part of QHC. The work carried out was guided by two main principles to maximize the sustainability of its interventions:

1. *Peruvian leadership and ownership.* QHC focused on ensuring that the process — including planning, designing, implementing, and monitoring activities — was driven by Peruvian health institutions and supported the decentralization of Peru's health sector. Throughout the five years of implementation, the MOH, DIRESAs, local HCFs, and their health workforces were actively involved in defining program activities, setting targets, and continuous monitoring of desired results.

2. *Institutionalization.* Every activity, from training to complex regional strategy design, was by and for local partners. This ensured that the permanent quality improvement approach, methods, materials, and activities were passed on and reinforced the application of the PIM and standards. This approach is depicted in the Road to Institutionalization designed by QHC in Annex E.

Below are the specific recommendations for sustainability of QHC's programs, interventions, and activities.

LEADERSHIP, PARTNERSHIPS, AND COLLABORATION

For HIV at the DIRESA Level

- DIRESAs need to continue coordinating with the universities to strengthen the capacity of the tutors working at the training sites.

- Coordination between DIRESAs and the Regional Multisector Health Coordination Council to assure communities' social participation is recognized as an essential component of health management in the region.

For TB the DIRESA Level

- Monitor and follow up on the different resolutions or ordinances about of TB prevention and control to continue involving more actors and to mobilize additional resources in favor of prevention, treatment and control of the disease.

- Continue strengthening the active social accountability component in support of TB patients.

For Other Public Health Threats at the MOH Level

The MOH should continue promoting expansion of the Infection Zero Initiative and the PIM as a managerial tool to standardize critical procedures associated with IHI. Technical meetings to share learning experiences and recommendations from participants in the pilot will be a powerful mechanism to get new participants on board. Association with healthcare providers from other sectors (e.g., social security, military, police, and the private sector)

must continue. The MOH should consider inviting the Association of Private Clinics of Lima during Phase 2 of the Infection Zero Initiative.

For MCH and FP/RH at the MOH DIRESA Levels

- Consolidate the partnerships established with universities, local governments, civil society organizations, and NGOs to reinforce their participation in advocating and supporting the performance and quality improvement processes at the HCFs following a similar model used in Ayacucho, where the Regional Coordination Council to Fight Poverty organizes monthly meetings. In those meetings, a close follow-up is conducted by the organizations represented in that council to the DIRESA interventions directed to improve the health of adolescents, most-at-risk vulnerable populations, women, children, and families.

- Make official the MOH's DGSP unit that will supervise the implementation of Administrative Directive 193-193-MINSA/DGSP-V.01regarding the PIM.

- Support the San Cristobal National University of Huamanga and the National University of Ucayali for continuing to offer the LLDP.

- Build a partnership with a human resources development institution in San Martin to offer LDDP in the region.

- Establish mechanisms to promote accountability from DIRESAs and micro-networks to local governments and civil society organizations that are similar to what is described in the first bullet above or the mechanism used by the Yanaoca micro-network in Cusco, which implemented quarterly visits for monitoring, supervision, and accountability with all its HCFs.

- Civil society organizations can and should participate in the advances and challenges for implementation of the PIM. Identify potential partners from USAID cooperation that can participate in building these mechanisms.

- Implement monthly follow-up meetings among PIM facilitators at the micro-network and DIRESA levels. These should be organized by the regional human resource directors or micro-network manager or director, if needed.

OWNERSHIP AND INTEGRATION INTO REGULAR SYSTEMS

For HIV at the MOH Level

The MOH needs to continue providing supervision at least every six months to training sites to verify that they continue operating regularly.

For HIV at the DIRESA level

DIRESAs should continue supervision efforts at least every six months to verify that newly accredited facilities provide HAART and periodic medical examinations to MARPS, as established in the current regulations.

For Other Public Health Threats at the Hospital and National Institute Levels

To increase the odds of sustainability, interventions need to be officially recognized as day-to-day activities, have funding activities and funding assigned in current budgets, and a trained team in charge of follow-up.

For Other Public Health Threats at the MOH/EsSalud Levels

To expand the Infection Zero Initiative to other hospitals, evidence of sustainable interventions from INSN and Guillermo Almenara that included the following actions should be considered:

- Their improvement plan, based on best practices, was official and substantiated by a directorial decree. The implementing teams were led by the Quality Management Office.

- The 2013 Annual Operations Plan included funding for improvement activities. This was a critical element to assure sustainability of the process, showing the efficiency of quality teams that demonstrated the results of its interventions.

- Almenara Hospital management issued several memoranda that made implementation of the Infection Zero Initiative official and assigned funding for its expansion to all ICUs in the hospital. These files should be forwarded to the executive office of EsSalud and be used as examples for other interested hospitals.

For MCH and FP/RH at the DIRESA Level

- Ensure the incorporation of PIM activities into DIRESA and micro-network annual operations plans. The micro-network manager or director should be responsible for leading this process.

- The regional health director is primarily responsible for maintaining and extending the accountability mechanisms for PIM implementation, by ensuring that DIRESAs follow Administrative Directive 193-193-MINSA/DGSP-V.01, management agreements, and other mechanisms.

- Incorporate PIM results as a potential mechanism for measuring performance in future performance-based schemes for DIRESAs and micro-networks.

- Keep explicit those budget line items dedicated to support PIM activities.

- DIRESAs should continue leading the development of mPIPs to finance activities that bridge performance gaps.

RECOGNITION OF SUCCESSFUL EXPERIENCES

For TB at the MOH Level

- Continue supporting the recognition activities of healthcare personnel who worked to support TB patients in the different levels of healthcare.

- Support the dissemination of successful activities in mass media outlets (e.g., MOH websites, regional and local government newspapers, TV channels, and radio stations).

For Other Public Health Threats at the Hospital, National Institute, and EsSalud Levels

In April 2012, the INSN held a recognition ceremony for workers who contributed to reducing CLABSI rates at the ICU and in other critical care areas. In December 2012, a presentation to all department and unit chiefs confirmed that the INSN was considered as the "gold standard"[25] to be followed by hospitals of a similar nature. The MOH should approach the INSN to assist other interested hospitals to develop their own programs. Consider the INSN as a center of excellence for best practices.

CAPACITY TO IMPLEMENT THE PERFORMANCE IMPROVEMENT METHODOLOGY

For HIV at the DIRESA Level

- DIRESAs should continue working with universities operating in the region to incorporate the PIM into the curricula of pre-service education, especially for health professions.

- DIRESAs should implement a regular mechanism for follow-up with the universities to identify possible knowledge gaps in the curriculum and assist in providing the updates.

- Identify and recognize successful experiences.

- The regional health directors and managers for social development should take advantage of the excellent relationship that has been built with representatives from different public and private sector organizations. The DIRESAs, following what is stated in Ministerial Decree 556-2012 approving the PIM administrative directive, should institute an annual ceremony where outstanding workers and HCFs can be recognized.

For TB at the MOH Level

Continue supporting the expansion of PIM implementation according to Ministerial Resolution 556-2012 in regions beyond the QHC coverage area.

For MCH and FP/RH at the DIRESA Level

- Develop a regular mechanism for PIM orientation, implementation, and training for new DIRESA and micro-networks officers.

- Maintain at least one PIM facilitator per micro-network. Provide regular orientation and training activities to replace facilitators who leave the micro-network.

- Continue using the NEOP that has included the PIM.

[25] Dr. Peter Pronovost, director of the Armstrong Institute for Patient Safety at the Johns Hopkins Hospital, used these words at the closing ceremony of the 29th International Conference of the International Society for Quality in Healthcare in Geneva, Switzerland, in October 2012.

FURTHER CONCLUSIONS

There were numerous important and sustainable achievements and results during QHC's five years of implementation. Though the team faced myriad challenges — from health worker strikes and poor staff retention/high turnover to dengue fever outbreaks and floods that led to emergency decrees to cease all operational activities — it managed to surmount the obstacles and leave behind a solid base upon which to improve the Peruvian healthcare system.

There are opportunities for current and future USAID programs to continue or build on this solid base. As new projects are designed or begin implementation, it is important to look at relevant associated activities from QHC and other programs. Special interventions such as LLDP and NEOP are applicable to other sectors and could be adapted with minimal difficulty. The PIM methodology should be expanded to the broader health community and could be adapted to other sectors. Of particular importance is that the PIM methodology is known and followed as much as possible by other USAID-funded projects, including those assisting the decentralization process of health and education in the Amazonian Region of Peru. These are just a few examples.

The legacy of QHC will thrive as long as there is participation and political buy-in at the highest level from the onset of any new projects or programs that incorporate its approach, methodology, and tools. QHC was able to achieve results because all levels of the health system actively participated in the process and there was the leadership necessary for success. The timing for introduction of the PIM, for example, coincided perfectly with a need identified by the MOH, ensuring that decentralized healthcare services provided and accessed throughout the country were equitable and met the quality standard. Regional and local authorities were engaged from Day 1 of implementation. The future of quality healthcare services is now in Peru's hands.

La Calidad esta en Tus Manos!
(Quality is Your Hands!)

ANNEX A. NORMS AND GUIDELINES UPDATED OR DEVELOPED WITH QHC TECHNICAL ASSISTANCE[1]

	Norm or Guideline Name	Status
1	Administrative Directive No. 193-MINSA/DGSP-V01: Performance Improvement Methodology Based in Best Practices for Healthcare in the Primary Care Level.	Approved by Ministerial Decree No. 556-2012/MOH
2	Health Technical Norm No. 097-MINSA/DGSP-V01: Comprehensive Care of Adults Infected by the Human Immuno-Deficiency Virus.	Approved by Ministerial Decree No. 607-2012/MOH
3	Health Directive No. 064-MINSA/DGSP-V2: Prophylaxis of the Mother-to-Child Transmission of HIV and Syphilis.	Approved by Ministerial Decree No. 946-2012/MOH
4	Health Directive No. 053-MINSA/DGE V0.1: Reporting of Cases for Tuberculosis Surveillance.	Approved by Ministerial Decree No. 179-2013/MOH
5	Health Directive for Evaluation of Obstetric and Neonatal Functions.	Approved by Ministerial Decree No. 853-2012/MOH
6	Technical Norm of Family Planning.	Undergoing the approval process
7	Manual of Family Planning.	Undergoing the approval process at the MOH
8	Manual of Orientation and Counseling in Reproductive Health.	Undergoing the approval process at the MOH
9	Health Technical Norm: Implementation and Use of the Maternal and Perinatal Record and the Applicative to conduct analysis of Maternal and Perinatal Production Indicators.	Undergoing the approval process at the MOH
10	Technical Norm: Comprehensive Care of Adolescents during Pregnancy, Delivery and in the Puerperal Period.	Undergoing the approval process at the MOH
11	Technical Norm: Comprehensive care and HAART treatment of children and Adolescents infected by HIV.	Undergoing the approval process at the MOH
12	National Guideline: Adherence to HAART of Adults Infected by HIV.	Undergoing the approval process at the MOH
13	Administrative Directive: Decentralization of HAART Provision in Peru.	Undergoing the approval process at the MOH
14	Clinical Practice Guideline: Management of the HIV/TB Co-infection.	Undergoing the approval process at the MOH
15	Technical Norm: Tuberculosis Prevention and Control.	Undergoing the approval process at the MOH
16	Technical Norms: Comprehensive Care of Patients Affected by XDR-TB.	Undergoing the approval process at the MOH

Ministry of Health; General Directorate of People Health; General Directorate of Epidemiology; HAART; HIV; TB; Extreme Drug Resistant Tuberculosis.

[1] Until June 10, 2013

ANNEX B. PERFORMANCE MONITORING AND EVALUATION PLAN RESULTS — 2013 (SUMMARY)[1]

No.	Indicator	Value	Years					
			2008[2]	2009	2010	2011	2012	2013[3]
1	Number of Periodic Medical Examinations (Evaluaciones Médicas Periódicas in Spanish) performed on MARPS	Target	Not determined (ND)	10000	10500	11025	ND	
		Actual	9109	9419	10746	38564	43349	
2	Percent of NSHIV guidelines current with generally accepted scientific knowledge, WHO recommendations and guidelines, and other relevant reference documents	Target	0	100	100	100	100	
		Actual	0	0	40	75	100	
3	Number of DISA/DIRESA that implement HIV prevention and control interventions with at least two other institutions addressing MARPS and responding to local needs	Target	ND	4	4	4	2	
		Actual	0	3	3	4	3	
4	Number of STI/HIV/AIDS health clinics that conduct performance assessments at least once per year	Target	ND	0	5	16	16	
		Actual	0	0	5	17	25	
5	Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful[4]	Target	ND	ND	ND	1500	650	
		Actual	0	0	75	420	684	
6	Number of local organizations provided with technical assistance for HIV-related institutional capacity building	Target	ND	ND	ND	50	50	
		Actual	0	16	105	393	421	

[1] Source: QHC monitoring and evaluation system 2013.
[2] Baseline as of program initiation, July 2008.
[3] Achieved as of 2012 for ID activities and 2013 for MCH and FP/RH. ID activities ended in December 2012.
[4] Periods correspond to USAID fiscal years.

No.	Indicator	Value	Years					
			2008[2]	2009	2010	2011	2012	2013[3]
7	Number of DISA/DIRESA that publish electronic bulletins with HIV/AIDS epidemiological and operational information	Target	Not available (NA)	0	0	0	5	
		Actual	0	0	0	0	2[5]	
8	Percent of registered new smear positive pulmonary TB cases that were cured and completed treatment under DOTS nationally - Treatment success rate	Target	ND	ND	ND	ND	95	
		Actual	87.6	89.1	89.6	88.1	NA	
9	Number of DISA/DIRESA with DOTS programs that perform at or above 95% on the identification of expected number of suspicious TB cases	Target	ND	3	7	6	2	
		Actual	0	0	0	0	0	
10	Number of DISA/DIRESA with DOTS programs which attain cure rates at or above 95%	Target	ND	3	7	6	2	
		Actual	0	0	0	0	NA	
11	Number of DISA/DIRESA with DOTS-Plus programs achieving 90% or higher drug-susceptibility testing among people with approval to initiate MDR-TB treatment	Target	ND	3	7	6	2	
		Actual	0	NA	2	4	0[6]	
12	Number of DISA/DIRESA with DOTS-Plus programs which attain MDR-TB cure rates of 60% or higher	Target	ND	11	11	6	2	
		Actual	NA	2	NA	NA	NA	
13	Number of people trained in TB sub-elements with USG funding[7]	Target	ND	ND	ND	800	500	
		Actual	0	106	812	1237	1003	

[5] NSHIV from the DISAs in Lima Ciudad, Lima Este, and Lima Sur, and the DIRESA in Callao elaborated their 2012 Semester I e-bulletin. QHC supported the DISAs and the DIRESA almost to completion of the activity; each completed its e-bulletins on its own.
[6] Available information considers only percentage of patients with drug-susceptibility testing results, excluding those with testing attempted but without results because of in adequate quality laboratory techniques.
[7] Periods correspond to USAID fiscal years.

No.	Indicator	Value	Years					
			2008[2]	2009	2010	2011	2012	2013[3]
14	Number of health networks that conduct performance assessments in their TB services at least once per year	Target	ND	4	9	22	15	
		Actual	0	3	8	10	7[8]	
15	Number of DISA/DIRESA that publish electronic bulletins with TB epidemiological and operational information	Target	NA	NA	NA	NA	6	
		Actual	NA	0	0	0	2[9]	
16	Number of hospitals that use the Infection Zero web application	Target	ND	0	5	10	10	
		Actual	0	0	0	0	2	
17	Model for institutionalizing hospital infection prevention and control activities tested	Target	ND	0	0	1	1	
		Actual	0	0	0	1	1	
18	Number of USG-assisted health institutions with quality improvement plans for preventing hospital infections[10]	Target	ND	ND	ND	18	10	
		Actual	0	0	7	7	7	
19	Number of hospitals that use the Infection Zero web application	Target	ND	0	5	10	10	
		Actual	0	0	0	0	2	
20	Percent of birth attended by a skilled doctor, nurse or midwife	Target	ND	ND	ND	ND	ND	
		Actual	79.4	82.5	83.8	85	86.7	

[8] QHC ended activities in the DISAs in Lima Ciudad, Lima Este, and Lima Sur, and the DIRESA in Callao earlier (July 2012).
[9] NSTB from the DISAs in Lima Ciudad, Lima Este, and Lima Sur, and the DIRESA in Callao elaborated their 2012 Semester I e-bulletin. QHC supported the DISAs and the DIRESA almost to completion of the activity; each completed its e-bulletins on its own.
[10] Periods correspond to USAID fiscal years.

No.	Indicator	Value	Years					
			2008[2]	2009	2010	2011	2012	2013[3]
21	Percent of micro-networks with improvement plans on MCH services according to PIM	Target	NA	100	100	100	100	100
		Actual	0	22	9	50	100	100
22	Percentage of HN that finance PIM activities for MCH services	Target	ND	100	100	100	100	100
		Actual	0	100	100	100	100	100
23	Number of institutions with improved management of maternal and child health programs or services	Target	ND	ND	ND	900	695	200
		Actual	0	100	57	143	754	628
24	Number of DISA/DIRESA with a Regional Staff Development Plan which integrates best clinical and management practices for maternal, neonatal and child services on MNCH into employee training activities	Target	ND	0	0	0	2	1
		Actual	0	0	0	0	2	1
25	Percent of micro-networks (MN) that attain 50% increase in or 80% compliance with best practices for child health services	Target	ND	5	10	40	100	100
		Actual	0	0	0	15.5	36.9	44.8[11]
26	Percent of MN that attain 50% increase in or 80% compliance with best practices for maternal and neonatal health services	Target	ND	5	10	40	100	100
		Actual	0	0	1.2	19.3	37.3	41.0[12]
27	Number of laws, policies or procedures drafted, proposed or adopted with USG assistance designed to improve prevention of or response to sexual and gender based violence at the regional, national or local level	Target	ND	0	0	0	1	1
		Actual	0	0	0	1	1	1

[11] Total achievement comparing last assessment against baseline.
[12] Total achievement comparing last assessment against baseline.

No.	Indicator	Value	Years					
			2008[2]	2009	2010	2011	2012	2013[3]
28	Percent of health facilities that use the maternal and perinatal information system	Target	ND	ND	ND	ND	100	100
		Actual	NA	NA	NA	NA	100	100
29	Number of designed posters with information about child health, nutrition and services availability ready for print	Target	NA	0	0	0	4	4
		Actual	0	0	0	0	0	4
30	Modern methods contraceptive prevalence rate	Target	ND	ND	ND	ND	ND	ND
		Actual	48.8	50	50.5	51.1	51.8	NA
31	Percent of MN with improvement plans on RH/FP services according to PIM	Target	NA	100	100	100	100	100
		Actual	0	22	9	50	100	100
32	Percent of HN that finance PIM activities for RH/FP services	Target	ND	100	100	100	100	100
		Actual	0	100	100	100	100	100
33	Number of institutions with improved management of RH/FP programs or services[13]	Target	ND	140	55	340	350	200
		Actual	0	100	57	143	754	628
34	Percent of satisfied users in FP/RH services	Target	ND	ND	ND	ND	ND	70
		Actual	NA	NA	NA	36.0	NA	30.9
35	Percent of MN that attain 50% increase in or 80% compliance with best practices for FP/RH services	Target	ND	5	10	40	100	100
		Actual	NA	0	1.2	16.7	20.2	31.0[14]

[13] Periods correspond to USAID fiscal years.
[14] Total achievement comparing last assessment against baseline.

No.	Indicator	Value	Years					
			2008[2]	2009	2010	2011	2012	2013[3]
36	Percent of MN with people trained to provide balanced counseling and orientation (BCO) to adults and adolescents in compliance with current regulations	Target	ND	NA	NA	NA	100	100
		Actual	0	0	0	20	42.7	53.2
37	MOH technical norm for services to pregnant adolescents that includes FP/RH counseling validated	Target	ND	NA	NA	NA	1	1
		Actual	0	0	0	0	1	1
38	Number of individuals trained on the use of the technical norm for services to pregnant adolescents that includes FP/RH counseling	Target	ND	NA	NA	NA	NA	25
		Actual	0	0	0	0	0	56
39	Percent of MN that produce reports on FP commodities use through SISMED	Target	ND	0	0	100	100	100
		Actual	0	100	100	100	100	100
40	Number of DISA/DIRESA with stocks of adequate mix of FP/RH commodities to meet clients' needs	Target	ND	0	0	3	2	1
		Actual	0	2	2	3	2	NA[15]
41	Number of DIRESA/DISA with basic and refresher training activities for SISMED and logistics management incorporated into their regional staff development plan	Target	ND	0	0	0	2	1
		Actual	0	0	0	0	2	1

[15] This intervention ended in March 2013. Consequently, there was not a final evaluation to determine stock levels for the year.

ANNEX C. QHC PROGRAM COLLABORATORS

Health Sector: Public Entities
1. Ministerio de Salud (MOH)
2. Ministerio de Economía y Finanzas - Dirección General de Presupuesto Público – PpR
3. Estrategia Sanitaria Nacional de VIH/SIDA
4. Estrategia Sanitaria Nacional de Tuberculosis
5. Estrategia Sanitaria Nacional de Salud Sexual Reproductiva
6. Dirección General de Salud de las Personas
7. Dirección Ejecutiva de Gestión Sanitaria de la (DGSP)
8. Dirección Ejecutiva de Atención Integral de Salud (DGSP)
9. Dirección General de Gestión del Desarrollo de Recursos Humanos
10. Dirección General de Medicamentos, Insumos y Drogas
11. Dirección de Salud V-Lima Ciudad
12. Dirección de Salud IV-Lima Este
13. Dirección de Salud II-Lima Sur
14. Dirección Regional de Salud Ancash
15. Dirección de Salud Apurímac I
16. Dirección de Salud Apurímac II-Andahuaylas
17. Dirección Regional de Salud Amazonas
18. Dirección Regional de Salud Ayacucho (teaching site, LLDP)
19. Dirección Regional de Salud Callao
20. Dirección Regional de Salud Cusco
21. Dirección Regional de Salud Huánuco
22. Dirección Regional de Salud Huancavelica
23. Dirección Regional de Salud Ica
24. Dirección Regional de Salud Lambayeque
25. Dirección Regional de Salud La Libertad
26. Dirección Regional de Salud Loreto
27. Dirección Regional de Salud Madre de Dios
28. Dirección Regional de Salud Puno
29. Dirección Regional de Salud San Martin
30. Dirección Regional de Salud Tacna
31. Dirección Regional de Salud Ucayali (teaching site, LLDP)
32. EsSalud
33. Instituto Nacional de Salud (INS)
34. Instituto Nacional Materno Perinatal
35. Instituto Nacional de Salud del Niño (INSN)
36. Hospital Nacional Guillermo Almenara
37. Hospital Nacional Docente Madre-Niño San Bartolomé
38. Hospital Nacional Cayetano Heredia
39. Hospital Nacional Daniel Alcides Carrión
40. Hospital Nacional Edgardo Rebagliati Martins
41. Hospital Central de la Fuerza Aérea del Peru
42. Hospital Regional de Loreto-Iquitos
43. Hospital de Apoyo de Iquitos
44. Hospital Amazónico de Yarinacocha (teaching site, LLDP)
45. Hospital Regional de Ayacucho (teaching site, LLDP)

Health Sector: Public Entities (Cont.)
46. Hospital Regional de Pucallpa - CERITS (teaching site)
47. PARSALUD II (teaching site, LLDP)
48. Centro de Salud Bartolomé de las Casas, Cusco (teaching site)
49. Centro de Salud San Juan - CERITS, Iquitos (teaching site)
50. Centro de Salud Campo Verde (teaching site)
51. Micro Red de Salud Urubamba (teaching site)

Regional and Local Governments
1. Gobierno Regional de Madre de Dios
2. Gobierno Regional de Loreto
3. Gobierno Regional de Ucayali
4. Gobierno Regional de San Martin
5. Oficina de Gerencia de Desarrollo Social Ucayali
6. Oficina de Gerencia de Desarrollo Social Loreto
7. Oficina de Gerencia de Desarrollo Social San Martin
8. Oficina de Gerencia de Desarrollo Social Ayacucho
9. Gerencias de Nacionalidades Indígenas Loreto
10. Municipalidad Provincial Canas, Yanaoca, Cusco
11. Municipalidad de Coronel Portillo Ucayali
12. Municipalidad de Ayna-Ayacucho
13. Municipalidad de Laberinto Madre de Dios
14. Municipalidad de la Victoria
15. Municipalidad Metropolitana de Lima
16. Municipalidad Provincial de Huamanga (teaching site, LLDP)
17. Municipalidad Distrital de Colta, Ayacucho
18. Municipalidad Provincial de Parinacochas, Ayacucho
19. Municipalidad Provincial de Paucar del Sara Sara, Ayacucho
20. Municipalidad de Pullo, Ayacucho
21. Municipalidad Distrital de San Francisco Rivacayo, Ayacucho
22. Municipalidad de Chavina, Ayacucho
23. Municipalidad de Pacapausa, Ayacucho
24. Municipalidad Distrital de Quinua, Ayacucho
25. Municipalidad Distrital de Sivia, Ayacucho
26. Municipalidad Distrital de Ayna, Ayacucho
27. Municipalidad Distrital de Luricocha, Ayacucho
28. Municipalidad Distrital de Iguain, Ayacucho
29. Municipalidad Distrital de Acoro, Ayacucho
30. Municipalidad Distrital de Chungui, Ayacucho
31. Municipalidad Distrital de Chuschi, Ayacucho
32. Municipalidad Distrital de Cangallo, Ayacucho
33. Municipalidad Distrital de San Juan Bautista, Ayacucho
34. Municipalidad Distrital de Belén, Ayacucho
35. Municipalidad Distrital de Barranquita, San Martin
36. Municipalidad Provincial de Moyobamba, San Martin
37. Municipalidad Distrital Piscoyacu, San Martin
38. Municipalidad Distrital Piscoyacu, San Martin

Regional and Local Governments (Cont.)
39. Municipalidad Distrital de Tingo de Ponasa, San Martin
40. Municipalidad Provincial de Lamas, San Martin
41. Municipalidad Distrital de Tingo de Ponasa, San Martin
42. Municipalidad Distrital de Morales, San Martin
43. Municipalidad Provincial de Picota, San Martin
44. Municipalidad Distrital de Tres Unidos, San Martin
45. Municipalidad Distrital de Chazuta, San Martin
46. Municipalidad Distrital de Saposoa, San Martin
47. Municipalidad Distrital de San Roque de Cumbaza, San Martin
48. Municipalidad Distrital de Nueva Cajamarca, San Martin
49. Municipalidad Distrital de Banda de Shilcayo, San Martin
50. Municipalidad Distrital de Buenos Aires, San Martin
51. Municipalidad Distrital de Bajo Biavo, San Martin
52. Municipalidad Distrital de Alto Biavo, San Martin
53. Municipalidad Distrital de Campo Verde, Ucayali
54. Municipalidad Distrital de Campo Verde, Ucayali
55. Municipalidad Distrital de Contamana, Ucayali
56. Municipalidad Distrital de Calleria, Ucayali
57. Municipalidad Distrital de Curimaná, Ucayali
58. Municipalidad Distrital de Iparia, Ucayali
59. Municipalidad Distrital de Irazola, Ucayali
60. Municipalidad Distrital de Manantay, Ucayali
61. Municipalidad Distrital de Nueva Requena, Ucayali
62. Municipalidad Provincial de Padre Abad, Ucayali
63. Municipalidad Distrital de Sepahua, Ucayali
64. Municipalidad Distrital de Yarinacocha, Ucayali
65. Municipalidad Distrital de Yurua, Ucayali
66. Municipalidad Provincial de Atalaya, Ucayali (teaching site, LLDP)

Other Public Entities
1. Instituto TELESUP
2. INPE: Instituto Nacional Penitenciario, oficina de Madre de Dios
3. DEVIDA
4. Ministerio de Economía y Finanzas (MEF) - Dirección de Presupuesto Público (teaching site, LLDP)

Other Entities
1. Colegio Médico del Peru (CMP)
2. Colegio de Enfermeras del Peru
3. CooperativaVirgen de las Nieves (teaching site, LLDP)

Health Sector: Private Entities
1. Clínica Ricardo Palma
2. Semillas de Palma Aceitera Nuevo Amanecer (SEMPALMA, S.A./teaching site, LLDP)

NGOs
1. The International Union Against TB and Lung Diseases
2. VOXIVA
3. Pathfinder International – Peru (teaching site, LLDP)
4. IRMA: Instituto Regional de la Mujer Ayacuchana
5. Instituto de Salud MSC “Cristóforis Denéke” ISDEN (teaching site, LLDP)
6. World Wildlife Fund-Peru (teaching site, LLDP)
7. Microfinanzas PRISMA
8. CARE Peru
9. Socios en Salud – Peru (Partners in Health)
10. IDID del Norte (Instituto de Desarrollo e Investigación del Norte)
11. Manuela Ramos
12. Futuras Generaciones
13. INPPARES
14. Red SIDA Peru
15. PROMSEX
16. APROPO: Apoyo a Programas de Población
17. INMED Andes-Alianzas por los Niños
18. Asociación Interétnica de Desarrollo de la Selva Peruana-AIEDESEP
19. Instituto de Salud MSC “Cristóforis Déneke”- ISDEN
20. World Wildlife Fund-Peru
21. Alianza para los Niños (INMED) (SERUMS Ucayali)

Universities
1. Universidad Nacional Amazónica de Madre de Dios (UNAMAD)
2. Universidad Nacional San Antonio Abad - Cusco (UNSAAC)
3. Universidad Alas Peruana – Filial Pucallpa
4. Universidad Alas Peruana - Filial Puerto Maldonado
5. Universidad Nacional Mayor de San Marcos (UNMSM)
6. Universidad Nacional de Ucayali (UNU)
7. Universidad Nacional San Cristóbal de Huamanga - Ayacucho (UNSCH)
8. Universidad Nacional de la Amazonia Peruana (UNAP)
9. Universidad Nacional de Trujillo (UNT)
10. Universidad Nacional de San Martin (UNSM)
11. Universidad Peruana Norbert Wiener

International Agencies
1. The Quality and Safety Research Group, affiliated to Johns Hopkins Hospital
2. Organización Panamericana de la Salud (OPS)
3. Organización Mundial de la Salud (OMS)
4. Fondo de Población de las Naciones Unidas (UNFPA)

Other USAID Programs
1. USAID|Peru|Municipios y Comunidades Saludables II (teaching site, LLDP)
2. Programa de Desarrollo Alternativo (PDA)
3. PRODES - Ucayali (teaching site, LLDP)
4. USAID|Peru|Suma
5. USAID|Programa de Desarrollo Alternativo - Ucayali

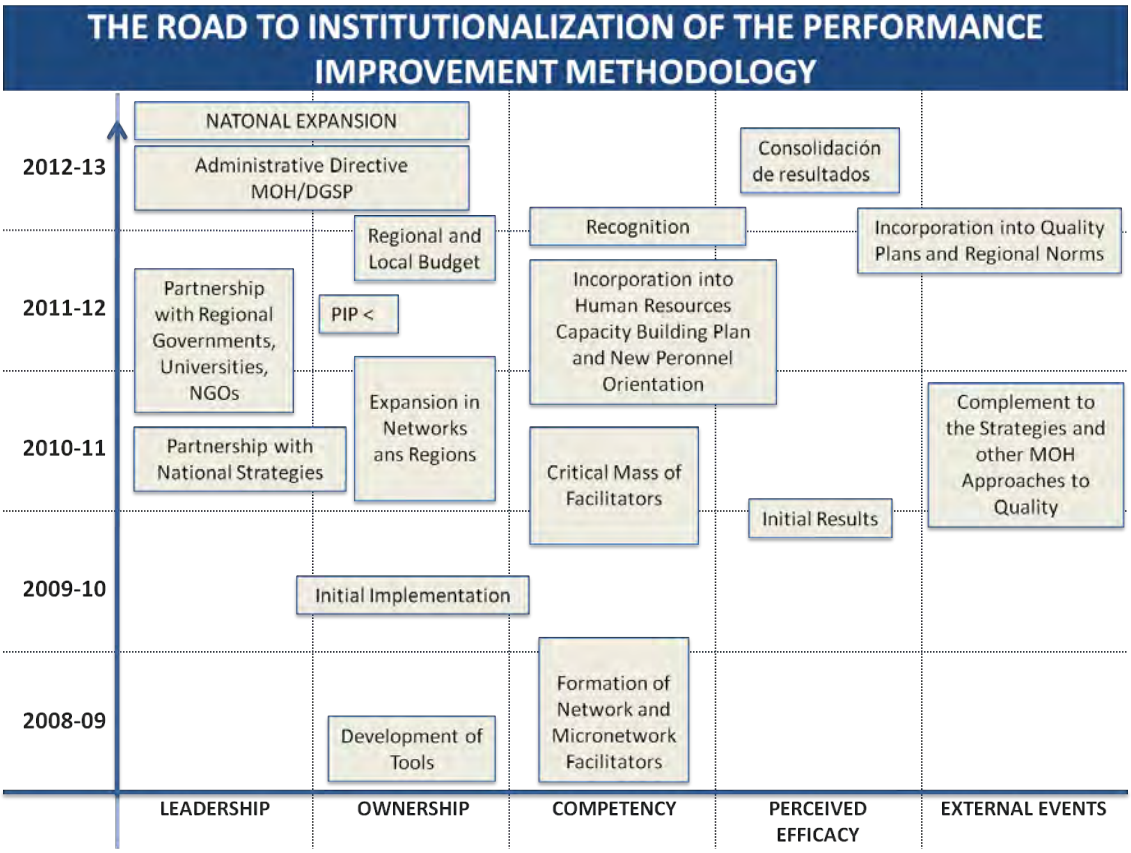
Associations
1. Asociación de Pacientes Afectados por TB-ASPAT
2. Asociación de Pacientes Afectados por VIH/SIDA
3. Asociación SOLARIS-Peru

ANNEX D. QHC TEAM MEMBERS

Name	Position
Marcia Alarcón	Contadora
Iris Allison	Digitadora Monitoreo y Evaluación
Pamela Alvarez	Recepcionista
Lourdes Álvarez	Especialista de Operaciones de Campo
Sweet Anderson	Asistente del Área SAPF
Cesar Arroyo	Especialista de Operaciones de Campo
Silvana Bolaños	Asistente del Área de Comunicaciones
Jorge Cachay	Especialista IT
Pablo Campos	Director Técnico
Paola Chacaltana	Apoyo de Comunicaciones
Giovanna Chumpitaz	Asistente Administrativa
Beatriz Cobian	Especialista de Monitoreo y Evaluación
Isabel Corahua	Asistente Contable
Oscar Cordón	Jefe de Proyecto
Dalila Correa	Asistente Contable
Cepriano Damas	Asistente de Oficina
Guillermo Frías	Gerente de Operaciones de Campo
Rigoberto García	Especialista del Equipo Materno Infantil
Ruth Juscamaita	Apoyo en M&E
Angel León	Chofer
Maria Elvira León	Especialista en Desarrollo de Capacidades Locales
Pamela Lovón	Gerente de Oficina
Selene Manga	Líder del Equipo de Enfermedades Infecciosas
Edith Marquez	Monitoreo y Evaluación
Alberto Mendoza	Líder del Equipo de Enfermedades Infecciosas
Catherine Mendoza	Asistente administrativa
Eva Miranda	Especialista en Desarrollo de Capacidades Locales
Ana Morales	Especialista del Equipo de Enfermedades Infecciosas
Jean Morote	Gerente SAPF
Araly Muñoz	Gerente de Operaciones
Ivanna Narduzzi	Especialista de Comunicaciones
Jose Luis Orbegoso	Especialista IT
Alberto Padilla	Líder del Equipo de Monitoreo y Evaluación
Pamela Peralta	Contadora
Maria Luz Pérez	Especialista de Comunicaciones

Name	Position
Cesia Quispe	Gerente de Oficina
Cesar Ruiz	Chofer
Luisa Sacieta	DCOP
Rosa Saenz	Asistente de Mantenimiento
Yuly Soria	Monitoreo y Evaluación
Andrea Soto	Asistente Comunicaciones
Beatriz Ugaz	Líder del Equipo Materno Infantil
Milka Urrutia	Oficina Principal de Finanzas
Rodolfo Valdez	DCOP
Rosa Maria Valle	Especialista de Operaciones de Campo
Rubén Vasquez	Especialista de Operaciones de Campo
Alfonso Villacorta	Líder del Equipo Materno Infantil
Marcela Youle	Gerente de Operaciones

ANNEX E. THE ROAD TO INSTITUTIONALIZATION OF THE PIM



ANNEX F. DVD CONTENTS[1]

A. Norms, Guidelines, and Technical Documents

Norms Approved
1. *Administrative Directive No.193-MINSA/DGSP-V01: Performance Improvement Methodology Based on Best Practices for Healthcare at the Primary Care Level, Directiva Administrativa No 193-MINSA/DGSP-V01Metodología para la Mejora del Desempeño basado en Buenas Prácticas • *Implementation plan for the normative document. Plan de Implementación del Documento Normativo: Directiva Administrativa "Metodología de Mejora del Desempeño en Base a Buenas Prácticas para la Atención de Salud en el Primer Nivel de Atención" 2012-2013 • *Guidelines to implement the performance improvement methodology workshops. Pautas para los talleres de implementación de la Metodología de Mejora del Desempeño en Base a Buenas Prácticas para la Atención de Salud
2. Norma Técnica de Salud de Atención Integral del Adulto con Infección por el Virus de Inmunodeficiencia Humana (VIH) No.097-MINSA/DGSP-V.01
3. *Health Technical Norm No946-MINSA/DGSP – V2: Prophylaxis of the Mother to Child Transmission of HIV and Syphilis. Norma Técnica de Salud para la Profilaxis de la Transmisión Madre – Niño del VIH y la Sífilis Congénita NTS No 946- MINSA/DGSP – V-02
4. *Health Directive No 053 – MINSA/DGE – V01. Reporting of Cases for Tuberculosis Surveillance. Norma Técnica de Salud para el Control de la Tuberculosis No. 053-MINSA/DGE V0.1 • Health Directive for Evaluation of Obstetric and Neonatal Functions. No. 853-2012. Directiva sanitaria de evaluación de las Funciones Obstétricas y Neonatales en los establecimientos de salud No 853-2012

Guidelines
*Methodological Guidelines for Training of Peers of the LGTB population. Guía Metodológica de Capacitación dirigida a los y las promotoras educadoras de Pares de la Población HSH Y TRANS

Technical Documents
1. *National Plan to Strengthen the Primary Care level. Plan Nacional de Fortalecimiento del Primer Nivel de Atención 2011-2021
2. *Desk review of quality interventions in Peru from 1990 – 2011. Revisión Documental de Experiencias de Mejora de la Calidad de la Atención en los Servicios de Salud. Periodo 1990-2011
3. * Decentralization of the Integrated Care of HIV/AIDS Affected Patients. Descentralización de la atención integral a personas con ITS/VIH/SIDA a través del desarrollo de capacidades del personal. La experiencia Ucayali y Loreto
4. Plan TBCero enfoque integral para la prevención y control de la TB en el Cerro San Cosme. Revisión de la Experiencia
5. Plan TBCero. A Comprehensive Approach to Tuberculosis Prevention and Control in the San Cosme Health Center
6. *Systematization Report of the Quality Healthcare Program. Reporte de sistematización del Proyecto USAID|Perú|Calidad en Salud
7. *Feasibility study of Neonatal Male Circumcision in Peru. Estudio de factibilidad de Circumcision masculine neonatal
8. *Survey Results of Perception of Quality in Family Planning Services. Encuesta de Satisfacción de Usuarias de Servicios de Planificacion Familiar en las Regiones de San Martín y Ayacucho 2013

[1] An asterisk indicates a title has been translated into English in this index but the document itself exists in Spanish only.

Technical Documents
9. Rapid Assessment of the Quality Healthcare Program Legacy
10. Resumen Técnico: Fortalecimiento del Sistema de Salud del Perú por el Proyecto USAID|Perú|Calidad en Salud
11. Resumen Técnico: 21 años de USAID|Perú mejorando la calidad de la atención en salud
12. Technical Brief: USAID|Peru's 21 Years of Effort to Improve the Quality of Healthcare Delivery
13. Technical Brief: USAID|Peru's Quality Healthcare Program Strengthens the Healthcare System in Peru
14. Reporte de las Tendencias hacia la Reducción Sostenible de las Infecciones Adquiridas en la Atención de la Salud (IAAS) en Servicios críticos del Instituto Nacional de Salud del Niño
15. *Guidelines for Performance Improvement Methodology workshops. Pautas para el Desarrollo de Talleres de la Metodología para la Mejoría del Desempeño
16. Quality Healthcare Final Report
17. Performance Monitoring and Evaluation Plan Results 2013 (Summary)
18. Performance Monitoring and Evaluation Plan Results 2013. Disaggregated indicators
19. *Health Management Syllabus/Syllabus de Gerencia en Salud

Norms Undergoing Formal Approval
1. *Technical Norm of Family Planning.: Undergoing the approval process. Norma Nacional de Planificación Familiar (en proceso de aprobación)
2. Manual of Family Planning
3. *Manual of Orientation and Counseling in Reproductive Health. Manual de Orientación y Consejería en Salud Reproductiva
4. *Health Technical Norm: Implementation and Use of the Maternal and Perinatal Record and the Application to conduct analysis of Maternal and Perinatal Production Indicators. Historia Clínica Materno Perinatal y el aplicativo analítico (SIP2000)
5. *Technical Norm: Comprehensive Care of Adolescents during Pregnancy, Delivery and in the Puerperal Period. Norma Técnica de Atención Integral de Adolecentes durante el Embarazo, Parto y Puerperio
6. *Technical Norm: Comprehensive care and HAART treatment of children and Adolescents infected by HIV. Norma Técnica de tratamiento integral y TARGA de niños y adolescents infectados por VIH
7. *National Guideline: Adherence to HAART of Adults Infected by HIV. Guía Técnica de Adehrencia al TARGA para Adultos infectados por el VIH
8. *Administrative Directive: Decentralization of HAART Provision in Peru. Directiva Administrativa de Descentralización de los Servicios de TARGA en el Perú
9. *Clinical Practice Guideline: Management of the HIV/TB Co-infection. Guía Técnica de Coinfección de TB y VIH
10. *Technical Norm: Tuberculosis Prevention and Control. Norma Técnica de Salud para el Control y Prevención de la Tuberculosis
11. *Technical Norm: Comprehensive Care of Patients Affected by XDR-TB. Norma Técnica del Tratamiento Integral de los Pacientes Afectados por TB-XDR

B. QHC MATERIALS

Health Care Providers' Materials
1. Afiche: Decisiones Iniciales Durante la Consulta de Planificación Familiar
2. Afiche: Colección Muestra de Esputo
3. Afiche: Flujograma de Identificación de Sintomáticos Respiratorios en Establecimientos de Salud
4. Afiche: Todos buscamos e identificamos Sintomáticos Respiratorios en el Establecimientos de Salud

Health Care Providers' Materials

5. Afiche: Genotype MTDR Plus
6. Afiche: Manejo Sindrómico de las Infecciones de Transmisión Sexual
7. Afiche: Flujograma para el tamizaje de VIH en el primer Nivel de Atención
8. Afiche: Flujograma para la atención a usuarios con ITS/VIH en el primer nivel de atención
9. Afiche : Flujograma para la atención a usuarios con prueba rápida de VIH reactiva en hospital
10. Panel: Sala Situacional TB
11. Fichero de seguimiento al paciente con TB
12. Rotafolios: "La Tuberculosis se cura"
13. Afiches Salud- Materno Infantil
14. Kit de orientación y consejería balanceada en planificación familiar

Informational Materials

1. Poster Metodología de Mejora del Desempeño (MMD)
2. Poster Planificación Familiar y Salud Reproductiva (PF SR)
3. Poster Salud Materno-Infantil (SMI)
4. Poster Infecciones Intra-hospitalarias (IIH)
5. Poster Programa de Desarrollo de Liderazgo Local (PDLL)
6. Poster Tuberculosis (TB)
7. Poster VIH/SIDA/TARGA
8. Infografía del Proyecto USAID|Perú|Calidad en Salud
9. Afiche: "Mi Derecho a una Atención de Calidad"

Brief Notes on Selected Topics of QHC implementation

1. Se inicia proceso de mejora de la calidad en Abancay
2. DIRESA Huánuco cuenta con nuevos facilitadores de la Mejora del Desempeño
3. Calidad en Salud con enfoque humano
4. Evaluación Nacional de Lucha contra el VIH y Sida
5. El Instituto Nacional de Salud del Niño (INSN) emprende mejoras por la seguridad del paciente
6. Vigilancia epidemiológica para la prevención de infecciones
7. Actores sociales, candidatos regionales y especialistas analizan la situación sanitaria de Ancash
8. Nuevo método para la prevención de VIH y SIDA
9. En el Día Mundial de lucha contra el SIDA Información que previene el VIH
10. MINSA premia a ganadores de VII Encuentro nacional de experiencias de calidad
11. El INSN avanza a paso seguro
12. Presidentes regionales electos reafirman compromiso por la salud materno infantil y la nutrición
13. Ucayali hace balance y reconocimientos de las intervenciones de mejora de la calidad
14. En la lucha contra la Tuberculosis
15. V Foro: Concertando esfuerzos para controlar la Tuberculosis en La Libertad
16. La salud en I Congreso Latinoamericano
17. DIU post-parto: un aliado contra la mortalidad materna
18. Un modelo de atención integral pensando en la familia y la comunidad
19. Nuevas oportunidades para prevenir el VIH. El Impacto de la circuncisión neonatal masculina
20. PROSALUD favorecerá el Aseguramiento Universal
21. Sedes docentes y pasantías en ITS, VIH y SIDA
22. 10 Años de Calidad en el Ministerio de Salud
23. CIGS: Avances y compromisos en la gestión sanitaria
24. Nuevos facilitadores para la Mejora del Desempeño

Brief Notes on Selected Topics of QHC implementation
25. Desarrollo Provincial Concertado y Monitoreado
26. Desarrollo de Liderazgo en Ayacucho y Ucayali -PDLL
27. Orientación y Consejería Balanceada en el Día de la Planificación Familiar
28. Mejorar la calidad del servicio de salud para enfrentar la mortalidad materna
29. Ucayali está de luto
30. Lima Respira Vida – propuestas multisectoriales contra la TB
31. Convocatoria a periodistas por la prevención del embarazo adolescente
32. Continúa Módulo II de Liderazgo en Ucayali -PDLL
33. Abordaje Intercultural en la salud de Ucayali
34. Ganadores de Concurso MINSA – Prevención del Embarazo en Adolescentes
35. Mejoras progresivas y sostenibles en el INSN
36. Balance de intervenciones de Calidad en Salud se realiza conjuntamente con MINSA
37. Proyectos de Inversión Pública, necesarios para mejorar los indicadores sanitarios
38. Participación multisectorial en la lucha contra la tuberculosis
39. El Programa de Desarrollo de Liderazgo Local sigue avanzando
40. El Proyecto Calidad en Salud en la 139a Reunión Anual de APHA
41. Calidad en Salud participa en el Encuentro Nacional del SNCDS
42. Socialización del plan conjunto para la prevención y control de ITS/VIH
43. Calidad en Salud participa en VIII Encuentro Nacional de Experiencias en Mejoramiento Continuo de la Calidad
44. Alcances de la mejora del desempeño en el INSN
45. Fortalecimiento de capacidades para las buenas prácticas de desempeño
46. MINSA y Calidad en Salud en reunión de validación de directiva administrativa para la mejora del desempeño
47. Hacia un Plan de Desarrollo de Capacidades en San Martín
48. Avances y desafíos en la respuesta regional a la TB y VIH/SIDA
49. The Lancet publica investigación en prevención de ITS en el Perú
50. Conversatorios MINSA sobre salud de los adolescentes
51. Alternativa para reducir impacto de la Tuberculosis en Madre de Dios
52. 24 de marzo, Día Mundial de Lucha Contra la Tuberculosis
53. Entrega de 2000 Kits de Orientación y Consejería Balanceada
54. Nuevo portal web de tuberculosis se presenta a regiones
55. MINSA presenta nuevo Portal Web de tuberculosis
56. Culmina exitosamente el Programa de Desarrollo de Liderazgo Local en Ucayali
57. Autoridades regionales reconocen y felicitan el esfuerzo a la mejora del desempeño en Ucayali
58. Estrategias para la implementación de la metodología de mejora del desempeño en base a buenas prácticas a partir del avance regional
59. Continúa la oficialización de la mejora del desempeño en Ucayali
60. Reconocimiento a la mejora de la calidad en los servicios críticos del INSN
61. Personal de salud de Lluyllucucha concursa con proyecto de mejora de calidad

Brief Notes on Selected Topics of QHC implementation

62. Culmina exitosamente el Programa de Desarrollo de Liderazgo Local en Ayacucho
63. DIRESA San Martín aplica metodología innovadora en inducción a personal nuevo – SERUMS
64. Formación de Facilitador de facilitadores en la Metodología de Mejora del Desempeño
65. MINSA aprueba la "Metodología de Mejora del desempeño en Base a Buenas Prácticas para la Atención de Salud en el Primer Nivel de Atención"
66. Ceremonia de Reconocimiento y Transferencia de la Metodología de Mejora del Desempeño en la Dirección de Salud Lima Este
67. Transferencia de Actividades y Ceremonia de Reconocimiento en Iquitos
68. Conferencia Mundial sobre el SIDA 2012 llegó a nuestro país
69. Región Ucayali cuenta con sede docente calificada para el desarrollo de capacidades en la atención integral de salud del niño
70. DIRESA Ucayali desarrolla programa de capacitación, con enfoque intercultural, para profesionales del SERUMS
71. Incrementado el acceso a servicios de calidad en ITS y VIH/SIDA en la Región Ucayali
72. Encaminados hacia la sostenibilidad
73. El proyecto Calidad en Salud transfirió las actividades del componente Materno Infantil, y Planificación Familiar y Salud Sexual y Reproductiva a la Región Ucayali
74. Los pacientes de Ucayali tienen diagnóstico de Tuberculosis Multi-drogo-resistente en tiempo record
75. Universidad Nacional San Cristóbal de Huamanga Incorpora la Metodología de Mejora del Desempeño en la formación de estudiantes de Ciencias de la Salud
76. Participante del Programa de Desarrollo de Liderazgo Local gana financiamiento del Fondo de Desarrollo Socioeconómico de Camisea
77. Laboratoristas participan de la Certificación de baciloscopistas de la DIRESA Ucayali
78. Auspicio académico permite la certificación de facilitadores regionales en la Metodología del Desempeño del componente de enfermedades infecciosas
79. DIRESA Ucayali cuenta con Plan de Desarrollo de las Personas Quinquenal que permitirá el fortalecimiento de capacidades de los recursos humanos
80. Incrementa el número de Facilitadores Regionales de la Metodología de Mejora del Desempeño en base a Buenas Prácticas para la atención de salud
81. DIRESA Ayacucho incorpora a profesionales SERUMS 2012-II desarrollando programa de inducción con enfoque intercultural y participativo
82. DIRESA San Martín aprueba Plan de Desarrollo de las Personas Quinquenal 2013-2017 que contribuye al logro de objetivos sanitarios
83. En la 29 Conferencia Mundial de la Sociedad Internacional para la Calidad en la Atención Médica, ISQUA 2012 se reconoce la experiencia de mejora de la calidad del Instituto Nacional de Salud del Niño.
84. Presentación del Plan Multisectorial para la Prevención del Embarazo en Adolescentes 2012 – 2021
85. Implementación de la prueba rápida molecular Genotype® MTBDRplus en la DIRESA Madre de Dios
86. Conferencia Internacional de la Sociedad Internacional para la Calidad de Atención Médica – ISQua 2012. Highlights from the conference
87. Profesionales de la Región Ayacucho mejoran capacidades en AIEPI clínico utilizando el software AIEPI – ICATT
88. Establecimientos CLAS son reconocidos por mejoras en el desempeño
89. La oferta de servicios de prevención y control de tuberculosis se ha incrementado en la Región Madre de Dios

Brief Notes on Selected Topics of QHC implementation

90. Capacidades de la Red Huamanga, Ayacucho para proveer servicios de calidad en salud sexual y reproductiva y en planificación familiar fueron fortalecidas
91. Mejoras en la Estrategia Sanitaria Regional de Prevención y Control de Tuberculosis de Madre de Dios son reconocidas
92. Presentación de la experiencia en ISQua 2012 motiva a los equipos de trabajo del INSN
93. La comunidad es informada sobre el Plan Estratégico Multisectorial para la Prevención y Control de ITS/VIH/SIDA en Madre de Dios
94. Se Fortalecen Capacidades para la Prevención y Control de la Tuberculosis en Ucayali.
95. Encuestadores reciben capacitación para la realización de la encuesta sobre Satisfacción de Usuarios de Planificación Familiar en Ayacucho.
96. DIRESA Ayacucho Inicia la Construcción del Plan de Desarrollo de las Personas Quinquenal 2013 – 2017
97. Ceremonia de reconocimiento, transferencia y cierre de actividades del Proyecto USAID|Perú|Calidad en Salud en Madre de Dios
98. Ceremonia de reconocimiento, transferencia y cierre de actividades del Proyecto USAID|Perú|Calidad en Ucayali
99. Región San Martín Forma Facilitadores Regionales en la Metodología de Mejora del Desempeño
100. Regiones Madre de Dios y Apurímac certifican facilitadores regionales de la Metodología de Mejora del Desempeño
101. La Universidad Nacional Mayor de San Marcos incorpora la Metodología de Mejora del Desempeño en el curso de Gerencia en Salud
102. La Capacitación en Planificación Familiar de la Adolescente Gestante motiva al personal de salud en Ayacucho
103. Proyecto USAID|Perú|Calidad en Salud hace entrega oficial de materiales elaborados al Ministerio de Salud
104. DIRESA Ayacucho cuenta con nuevos facilitadores regionales para la implementación de la Mejora del Desempeño en base a Buenas Prácticas para la Atención en Salud
105. Universidad San Cristóbal de Huamanga incorpora la Metodología para la Mejora del Desempeño en la currícula de la carrera de Medicina Humana
106. Facilitadores de Ayacucho y San Martin fueron capacitados en el uso del Aplicativo para el Procesamiento de las Mediciones del Desempeño
107. Taller para reformular el Plan de Desarrollo de las Personas se realizó en Ayacucho
108. Ceremonia de Reconocimiento, Transferencia y Cierre de Actividades del Proyecto USAID|Perú|Calidad en Salud en Ayacucho

SNAPSHOTS

1. A Successful Model of Intersectoral Work to Develop Local Capacity (Un modelo exitoso de trabajo intersectorial para el desarrollo de capacidades locales)
2. Public Investments Improve Local Health (Fomento de la inversión pública para mejorar la salud local
3. Cambios posibles y visibles)
4. Pensando en ellas …
5. Un Mapa para acercarse al VIH y SIDA
6. INSN Working to Increase Patient Safety; El INSN avanza a paso seguro
7. Anita, una paciente exitosa
8. Polita, una facilitadora del cambio
9. Ucayali: un ejemplo de diálogo social y mejora del desempeño
10. Un ambiente seguro para la atención de la TB
11. No hay cambio sin liderazgo
12. Campo Verde dice NO a las infecciones
13. Elsa, contra viento y marea
14. Mejoras progresivas y sostenibles
15. Inversión pública para mejorar la salud local (PIPS)

SNAPSHOTS

16. Lluyllucucha, Achieving Patient-Oriented Healthcare; Lluyllucucha, una atención de salud pensada en sus usuarias
17. Modeling Culturally Responsive Services; Implementando servicios culturalmente adecuados-Taschitea

Bulletins

Boletín No. 1
Pucallpa: Identifican competencias para proveer servicios de ITS, VIH y Sida | Lima: Calidad en Salud participó en VI reunión de calidad – Hospital Casimiro Ulloa | Lima: Infecciones Zero, es pionero en Latinoamerica | Se fortalecerán capacidades del personal de salud con la implementación de AIEPI

Boletín No. 2
Loreto – Ucayali: Se evalúa impacto de circuncisión neonatal masculina para prevenir VIH | Lima: MINSA y Calidad en Salud, juntos en el fortalecimiento del primer nivel | Lima: Se incrementa captación de sintomáticos respiratorios en Santa Luzmila | Lima: Una forma educativa de hacer consejería en planificación familiar | Lima: Resolución ministerial reconoce el cumplimiento de estándares de calidad | Ucayali: AIEPI-ICATT una tecnología de capacitación para mejorar la salud infantil | Lima: 33 nuevos facilitadores en MMD para los servicios de TB de la Red Lima Ciudad

Boletín No. 3
Ayacucho y Ucayali: Líderes en Ayacucho y Ucayali | Cusco y Lima: Manejo activo del alumbramiento para una maternidad segura | Lima y Callao: Se fortalecen competencias de consejería en ITS y VIH para gestantes | Ucayali: Pasantía en ITS,VIH y SIDA | Ucayali: Municipalidad Provincial Coronel Portillo invierte en prioridades de salud

Boletín No. 4
Ucayali: Visitas guiadas para mejorar el desempeño en promoción de la salud | Lima: Un enfoque multisectorial para el control de la Tuberculosis en Lima Cercado | San Martín: Concertación y financiamiento para fortalecer capacidades en salud | San Martín: Mejores servicios de salud para mejorar la nutrición infantil | San Martín: Establecimientos de salud miden su desempeño y elaboran planes de mejora | Lima: Acreditación de Calidad asegurada en Institutos de Salud | Lima – Comas: en marcha la articulación intersectorial para prevenir Tuberculosis

Boletín No. 5
Callao – Lima: Participación de la sociedad civil en la sostenibilidad de la mejora del desempeño | Callao – Lima – Loreto – Madre de Dios – Ucayali: Motivando al cambio: nuevo enfoque de acción | Ayacucho – San Martín – Ucayali: Usuarios y usuarias satisfechas en los servicios de planificación familiar | Ayacucho – San Martín – Ucayali: Mejora la información de planificación familiar | Ayacucho – Ucayali: La mentoría en el Programa de Liderazgo Local | Andahuaylas – Cusco – Puno: Trabajo conjunto con SOLARIS Perú | Ayacucho: Fortalecer capacidades para reducir brechas

Boletín No. 6
Lima: Se valida directiva administrativa para institucionalizar la mejora del desempeño | Lima: Experiencia exitosa de la estrategia TBCero | Madre de Dios: Reconocimiento a la mejora del desempeño de personal de salud en Madre de Dios | Lima: Iniciativa conjunta contra la TB | Lima: Contribución de Calidad en Salud en Reporte de Parto Normal y Parto Complicado | San Martín: Próximos pasos en la reducción de la mortalidad materna

Boletín No. 7
Ucayali: Plan de mejora para el diagnóstico de tuberculosis en Ucayali | Lima: Reconocimiento a la mejora de la calidad en el INSN | Ucayali: Exitosa clausura del Programa de Desarrollo de Liderazgo Local en Ucayali | Lima: Mejorando los servicios de salud reproductiva y planificación familiar | Lima: Experiencias exitosas en mejora de calidad serán presentadas en Ginebra | San Martín: Personal de salud de Lluyllucucha gana pasantía con proyecto de mejora

Boletín No. 8
Iniciativas regionales utilizando la Metodología de Mejora del Desempeño en base a buenas prácticas | TBCero, un plan para San Cosme | Presupuesto por Resultados garantiza mejoras en la calidad de atención en salud | Un diagnóstico rápido y efectivo: Genotype® MTDRplus | Programa de Liderazgo Local fortalece competencias en salud de líderes locales | Fortalecimiento de capacidades para el
desarrollo de competencias

Bulletins
Boletín No. 9 Proyecto USAID|Peru|Calidad en Salud presentó resultados de encuesta satisfacción de usuarias de servicios de planificación familiar en Ayacucho y San Martín | Infografía del proyecto USAID|Perú|Calidad en Salud: 5 años de trabajo en una imagen | DIRESA Ayacucho cuenta con nuevos facilitadores regionales para la implementación de la mejora del desempeño en base a buenas prácticas para la atención en salud.

Videos
1. Quality Healthcare reaches remote Peru 2. Acción comunitaria de salud en Lluyllucucha – San Martin 3. Alto Amazonas y Datem del Marañón, un corredor social para la salud 4. Ceremonia de reconocimiento: Mejora de la calidad en los servicios críticos del INSN 5. Entrega de oficial de Kits de Orientación y Consejería Balanceada 6. Entrevista a la Lic. Rita Vela Saavedra. Directora de la Oficina de Desarrollo Institucional - DIRESA San Martín / Programa "Criterios y Opinión" 7. Entrevista Antropóloga Helga Prado 8. Método anticonceptivo de planificación familiar 9. Proyecto Calidad en Salud 2008-2013 10. Testimonio de Presidenta de Asociación de Pacientes de TB de Madre de Dios 11. Testimonio Dr. Ángel Luis Gutierrez 12. Testimonio Dr. Jorge Luis Asencios 13. Testimonio Dr. José Luis Aparcana 14. Testimonio Dr. José Luis González 15. Testimonio Dra. Doris Lituma 16. Testimonio Enf. Filida Rabanal Díaz 17. Testimonio Ing. Guisela Godier 18. Testimonio Ing. Guisela Godier - Ceremonia de Clausura Programa de Desarrollo y Liderazgo Local 19. Testimonio Lic. Sofía Velásquez 20. Testimonio Obs. Jovany Acosta 21. Testimonio Obs. Rosario Luciano Aguirre 22. Video de Orientación y Consejería Balanceada 23. Video Resumen: Inducción a serumistas en San Martín 24. Video Demostración en Maqueta de Colocación del DIU 25. Prácticas en maquetas del personal de la red de salud de Huamanga - Ayacucho 26. Demostración del condón femenino- Red de Salud de Huamanga – Ayacucho 27. Photo álbum of TB patients

U.S. Agency for International Development
1300 Pennsylvania Avenue, NW
Washington, DC 20523
Tel: (202) 712-0000
Fax: (202) 216-3524
www.usaid.gov