

Identification of the Degree of Application of the Prioritized Listing of
Guaranteed Health Interventions for the Reduction of Chronic Child
Malnutrition and Neonatal Maternal Health and Guidelines for Technical
Assistance for the Regions of Ancash and Huancavelica.

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Executive Summary

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INTRODUCTION

One of the most important children's health problems in Peru is chronic malnutrition that, according to the 2011 Demographic and Family Health Survey (ENDES), is present nationwide in 16.6% of children less than five years of age, a statistic that increases to 32% in rural areas and in the bottom quintile of poverty, reaches 36.4%.

The comprehensive health of children requires not only the promotion of favorable conditions for their growth and development, but also ensuring that pregnant mothers, and girls and boys benefit from the measures of prevention and treatment available.

Thus, the Partnership for Child Nutrition Project implemented by ADRA, CARITAS, CARE and PRISMA, Non-Governmental Development Organizations with vast experience in the field of health, nutrition and food security projects, develops joint activities to: (i) have an impact on the three levels of government in order to strengthen the implementation of the national policy of fight against chronic child malnutrition (CCM, for its name in Spanish); (ii) strengthen the capacities of the regional governments of Ancash and Huancavelica and eight local governments in these regions in the management of interventions with impact on CCM; (iii) develop, implement, and validate forms of public-private partnership for the management of interventions to combat CCM in district areas; and (iv) promote transparency and accountability in public administration.

To contribute to the design of the forms of public-private partnership, the project needs to know the state of the application of the Prioritized Listing of Guaranteed Health Interventions for the Reduction of Chronic Child Malnutrition and Maternal-Neonatal Health (PLGHI) in the health facilities in the eight districts of Ancash and Huancavelica where it carries out its intervention. The present consultancy performs this diagnosis and proposes guidelines for technical assistance aimed at improving the quality and opportunity of the provision of health care services that affect the reduction of chronic child malnutrition and the improvement of the maternal - neonatal health in those spheres.

The document has four chapters. The first mentions the background and objectives that motivated the preparation of the document; the second chapter presents the methodology used to establish the degree of application of the PLGHI. In the third chapter, the main results found in Ancash and Huancavelica are included; and in the final chapter, the guidelines to consider in the corresponding technical assistance are proposed. Additionally, the annexes are included which contain the criteria of qualification of the degree of application of the PLGHI and the results reached in each one of the 15 health facilities that participated in the study, and other results which were contemplated in the baseline study, in addition to the instruments used for obtaining the qualitative and quantitative information.

CHAPTER I

BACKGROUND AND OBJECTIVES

1.1. BACKGROUND

One of the most important problems of child health in Peru is chronic malnutrition. According to the 2011 ENDES survey, at the national level chronic malnutrition is present in 16.6% of children of less than five years of age, a statistic that increases to 32% in rural areas and reaches 36.4% in the bottom quintile of poverty. Chronic malnutrition is an important indicator of retardation in the physical growth of children as well as of unfavorable surroundings for the optimal development of their potential.

Thus, in the 2006-2011 period the Peruvian State, with Supreme Decree (DS) No. 055-2007-PCM, approved the "CRECER" National Strategy, which established the joint intervention of the National, Regional and Local Government entities related to the fight against CCM.

In that framework, in 2008 the Ministry of Health approved the "Prioritized Listing of Guaranteed Health Interventions for the Reduction of Chronic Child Malnutrition and Maternal-Neonatal Health" (PLGHI). This listing identifies 12 interventions to deal with this problem that have been selected using cost-effectiveness criteria to diminish CCM¹.

The complementary "Technical Health Standard for the Implementation of the PLGHI for the Reduction of Chronic Child Malnutrition and Maternal-Neonatal Health" that contains the standards of fulfillment of the interventions that are subject to audit and which in turn are comprised in the Basic Health Insurance Plan (PEAS) that constitutes a minimum insurance platform for all citizens aimed at the improvement of the quality of health care.

Likewise, the National Government promotes the use of Results-Based Budgeting (PpR), a methodological tool whose objective is that the budgetary process promotes and develops management based on results. PpR is a tool that guarantees not only budgetary availability but that establishes clear results for the attainment of goals in the PLGHI².

1.2. OBJECTIVES OF THE STUDY:

GENERAL OBJECTIVE:

- To determine the degree of application of the Prioritized Listing of Guaranteed Health Interventions for the Reduction of Chronic Child Malnutrition and Maternal-Neonatal Health

¹ Technical Health Standard for the implementation of the Prioritized List of Guaranteed Health Interventions for the Reduction of Chronic Child Malnutrition and Maternal-Neonatal Health. Ministry of Health, Lima 2008.

² PpR is aimed at improving budgetary management, allowing better coordination of intervention planning with the budget and with the implementation of operations and orientation of public expenditures for the attainment of concrete results and impacts.

in the scope of the “Partnership for Child Nutrition” project and to propose guidelines for a Technical Assistance Plan.

SPECIFIC OBJECTIVES:

- To identify the aspects that facilitate or make difficult the application of the interventions contemplated in the PLGHI in Ancash and Huancavelica.
- To propose strategies that allow monitoring and control of the implementation of interventions aimed at the reduction of CCM in Ancash and Huancavelica.
- To develop a proposal for guidelines for a Technical Assistance Plan aimed at the reduction of CCM and maternal - neonatal mortality for the health sector and for the Regional and Local Governments.

1.3 PREVIOUS CONCEPTUAL ASPECTS

The interrelation between the PLGHI and the purposes of the PpR requires that it be conceptualized within the framework of the Comprehensive Health Care Model based on the Family and Community (MAIS-BFC) and the health policies aimed at the reduction of CCM, for which reason a summary is provided below of conceptual aspects that permit their better understanding.

1.3.1 COMPREHENSIVE HEALTH CARE MODEL BASED ON THE FAMILY AND COMMUNITY (MAIS-BFC)

The health care benefits are oriented by the Comprehensive Health Care Model (MAIS) that constitutes the conceptual framework that defines the set of policies, components, systems, processes and instruments that, operating coherently, ensure attention to the person, the family and the community to satisfy their health needs. The MAIS defines the terms on which health care services are organized and perform their activities as well as the manner in which other sectors are complemented by the health sector and how the resources of the State are aimed at improving the health of the population.

The MAIS promotes as its main concern the addressing of the health needs of the people in the context of the family and the community, in coordination with the health sector, the society and other sectors for health promotion, protection, recovery and rehabilitation, while recognizing the rights of people, families and the communities to an equitable, comprehensive care with explicit guarantees regarding quality and timeliness of health care delivery.

Consequently, the MAIS-BFC assumes the political inter-sector intervention from the various levels of government (national, regional and local) on the social determinants of health. It is the cornerstone for improvement of the health condition of the prioritized population. Political advocacy is the fundamental intervention that allows making the MAIS-BFC viable.

Its regulation arises from the necessity that the delivery of these benefits be guaranteed and, and this is achieved by issuing the regulations that approve the implementation of the Prioritized Listing of Guaranteed Health Interventions for the Reduction of Chronic Child Malnutrition and Maternal-

Neonatal Health (PLGHI)³. Likewise, to strengthen the management of health care services, facilitating the performance of comprehensive health care for boys and girls of less than five years of age, and of adolescents and pregnant women, during pregnancy, childbirth and postpartum, that constitute the main strategies to ensure health care for the population.

1.3.2 PRIORITIZED LIST OF GUARANTEED HEALTH INTERVENTIONS (PLGHI)

In order to strengthen the management of health care services and facilitate the implementation of a set of coordinated benefits and actions of comprehensive care directed to children of less than five years of age, and adolescents and pregnant women during pregnancy, childbirth and postpartum, and that these contribute to the reduction of CCM and the protection of maternal-neonatal health, the Ministry of Health approved the “Prioritized Listing of Guaranteed Sanitary Interventions for the Reduction of Chronic Child Malnutrition and Maternal-Neonatal Health”.

The interventions that are considered in the PLGHI are:

a. Preventive interventions that include activities of primary prevention:

- Immunizations of children and pregnant women according to MINSa norms.
- Comprehensive care for children and adolescents according to MINSa norms.
- Reproductive health (counseling and family planning).
- Pregnancy Control.
- Detection, counseling and prevention of infectious diseases.
- Prevention of micronutrient deficiencies in young children.
- Nutritional assessment and counseling.
- Care for newborns without complications.
- Care during pregnancy, childbirth and postpartum.

b. Prioritized recuperative interventions to avoid deterioration of the nutritional state (early diagnosis and early treatment) of the age groups:

- Diagnosis and treatment of acute respiratory infections
- Diagnosis and treatment of acute diarrheic diseases and parasitism of the digestive system
- Diagnosis and treatment of deficiency diseases in children, adolescents and pregnant women.

1.3.3 RESULTS-BASED BUDGETING⁴

Results-Based Budgeting (PpR) is a methodology that is gradually applied to the budgetary process and that integrates the programming, formulation, approval, execution and evaluation of the budget in a vision of achievement of outputs, results and of effective and efficient use of the resources of the State in favor of the population, providing feedback to the annual public budget allocation processes and improving the administrative management systems of the State.

³ Technical Health Standard for the implementation of the Prioritized List of Guaranteed Health Interventions for the Reduction of Chronic Child Malnutrition and Maternal-Neonatal Health. Ministry of Health, Lima 2008.

⁴ Idem supra

The PpR uses instruments such as strategic budget programming, the monitoring of outputs and results through performance indicators, and independent assessments, among others to be determined by the Ministry of Economy and Finance (MEF) in collaboration with other government entities.

The health sector has been implementing the PpR in the coordination of activities in the area of Maternal and Neonatal Health and in the Coordinated Nutrition Program that has allowed the integration of the programming, formulation, execution and evaluation of the budget in a vision of achievement of health outcomes in the reduction of negative health indicators (prevalence of chronic malnutrition in children of less than five years of age, maternal mortality rate and neonatal mortality rate). This allows for the assessment and feedback of the annual expense processes for the reassignment, reprogramming and adjustments in health interventions in the various regions of the country.⁵

1.3.4 STRENGTHENING OF THE FIRST LEVEL OF HEALTH CARE ⁶

In order to guarantee the right of the population to health, the MINSA and the regional governments offer, through the health care services networks, a total of 7,469 health facilities in the country⁷. Of them, 1,306 are Health Centers (HCs) and 6,017 are Health Posts (HPs).

These facilities (HCs and HPs) constitute 98.05% of all the health facilities (HFs) and account for the supply of primary health care; that is to say, they directly provide health care to the citizens. For that reason primary health care is being strengthened within the framework of national health policies and universal health insurance that establish the guidelines to follow to ensure the delivery of health care services.

Among the guidelines, the following are noteworthy: (i) the formation and development of human resources, (II) the development of management capacities, (III) the orientation of health care services towards quality, based on the improvement of care delivery processes, the continuity of care and the timely flow of quality information, key inputs for the planning, monitoring and assessment of performance, (IV) the comprehensive, integrated and continuous care that must locally solve between 70% and 80% of the more frequent basic health care needs of the population throughout life, among others.

1.3.5 INTEGRATION AND COMPLEMENTARINESS OF NORMS FOR THE FULFILLMENT OF (PLGHI)

Given that the LPSIG includes a coordinated set of interventions, it is necessary to develop/provide a conceptual framework of reference that defines the set of policies, components, systems, processes and instruments that, operating simultaneously, organize the health care services and

⁵ See Annex 3. Figure No. 1: Logical Model of the Coordinated Nutrition Program for the allocation to the Results-Oriented Budget.

⁶ National Plan for Strengthening Primary Health Care 2011-2021. Ministry of Health, Lima 2011

⁷ National Register of Health Care Facilities and Supportive Medical Services, accessed on Friday, January 28, 2011, <http://www.app.minsa.gob.pe/renaes/views/inicio.aspx>

guarantee care for persons, family and community, orienting them to satisfy their health care needs, whether or not they are perceived by the population.

This conceptual framework is the MAIS-BFC, given that the set of benefits cannot be delivered without a proper organization of the HFs into functional networks and by levels of care, depending on the complexity of the health care needs of the population, that allows resolving the majority of health problems locally, selecting and referring the more complex cases that require that they be solved at other levels of care⁸.

For the fulfillment of these interventions, there are two forms of budgetary allocation available, the first is through the programmatic demand of health care services, based on historical information on implementations in the jurisdiction of HFs, and the second is the budgetary allocation under the capitated or advance payment mechanism according to the size of the beneficiary population; with both one looks to generate a virtuous circle of financial allocation, efficient use of the resources and achievement of expected health outcomes and impacts.

⁸ See Annex 3. Figure No. 2: Integration of the Prioritized Listing of Guaranteed Interventions with MAIS-BFC, PpR and Strengthening of primary health care.

CHAPTER II

RESEARCH METHODOLOGY

The design of this investigation was cross-sectional and descriptive. The study was developed through a mixed methodology that combined quantitative and qualitative aspects, and documentary analysis.

POPULATION AND SAMPLE

The population of the study consisted of health establishments, health care personnel, regional officials, mayors, community agents and representatives of grassroots organizations in the districts of the study areas in the regions of Huancavelica (Ascension, Yauli Huando and Nuevo Occoro) and Ancash (Marcará, Cátac, Cashapampa and Huayllabamba).

The population of health facilities was 43 in Huancavelica (7 HCs and 36 HPs) and 26 in Ancash (3 HCs and 23 HPs).

CRITERIA FOR SELECTION OF THE SAMPLE

a. HEALTH FACILITIES

- ✚ Health facilities in the area of the districts of the project:
 - Health centers heading micro-networks in the areas of intervention
 - Health posts that maintain a structural and functional relation with the immediately superior HC in the micro-network in the area of intervention.

b. KEY INFORMANTS

- ✚ **HEALTH CARE PERSONNEL:** Health care personnel working in the selected HFs at the moment of the information gathering visit.
- ✚ **COMMUNITY HEALTH AGENTS (ACS) AND OTHER COMMUNITY ACTORS:** Active ACS⁹ and representatives of OSB¹⁰ involved in the health actions that attended the call of the HFs selected to participate in the focus group.
- ✚ **REGIONAL AND LOCAL AUTHORITIES: (I)** Regional officials with technical responsibility in the execution of public health policies and in the application of the PLGHI and **(II)** District Mayors in the area of the project.

⁹ That maintain permanent relations with the HF personnel.

¹⁰ Glass of Milk Program, governors, community boards, community assembly, guide mothers, community dining rooms and mothers club

INDICATORS

Components	Indicators	Instrument/means for verification	Evaluation criteria
Strategic resources for LPSIG delivery	Availability of infrastructure	Health care personnel survey	Health survey (Question No. 8c)
	Availability of equipment	Guidelines for HF observation	Standard 1
	Availability of medicines	Guidelines for HF observation	Standard 6 Standard 13b
Organization for LPSIG care	Referral and counter-referral	Guidelines for HF observation	Standard 8 Checklist No. 4
	Identification of barriers to access of implementation of LPSIG	Guidelines for HF observation	Standard 5
	Implementation of information systems	Guidelines for HF observation	Standard 4
	Implementation of programming, monitoring and assessment	Health care personnel survey	Survey 20 and 22
Human resources required for LPSIG delivery	Availability of HR	Guidelines for HF observation	Standard 2
	Training of HR	Guidelines for HF observation	Standard 3
Provision of necessary health care services for LPSIG delivery	Care packages/health care services portfolio for RN	Guidelines for HF observation	Standard 12 (Checklist 5)
	Care packages/health care services portfolio for children	Guidelines for HF observation	Standard 12 (Checklist 5)
	Care packages/portfolio of health care services for pregnant women	Guidelines for HF observation	Standard 12 (Checklist 5)
Financing for LPSIG compliance	Reimbursement by SIS	Guidelines for HF observation	Standard 7a to Standard 7b Regional ODSIS Report
	Health expenditure capacity at the regional level	Friendly consultation of MEF	Expenditure execution report for MEF
	Alignment of public and private resources	Health care personnel survey	Health survey (Ques. 17) Interview of mayors for health survey (Question No. 18)
Sector coordination for LPSIG delivery	Community management	Guidelines for HF observation	Standard 17a to Standard 16 b
	Mobilization and integration of sectors	Guidelines for HF observation	Standard 17b Standard 17c Standard 15a

INSTRUMENTS

- Checklist and observation of health establishments
- Structured interviews to key informants
- Health care personnel survey
- Focus groups with social actors

To assess the provision of health care services, an instrument was constructed that allowed collecting primary source information on the processes and areas that have implications in the delivery of the PLGHI¹¹.

The standards evaluate the key processes in the health care services, such as the availability of strategic resources, human resources, information systems, financing, referral and counter-referral, internal organization, out-patient care, emergency care and hospitalization, support for diagnosis, the management health promotion and risk prevention. The standards used identify the key processes related to the fulfillment of the PLGHI and allow focusing the decisions on those which are going to contribute to improve institutional performance.

The assessment of compliance with the standards was performed at the discretion of the consultants, following the same logic used in the MINSA matrix instrument but adapting it to the needs of the study. A point was granted to each one of the 27 fulfilled key processes. The qualification was stratified into three levels:

- **Inadequate:** when the total score is less than 16 points or < 60%
- **Regular:** when the total score is from 17 to 21 points or from 60% to 79%
- **Adequate:** When the total score is 22 or more points or more than 80%

VALIDATION OF INSTRUMENTS

All the instruments designed were validated on a “discretionary basis by the judges.” To this end, six specialists involved in the application of the PLGHI were summoned to gather their observations and contributions regarding the instruments. These were submitted to the project technical team and their analysis led to the adjustment of the instruments.

INFORMATION GATHERING

The gathering of information was carried out from November 21 to 29 in Ancash and from November 28 to December 8 in Huancavelica.

The gathering of quantitative information was done through surveys applied to the health care personnel and the guidelines for observation of the selected health establishments. The qualitative information was obtained from interviews to authorities and government officials and from focus groups with ACS and representatives of the OSB of both regions.

Instrument	Population	Project area	
		Ancash	Huancavelica
Interview	District authorities and regional officials	7	8
Focus group	ACS and representatives of OSB	4	4

¹¹ Is an adjustment of the assessment instrument of the performance of HF primary care included in the technical document “Strengthening of Primary Care within the Framework of Universal Health Insurance and Decentralization” with emphasis on the “Renewed Primary Health Care” of MINSA, from where 17 standards were obtained related to the fulfillment of the interventions contemplated in the PLGHI.

Survey	Health care personnel:	37	66
Guidelines for HF observation	Health establishments	9	6

QUALITY CONTROL OF THE INFORMATION

The information was consolidated in the respective data bases and the pertinence of the content of each one of them was examined. The information contained in the instruments was cross checked. In this way, of the 109 surveys applied, six were set aside and were filled by nursing trainees and medical instructors and personnel SERUM who just had arrived at HFs.

METHODOLOGICAL ASSESSMENT ASPECTS OF THE DEGREE OF APPLICATION OF THE LPSIG

Six components were established that allowed holistic exploration of compliance with the necessary processes for the application of the LPSIG: (i) Strategic resources, (II) Organization of care service, (III) Human Resources, (IV) Provision of services, (v) Financing and (vi) Multi-sector coordination.

The relative importance of each component was determined for which a weighted scale was assigned that privileged components (III), (IV) and (v), which constitute pillars of the application of the LPSIG. To those, a weight of two over the remaining components was applied that, despite their contributing to the fulfillment of the interventions, are complementary to the former.

Each component was disaggregated into indicators, which permit the quantitative valuation of progress by means of the established criteria. In order to clearly bring about the fulfillment of each component, use is made of the traffic light analogy in the following manner:

Indicator	Situation	
Advanced	<60%	
In process	60 to 80%	
Incipient	80%	

The assessment of progress made in these six components determines the degree of progress in the application of the LPSIG in the HFs in the project area.

CHAPTER III RESULTS

3.1. GENERAL CHARACTERISTICS OF THE POPULATION UNDER STUDY:

HEALTH CARE PERSONNEL SURVEYED

Most of the surveyed health care personnel were female, and the majority was between 20 and 40 years of age. The group of professionals (doctors, nurses and obstetricians) was the one most frequently encountered.

In reference to their length of service, 42.7% (44/103) has been in the health sector for more than five years, and 29% (20/103) has served for less than a year. In Ancash, 64% (20/37) has been in the health sector more than five years, and in Huancavelica this figure is only 33% (22/66). In addition, however, most of them have been in the HFs for more than five years (82% in Ancash and 85% in Huancavelica)¹².

HEALTH FACILITIES ASSESSED

Two types of HFs were evaluated for each district in the intervention (Health Posts and Health Centers), selected according to their convenience, which represent the existing health care reality in each district, considering the dependency, functionality and interaction that exists between them for the delivery of PLGHI services¹³.

In this way 15 HFs were evaluated; nine in the region of Huancavelica and six in the region of Ancash. Of these establishments, 53% (8/15) were Health Centers and 47% (7/15) were Health Posts.

Table No. 2:
Health facilities selected to identify the degree of application of the PLGHI in Huancavelica and Ancash. November-December 2012

DIRESA	NETWORK	Micro-Network	Health Facility
Huancavelica	Huancavelica	Yauli	Yauli HC
	Huancavelica	Yauli	Ambato HP
	Huancavelica	Yauli	Ccasapata HC
	Huancavelica	Huando	Huando HC
	Huancavelica	Huando	Nuevo Acobambilla HP
	Huancavelica	Izcuchaca	Conaica HC
	Huancavelica	Izcuchaca	Nuevo Occoro HP
	Huancavelica	Ascensión	Ascensión HC

¹² See Annex 3. Table No. 1: Characteristics of the health care personnel interviewed to identify the degree of application of the LPSG in Huancavelica and Ancash. November-December 2012.

¹³ By exception, in Huancavelica Ccasapata HC (Micro Network Yauli) was included given that it depends functionally on Yauli HC.

	Huancavelica	Ascensión	Calqui Chico HP
Ancash	Huaylas Sur	Marcará	Vicos HP
	Huaylas Sur	Cátac	Cátac HC
	Huaylas Sur	Marcará	Marcará HC
	Huaylas Sur	Cátac	Tapacocha HP
	Conchucos Norte	Sihuas	Cashapampa HP
	Conchucos Norte	Sihuas	Huayllabamba HC

Office of statistics and information technology- Huancavelica DIRESA / Ancash DIRESA 2011

3.2. GENERAL OUTCOMES

DEGREE OF APPLICATION OF THE PLGHI IN THE REGIONS OF ANCASH AND HUANCVELICA

The findings demonstrate that the beginning of the life and the adequate growth and development of children are at risk because the primary care facilities are not properly assuming their role as the entryway to the health care system because of their weak operation and interrelationship with the other levels of health care.

Table No. 3

Degree of application of the PLGHI by health facilities in Huancavelica and Ancash. November-December 2012

DIRESA	Degree of LPSIG Application	
	Health Facilities	Degree of Application
Huancavelica	Huando HC	60.81
	Nuevo Acobambilla HP	45.95
	Conaica HP	60.81
	Ccasapata HC	50.00
	Yauli HC	62.16
	Ambato HP	51.35
	Nuevo Occoro HP	47.30
	Ascensión HC	56.76
	Calqui Chico HP	37.84
Degree of application in Huancavelica		52.55
Ancash	Marcará HC	60.81
	Cátac HC	60.81
	Vicos HP	50.00
	Tapacocha HP	45.95
	Cashapampa HP	48.65
	Huayabamba HC	55.41
Degree of application in Ancash		53.61
Overall degree of application		52.97

The general assessment of the degree of application of the PLGHI was determined, by averaging the scores obtained by the HFs evaluated in each of the regions. In none of the areas of intervention is there an advanced degree of implementation of the LPSIG. Only three health facilities in Huancavelica and two in Ancash reached a degree of implementation greater than 60% receiving the rating of “in process.”

3.1. STRATEGIC RESOURCES

For the delivery of the health care services, every HF must count on fundamental elements that will permit it to guarantee its quality. Among them are the infrastructure and the equipment. Pharmaceutical inputs also belong to this category, especially emergency health care services. These resources are complemented with the availability of HR that provide the health care services and develop the interventions of the PLGHI. These elements are considered strategic resources, and are the minimum elements that all health facilities must have according to their response capacity level.

a. INFRASTRUCTURE:

The health care infrastructure is a fundamental part of the strategic resources required to ensure that the health care requirements can be met and that the health interventions considered in the PLGHI are fulfilled. The MAIS-BFC raises the need for modern physical infrastructure, facilities and equipment with current technology according to the health networks and the level of complexity of the HF, considering the intercultural and territorial management approach.

In that sense, the opinions of the health care personnel were gathered in respect to changes made in the HF in relation to the infrastructure and the present availability of the settings necessary for the fulfillment of the interventions contemplated in the PLGHI¹⁴.

In addition, the exploration for extension of the study was referred to the increase in number of settings according to the category of HF. This extension is oriented to improve compliance with the health interventions contemplated in the PLGHI.

Of 103 HR interviewed, only 26 mentioned that the extension of the infrastructure for the implementation of the PLGHI interventions was made, of which six were HP personnel and 20 were HC personnel. The difference in appreciation the HP personnel has for the HC personnel is due to the fact that in most cases the more important HFs are privileged.

With respect to the availability of venues for the PLGHI interventions, 45% mentioned that at the present time they have suitable settings to deliver their services.

It was noted that in of each of the areas of intervention in Huancavelica, greater progress has been made in infrastructure and equipment. In Ancash, the DIRESA personnel declared that very little has been invested in the improvement of the HFs, except for the progress made by the Mining Fund that built seven, among them the Cátac HC. This represents only 1.7% of the HFs in that region.

¹⁴ See Annex 3. Table No. 4: Perception of the health care personnel with respect to the infrastructure for the implementation of the PLGHI according to the project intervention areas. November – December 2012.

In the Huancavelica DIRESA, nevertheless, all the personnel interviewed mentioned that the infrastructure has been significantly increased and the Manager of Social Development of the Regional Government stated that 50 new HFs were opened to meet the requirements of the population.

b. EQUIPMENT:

For the evaluation of equipment, a standard was used that contains two key processes: (i) verify availability of the basic equipment required for care; and (ii) the equipment is in a good state of repair and is operative. A checklist was applied that includes the equipment that the MINSA has arranged for each of the HFs according to their response capacity.

To rate the standard, the availability of the equipment listed was recorded according to the category of HF, granting each of them one point. The percentage rating was obtained from the total score obtained: (i) inadequate: < than 100%, (ii) adequate: 100%¹⁵

Of the 15 HFs, only in one of the two project areas was a HP found that has adequate equipment in each of its sites for the care of pregnant women, newborns, girls, boys and adolescents (Nuevo Occoro HP - Huancavelica)

Although the others have equipment for health care delivery, it is limited and is shared with different areas. The equipment generally lacking was: manual resuscitator for adults and newborns, negatoscope, examination table for nursing babies, pediatric pantoscope and pediatric tensiometer.

Although only one of the HFs evaluated has adequate equipment to fulfill the interventions, in Huancavelica, 65.2% of the health care personnel thought that the equipment for the care of newborns is very adequate, 50% had the same opinion with respect to the equipment for the care of girls and boys, and 69.7% thought likewise about the equipment for the care of pregnant women.

In Ancash, 48.6 per cent of health care personnel was of the view that the equipment for the care of the newborn is either very adequate or adequate, 45.9% thought the same with respect to the equipment for the care of girls and of boys, and 70.3% agreed with respect to the equipment for the care of pregnant women¹⁶.

When examining the opinion of the DIRESA personnel regarding the equipment of the HFs, it was found that in Huancavelica, six of seven interviewed people reported that it has been significantly increased in the primary care HFs. However, the mayors of the districts of Ascensión and Nuevo Occoro do not know if investments have been made in equipment for the HFs, whereas the Mayor of the district of Huando reports that improvements were not made.

¹⁵ See Annex 3. Table No. 5: Equipment of the health facilities according to category for the fulfillment of the interventions included in the PLGHI according to project intervention areas. November – December 2012.

¹⁶ See Annex 3. Table No. 6: Perception of health care personnel with respect to the availability of equipment for the care contemplated in the PLGHI according to project intervention areas. November – December 2012.

In the Ancash DIRESA, all the people interviewed reported that no important changes in equipment of the HFs have been made, except for equipment made available by the Antamina Mining Fund that provided communication equipment intended to strengthen the system of referrals and counter-referrals and the perinatal information system, as well as basic medical equipment to some of the HFs in the area of mining interest.

The mayor of the district of Marcará mentioned that the equipment in the HCs had been improved but that he does not have the details. The Mayor of Huayllabamba reported that it has been improved, but not by much, and that they still lack modern equipment.

The opinion of health care personnel was sought regarding the need for equipment to comply with the interventions considered in the PLGHI. To this end, a question regarding this subject was included in the surveys applied to the personnel in the HF visited¹⁷.

The majority of health care personnel are of the view that the equipment they have is what they need, but direct observation demonstrates the existence of a health infrastructure with inadequate response capacity in Ancash as well as in Huancavelica.

c. AVAILABILITY OF MEDICATION

To evaluate this area, a medical standard was set that assesses the management processes of pharmaceutical products, medical devices and health care supplies, which allowed verifying that their availability was sufficient to meet the demand for hospitalization and out-patient services. For this purpose, a report was requested on the availability of medicines during 2011, which should not be less than 90%.

This report revealed that only two HFs have sufficient medicines available for proper health care and recovery. Both of them are HCs, and one belongs to the district of Marcará in Ancash and the other to the district of Huando in Huancavelica.

None of the facilities visited had the complete battery of necessary medicines for the care of obstetrical and neonatal emergencies, fundamental to avoid the complications that can present at the moment of childbirth, which can even lead to the loss of the newborn despite their being in an HF.

Included in the survey was a question that permitted rating the opinion of the health care personnel under the categories of “Very adequate” (when they have all the medicines and necessary medical supplies to meet the demand for out-patient and emergency health care services), “Adequate” (when they have the medicines and medical supplies to meet the demand for emergency health care services), and “Partially adequate” (when they have some of the medicines required to meet the

¹⁷ See Annex 3. Figure No. 3: Perceptions of the need for equipment for the fulfillment of the interventions included in the PLGHI according to project intervention areas. November – December 2012.

demand for health care services), and “Inadequate” (when they do not have medicines to meet the demand for emergency or out-patient health care services).¹⁸

The perception that the health care personnel has with respect to the supply of medicine is opposite to that observed in the direct assessment, which is that only two facilities have medicines available. For example, it is usual to find that the medicines required for medical attention of obstetrical emergencies are not available (Codes Red, Blue and Yellow). Only the HC of Conaica - Huancavelica has them available.

When exploring the opinion of the Director General (e) of the Huancavelica DIRESA and the rest of the personnel of that institution, they stated that as a result of the supervisions performed, they were able to verify the medicine supply shortage in the HFs, concluding that this was mainly due to their inadequate management at the level of the networks.

The Ancash DIRESA personnel stated that in the HFs, the priority use of the SIS reimbursement is directed to supplying medicines. They do not know if any shortage of medicine supplies exists at the local level.

It can be concluded that there are weaknesses in the institutional management of the provision of pharmaceutical products, medical devices and health care products at the regional and local levels, and it would be desirable to strengthen the competencies of the personnel regarding administrative and health management at the regional and local levels, and arrange for adequate pharmaceutical services provision, storage, dispensing and sale, and the rational use of pharmaceuticals.

d. LABORATORY PROCEDURES

Due to its importance, a standard was included in the observation guidelines that values the performance of diagnosis support procedures that is evaluated by means of two checklists¹⁹ according to the level of response capacity of the primary care HF. The opinions of the health care personnel were also gathered regarding the provision of laboratory materials and supplies required for the fulfillment of the interventions contemplated in the PLGHI.

The observation showed that 78% of the HFs in Huancavelica performs the laboratory procedures adequate for the response capacity level that corresponds to their category. In Ancash this value reached 67%.

The HFs obtain the laboratory test samples that are then processed in the referenced CS. This procedure is adequately organized in both regions. The HFs have registries of samples collected and delivered for processing. The HCs, as well, forward the results that determine the diagnosis and treatment of the patient.

¹⁸ See Annex 3. Table No. 8: Perception of the health care personnel regarding the availability of medications for the fulfillment of the interventions included in the PLGHI. November - December 2011

¹⁹ Observation guidelines for health facilities - Checklists No. 08 and No. 09

3.2 ORGANIZATION OF HEALTH CARE DELIVERY

The organization of health care services ensures the delivery of benefits, among which are the interventions included in the LPSIG and that are delivered according to the category determined by the response capacity level of each HF. Thus it is necessary to know the status of the three following aspects.

a. CATEGORIZATION

Categorization is a process that leads to classifying the different HFs on the basis of levels of complexity and functional characteristics that allow them to respond to the health care services requirements of their respective client populations. Clearly determining the categories of HFs allows differentiating the delivery of the services of the PLGHI in primary care.

Huancavelica: The HFs are organized functionally into seven networks, 29 micro-networks and 2 hospitals. Each network has territorial jurisdiction over a province. The districts where the project will be developed have 43 HFs of which seven are HCs and 36 are HPs.

Although in the region fifty HFs have been created, this supply of services is not well defined yet, and it still has not entered the formal health care system. This situation places at risk the fulfillment of the interventions oriented to the achievement of health objectives such as the reduction of CCM, and it is of transcendental importance to strengthen the regional and local management that would allow the reorganization of the health care supply and updating of the categorization of the HFs.

Ancash: The HFs are organized functionally into six networks, 56 micro-networks and three hospitals. The districts where the intervention is developed have 23 Health Facilities, three of which are HCs and 20 are HPs.

It has been observed that in Ancash there are 10 closed HFs, for lack of personnel willing to remain in the most remote places, and others exist for which a category has not yet been determined. This situation does not allow the clear establishment of the portfolio of services, and therefore the fulfillment of the health interventions related to the PLGHI is made difficult.

b. SYSTEM OF REFERRALS AND COUNTER-REFERRALS

The implementation of the coordinated set of services and preventive actions contemplated in the PLGHI allows the recognition of signs of alarm in newborns, girls, boys and pregnant women for care in the HFs. The continuity of these services is done successfully if there is a system of referrals and counter-referrals that ensures timely and comprehensive care in the HFs capable of addressing the health care needs that arise. Therefore, the HFs must work in networks, considering their categorization and response capacity, generating an agile flow of referred and counter-referred people in the different levels of care.

To guarantee the continuity of care for users of the health care services at the national level, with timeliness, quality and comprehensiveness, the implementation of the National System of Referrals

and Counter-referrals is promoted by means of the use of standardized procedures among the institutions.²⁰

The results show that in Huancavelica most of the HFs are organized to refer the users who require to be taken care of in an HF of greater capacity. The majority of HCs are equipped with rural ambulances and provides health care coverage in the territorial jurisdiction of the Micro-Networks. They also count, in the majority of cases, with operative radio communications equipment which allows them to communicate with the HFs regarding reception of referrals. Nevertheless, 33% of HFs have not complemented this process.

In Ancash, on the contrary, this process is deficient. Although highways exist that allow the population to have access to the HFs, they do not have population registries or a documented ordering to arrange for referrals and ensure that these are effective.

In relation to the perception of the health care personnel regarding the organization of the system of referrals and counter-referrals, 79% stated that it is done in coordination with the different areas of the HFs, whereas only 13.6% indicates that it is carried out with the participation of the organized community. Nevertheless, the last figure corresponds wholly to Huancavelica, given that in Ancash, apparently, the organized community has not been incorporated to provide support to the interventions of the HFs.

C. INFORMATION SYSTEM, PROGRAMMING, MONITORING, TRACKING AND EVALUATION

The health information system is an indispensable element for comprehensive care and decision making with less uncertainty, not only at the time of promoting relevant health policies, but also regarding routine decisions.

For that reason, the establishment of the means and instruments that guarantee the flow of information between the different subsectors that compose the health care system is a necessity that must be cared for. At the moment, to satisfy the information requirements in the different levels of management, health care personnel on average complete 28 types of formats per month on the activities it has performed during that time, which may have to be duplicated according to whether the requirement comes from the head of the micro-network or the network.

Observation shows that 73% of the HFs have a formal and permanent system of information gathering, processing and analysis. The differences between the sites are not significant; nevertheless there is still an important 27% of HFs that do not have this system implemented in all their processes.

²⁰ See Annex 3. Table No. 9: Organization of the supply of the health facilities for the referral and counter-referral of patients according to project intervention area. November - December 2011. Table No. 10: Perception of the health care personnel with respect to the organization of the System of Referrals and Counter-referrals of patients according to project intervention areas. November - December 2011

The availability of an efficient and integrated information system permits the provision of supplies that orient the development of the interventions defined in the PLGHI and directed to the fulfillment of health indicators at the regional and local levels, as is the case with the reduction of CCM.

In general, displeasure has been perceived among the health care personnel because of their having to dedicate an important amount of time to the recording of information according to the specific requirements of the regional level and the national level, given that they do not share a common information system. This directly affects the development of the interventions of the PLGHI by reducing by at least one week the time available for the delivery of health care to the population, to dedicate it instead to the consolidation of information.

Programming is the process by which the objectives planned are rendered into concrete actions or activities. This process allows defining the activities and tasks necessary to attain each specific objective, assigning them the resources that their performance requires, as well as the responsibilities of each area.

Management which is coordinated with representatives of the organizations that agree on common goals such as the reduction of CCM strengthens their achievement and makes the interventions more productive. Therefore, the development of coordinated actions for the fulfillment of the PLGHI should be initiated beginning with the joint programming of activities with the social actors involved in the achievement of health results.

When evaluating, from another perspective, the participation of social actors in the programming of interventions aimed at the reduction of CCM, it was concluded that, as in the previous case, the greater percentage of participation is granted to the health care personnel in all the areas; nevertheless it is followed closely by the 43% that thinks that the programming is made between the health care personnel and the community representatives. Mainly this judgment comes from the Marcará HC, where they work under the CLAS modality.

Although evaluation is a strategy that allows measuring the progress and difficulties in the development of health interventions, it must be part of a permanent policy of the HFs in the spirit of improving the processes and optimizing the results so that the interventions that are contemplated in the PLGHI can be developed.

In that sense, it is observed that the most frequent type of evaluation is the one that is done quarterly (54.4%), which is followed in frequency by the annual evaluation (33%), and thus it would be necessary to emphasize permanent technical assistance that would allow the reorientation of interventions according to the fulfillment of health objectives.

The participation of actors in the evaluation of the goals, as in the programming, is limited to the health care personnel of all the areas. It is evident that the regional authorities are involved in this activity, with greater emphasis in Huancavelica.

In reference to the subject, the majority of health care personnel at the regional and local levels report that the monitoring and evaluation of the goals decided for the PpR is conducted permanently.

3.3. HUMAN RESOURCES

One of the critical factors for the health care system is human resources (HR), whose performance is based on its competences, motivation, distribution, productivity and quality; that it be available at the correct moment and place and that the health care services be efficient and effective in satisfying demand, with accessibility, and technical and human quality.

The availability of human resources is determined according to the category of HF. The type and number of required personnel in a primary care HFs is established in line with the MAIS-BFC which includes the demand of health care, diagnosis of health needs, and the existing epidemiological profile.

a. AVAILABILITY OF HUMAN RESOURCES

It is observed that the HPs have more difficulty in having the personnel required to fulfill the interventions of the PLGHI. Among the HPs that do not have sufficient personnel the most noteworthy are those of category I-2. This can be explained by the difficulty of having medical professionals in the rural areas or of assuring their permanence beyond the SERUM.²¹

In addition, the opinion of the health care personnel was gathered with respect to the availability of human resources for the development of the interventions contemplated in the PLGHI, finding that 73% think that the human resources in the health facility is very adequate for the care of newborns, 50% for the care of girls and boys, 55% for the care of adolescents and 61% for the care of pregnant women.

The General Directorate of the Huancavelica Diresa declared having incorporated health professionals in the HF to an important degree as a result of the programming of interventions by the Coordinated Nutritional and Maternal Neonatal strategic programs, which are still insufficient to meet the health care demand of the population. This situation is also perceived by all the mayors of the visited districts, who state that the available personnel are still insufficient for the activities that must be fulfilled in the HF.

In the case of the Ancash Diresa, 100% of the personnel interviewed reported that the available human resource is insufficient for the fulfillment of the interventions of the PLGHI, and even more so in the HP in the rural area.

With respect to the existing breaches of HR to fulfill the development of the interventions specified in the PLGHI, 70% of the Ancash personnel interviewed think that it is very necessary to solve the HR deficiency, whereas 59% have the same belief in Huancavelica. In both cases, the Diresa have initiated an assessment of the situation of human resources to determine the economic incentives

²¹ See Annex 3. Table No. 11: Availability of HR by type of facility according to project intervention areas. November – December 2012.

(e.g., wage increases differentiated by risk areas), administrative incentives (e.g., such as recognition or commissioning by a HF) and educational incentives.

b. QUALIFICATION OF HUMAN RESOURCES

The competences of human resources in primary care depend on the previous formation, the training and experience gained in daily practice.

The MINSA has defined the basic health team (EBS) for primary care and considers that it consists of a doctor, a nurse, an obstetrician and a nursing technician. This team should have the competencies necessary to provide optimal health care and be the fundamental pillar required to implement a decentralized health care system of quality based on primary health care and the MAIS-BFC strategy.

Therefore this study proposes the valuation of personnel training from two perspectives, first by using the registry of trainings which they attended and second by considering the perceptions of the personnel, of the users and their directors.

In general, it is noted that 80% of the health care personnel are capable of performing the interventions of the PLGHI, with no existing significant differences between the two sites of the study. The remaining 20% of the personnel who were not trained during last year pertains to four health establishments, three HPs and one HC.

On the other hand, the personnel of both DIRESAs agreed that while progress was made with the training, it only responded in most cases to specific aspects of socialization of the regulations and in the least of cases to modularized training, of the internship type, where the health care staff becomes an active agent of generation of new knowledge from the experiences in the course of their work. Hence the importance of promoting this form of training that allows the development of HR and the organization.

Also, when exploring the opinion of the mayors of the districts in Huancavelica with respect to the training of HR, they stated that they lack knowledge of what occurs in the HFs, and that they only have the overall knowledge that all users of the services have.

In Ancash, the opinion of the mayors was divided; three of them do not know how the processes occur in the HFs and recognized their absence, which they committed to correct. Only the mayor of Catac is committing the resources of the PIM to the improvement of the response capacity of the HFs.

3.4. PROVISION OF HEALTH CARE SERVICES

The provision of health care services occurs through a set of activities and services that incorporate aspects of promotion, prevention, recovery and rehabilitation that are performed by the basic health care team with the cooperation of community health agents and other social actors to cover the health care needs of the people, the families and the community.

It was possible to observe that although the portfolio of services of the PLGHI has been published, and the care given at both sites is detailed in the daily registry, these could not be verified in most of clinical histories.

It was also observed that all of the health facilities of Huancavelica have an updated directory of users by sector in the area of influence, whereas in Ancash, their availability was verified in only three of the six facilities visited.

Regarding the delivery of the comprehensive care package by life stage, the medical records of three clients in each stage (three children, three adolescents and three pregnant women) served during last month, were examined, finding that only one of the health facilities in Huancavelica records the care package in the HC according to life stage, and none do so in Ancash.

The exploration of the reasons for which the care given is not registered in the HC indicates that this omission is due to the workload and the multiplicity of records that must be filled for each instance. It is important to mention that these health care deliveries are registered in the HIS²² and in other registries for the corresponding monthly notice.

Finally, with regard to the identification of barriers to access by the population (geographical, economic, or cultural) this is done in only 44% of facilities in Huancavelica and 33% of health facilities in Ancash.

In the exploration with the health care personnel regarding how they themselves rate the delivery of interventions to newborns, girls, boys, adolescents and pregnant women, they reported that it is very adequate to adequate, and that the services that are rendered respond to the expectations of the beneficiary population and to the national norms, and is hardly adequate to inadequate in supplies, HR, infrastructure, etc.

With respect to care for the newborn, 91% of the health care personnel in the HFs of Huancavelica rate the care they offer these users as very adequate to adequate, whereas in Ancash only 76% rates it in the same way. Care for pregnant women instead is rated similarly in both areas of intervention, as very adequate and adequate, with a similar rating given to the care provided to boys and girls in both areas. Nevertheless, care provided to adolescents is rated the lowest of all, in both areas, with an average rating of 76% assigned to very adequate and adequate.

On the other hand the opinions of community health agents and social actors were explored, about the way health care services are rendered in the HFs. Their comments showed that although the services and the delivery of health benefits have improved, interest in improving the quality of life has also been awakened, mainly regarding the feeding and nutrition of the girls, the boys, and of pregnant women, which contributes to the community interventions aimed at the reduction of CCM.

According to the perception that health care personnel have with respect to access to health care services by the population, it was noted in Huancavelica that 43% of the people demand services because of the health insurance benefits they receive (SIS and AU), whereas in Ancash the figure was

²² The HIS (Health Information System) is the system that guarantees the proper registration of health activities, contributing to improve the quality of the data registry, homogenizing criteria, incorporating new forms of recording and consolidating it as the only source of information, in order to provide support for decision making.

40%. Likewise, 42% in Huancavelica think that they demand health care services due to the calls that health care personnel make for different interventions, whereas 36% in Ancash agreed with this.

3.5. FINANCING

The financing component of the MAIS-BFC is made up of a set of elements that articulate to guarantee that the delivery of health care services is developed in adequate terms.

One way of financing health care services is Comprehensive Health Insurance (SIS) which administers the funds destined to the financing of individual health care services in the form of a public subsidy in favor of the poorest and excluded. Their coverage strategies depend on the capacity to identify their target population, reducing filtrations and crossed subsidies.²³ In consideration of the epidemiological profile of the country, and to provide health coverage to the whole population, the SIS adopted the Basic Health care services Plan (PEAS) that will cover 80% of the more frequent diseases and for which the State guarantees financing by means of the Universal Health Insurance (AUS), supported by the MAIS-BFC, coordinating and guaranteeing care for the poor populations not assigned to another type of insurance.

This financing, in addition, regulates the interventions considering the programming of prioritized interventions under the methodology of the PpR, whose objective is that the budgetary process promote and develop results-based management.

Another financing method consists of the Municipal Incentives Program, created with the purpose of promoting reforms that allow the achievement of growth and sustainable development of the local economy and the improvement of its management within the framework of the decentralization and competitiveness improvement processes.

It is observed that the average affiliation of the population with the SIS in the districts of Ancash is 91%, unlike that of Huancavelica, which reaches only 73%, a figure that would make the return of financing to the HFs difficult and does not allow them to have the resources necessary to make the PLGHI benefits effective and efficient.

It is important to consider that the rejection of health care delivery records gives rise to the non-recognition of the care provided, failing to replace the supplies used in the delivery of benefits. This originates the shortage and deficit of supplies for the application of the interventions of the PLGHI.²⁴

The assessment of the HFs allowed observing that only one of them has documentation that supports the reimbursement for the care services delivered to the insured population. All declared that the party who executes the budget is the pertinent Health Network and that they do not know the assigned amounts. The exploration demonstrated that they are not aware of the process or

²³ Comprehensive Health Insurance. Strengthening Comprehensive Health Insurance in poor areas. MINSA/UNFPA. 2009, p. 107.

²⁴ See Annex 3. Table No. 12: Reimbursement by the Comprehensive Health Insurance program for the development of the interventions included in the PLGHI and the PPR according to project intervention sites. November - December 2011

procedure that health care services record follow for their approval, nor do they receive the feedback required for their improvement.²⁵

The examination of the subject with the Huancavelica officials revealed a cracking of communications regarding the rejections of the health care services records with the generators of the information, that is to say, with the HF personnel, despite the fact that the feedback regarding the records observed/rejected, for each one of the Executive Directors of the Networks, has been organized.

The reduced budget assigned to the HFs in this area is oriented mostly to the replacement of medicines that, as has been seen, is insufficient and does not allow meeting the requirements of the population for medication.

In the case of Ancash, the problem is different given that they have an important reimbursement for health care services provided by the SIS due to the small percentage of health care records that are rejected. Nevertheless, the HF personnel does not have clear information regarding the reimbursed amounts, nor do they decide on how the budget is executed since the indication for its execution is centered basically on medicines.

Despite the lack of information among the health care personnel with respect to the amounts of reimbursement for health care services delivered by the SIS, they consider it to be the main source of financing in Huancavelica (71%) as well as in Ancash (65%). The other source of financing identified by health care personnel is directly collected amounts (12.6%), though the mechanism of budgetary allocation has not been determined.

The survey of health care personnel on investment projects that are being implemented or are about to be implemented in the project area revealed that most of them (74% in Huancavelica and 68% in Ancash) are not aware of the existence of investment projects. This appreciation is corroborated by the declarations of the 15 regional officials interviewed in the DIRESA (seven in Ancash and eight in Huancavelica).

In Huancavelica, two of three interviewees showed that they are preparing the technical dossiers for their evaluation and approval. This situation demonstrates the weakness of the HR in competencies required for the formulation of technical dossiers as well as for the administrative proceedings for their approval, given that although the dossiers are prepared, they are rejected for not having been properly supported.

On the other hand, three of four mayors of Huancavelica expressed that they have projects underway and others will be implemented in 2012, all of them aimed at agricultural development with the purpose of increasing the availability of food and thus contribute to the reduction of CCM.

In Ancash, four of six officials of the DIRESA declared that they were implementing investment projects for construction, improvement and extension of the infrastructure and equipment of the HFs. Nevertheless, three of four mayors declared not knowing about the projects that the health sector has for their development and commented that they have thought of developing projects for

²⁵ See Annex 3. Table No. 13: Percentage of health services records rejected by the SIS according to health facilities in Huancavelica, November - December 2011

improvement of housing and agricultural infrastructure. They have no information with respect to the health input requirements for the development of interventions included in the PLGHI, possibly related to administration by new mayors or limited communication with the health sector.

- **Regional spending capacity for the fulfillment of interventions contemplated in the LPSIG**

To evaluate spending performance in the regions under study, the friendly consultation of the MEF was reviewed regarding the interventions established for the PpR. From this consultation it is seen that six of 10 interventions in the area of Huancavelica reach 95% or more of budgetary execution. Among them are pregnancy care, prevention of micronutrient deficiencies, comprehensive care for children and adolescents, etc., which implies the use of the budget in the activities in the LPSIG.²⁶

In Ancash, on the contrary, spending performance is adequate only in two interventions (Diagnosis and treatment of the deficiency diseases in children, adolescents and pregnant women and reproductive health). In general terms, difficulties were evidenced in completing the spending required for the fulfillment of interventions in the PLGHI.

It is important to indicate that the spending for the intervention of children with complete vaccines did not reach 50% in Huancavelica, which generates a serious limitation for the delivery of preventive-promotional actions in the LPSIG.

3.6. MULTI-SECTOR COORDINATION

a. LOCAL AND COMMUNITY MANAGEMENT:

The management of health with a territorial approach is a process of political, institutional, governmental and social coordination that is developed in a given territory for addressing the social determinants in order to optimize the level of human development of the population. Coordinated local management allows the optimization of the available resources to achieve greater impact on health indicators, empowers the community and it turns it into a strategic partner to develop interventions aimed at its health care, such as the ones established in the PLGHI.

In that sense, behavior was explored regarding the promotion and strengthening of local management as key strategy to coordinate interventions that allow reducing CCM and maternal-neonatal mortality.

In Ancash, there is a better district coordination and coordination strategies (66.7%), which is based primarily on the continuity of participation by the health representatives in the Roundtables for Poverty Reduction at the regional level who retake the coordination required by the political changes that occur in the region.

²⁶ See Annex 3. Table No. 15: Spending performance for interventions included in the PLGHI by project intervention area. November – December 2012.

This strategy has an approach that dates back several years, but despite this, the operative reach it has is insufficient due to the scarce empowerment of its representatives who attend only to seek support rather than in the logic of a work coordinated in favor of the health of the population.

In Huancavelica there is little participation in the spaces of multi-sector agreement at the district level, but there is a Regional Food Security Council – Lliamkasu Wiñaipacc which channels and coordinates interventions aimed at the reduction of CCM. This Council is installed in the office of Management of Social Development, and has a regional plan whose goal is to reduce CCM that is included in the rendering of accounts that is made to the population every year. Nevertheless, and despite being conducted by officials in the Regional Government, it has achieved very little as far as the reduction of the indicator is concerned.

CONCLUSIONS

- The regions evaluated, considered as a whole, have attained an “incipient” degree of application of the PLGHI. Nevertheless, 33.3% of the facilities evaluated have an “in process” degree of application (three health facilities in Huancavelica and two in Ancash), which means that in primary health care, the role of being the front door to the health care system is not being assumed.
- The delivery of the health care package for newborns, girls, boys and pregnant women in all the HFs is in incipient progress, partly because the delivery of health care services is not made with the frequency established in the PLGHI for each age group, and on the other hand, because the services that are rendered are mostly registered in an untimely manner in clinical histories or are only registered in the tracking book.
- The equipment of the HFs has improved during the last couple of years; nevertheless its availability is still insufficient, especially for the care of newborns. There are no instances of equipment for neonatal emergencies that is complete, causing neonatal mortality to remain high in both regions.
- Although the number of HR has been gradually increasing, especially in Huancavelica, training in subjects related to the delivery of health care in the PLGHI is limited.
- In Huancavelica, although new health facilities have been created, their categorization is still in process, which makes the fulfillment of the health interventions in the PLGHI difficult because the portfolio of services offered by these facilities cannot be clearly established.
- The remuneration policies in force in the Ancash region have limited the presence of professionals in rural areas, especially in the more remote places, which has resulted in the closure of 10 HFs²⁷, leaving the population of those areas without permanent coverage.
- Only two HFs have sufficient availability of medicine for proper health care and recovery. Nevertheless, none have the basic medicines and supplies kit for the care of obstetrical and neonatal emergencies (codes red, blue and yellow), which are fundamental to care for complications in the attention of childbirth and post-partum.

²⁷ Management Report, Ancash DIRESA - Public Hearing; November 2011

- Although health care personnel spends time in completing monthly reports submitted to the Micro-Network, the Network and the DIRESA, this information is not used for the implementation of actions that allow implementing the PLGHI.
- In their majority, the mayors of the districts of interest are not involved in the development of the interventions of the PLGHI and are not aware of the budgetary spending as well as the fulfillment of the goals of the local health indicators.
- There is a limited capacity for local institutional management by the health team in administrative, planning and control aspects, which restricts the identification of gaps and the implementation of actions that lead to the improvement of the health care services in the PLGHI.
- Although the health facilities offer health care services of a primarily preventive-promotional nature, citizen participation in health interventions aimed at the reduction of CCM is still weak.
- The financing of primary health care is insufficient, which jeopardizes the availability of the necessary supplies and procedures for the fulfillment of standards for the management, organization and delivery of health care services for the application of the PLGHI.
- In Huancavelica, the percentage of records for the reimbursement of the SIS to the primary health care facilities that are rejected exceeds 20%, which limits the financing of the activities covered in the PLGHI.
- It is observed that the average affiliation of the population with the SIS in the districts of Ancash is 91%, unlike that of Huancavelica which reaches only 73%, which would make the return of financing to the HFs difficult and does not allow them to have the resources necessary to make the PLGHI health care services effective and efficient.
- The ability to spend the budget allocated to Ancash and Huancavelica for delivering PLGHI health care services is below 90%, which explains, in part, the deficiency in the implementation of interventions to reduce CCM and maternal and neonatal mortality.

CHAPTER IV

GUIDELINES FOR TECHNICAL ASSISTANCE

4.1 IDENTIFICATION OF CRITICAL PROCESSES

The results demonstrate that none of the areas of intervention of the Partnership for Child Nutrition Project have an advanced degree of implementation of interventions aimed at the reduction of CCM. Only three health facilities in Huancavelica and two in Ancash reached a degree of implementation greater than 60%, with these receiving the qualification of “in process.”

The situational diagnosis of the degree of application of the LPSIG consists of a detailed description of the findings in each one of the evaluated components and identifies, in each case, the critical processes that allow the determination of requirements. This identification contributes to the formulation of guidelines for the development of technical assistance plans for improvement in the application of interventions aimed at the reduction of CCM.

The critical processes found were:

STRATEGIC RESOURCES

- Only 25.2% of the health care personnel interviewed perceive that there has been an extension in the infrastructure for the implementation of the PLGHI, and only 45.2% believes that they have adequate environments for comprehensive care delivery. In Huancavelica greater progress has been had as far as infrastructure and equipment is concerned, whereas in Ancash the DIRESA personnel stated that very little has been invested in the improvement of the HFs, except for the progress attained with the Mining Fund.
- The equipment available does not respond to the requirements of the health interventions, which does not allow offering quality services to the population. In only one HF in Huancavelica was the right equipment found in each of the rooms dedicated to the care of pregnant women, newborns, girls, boys and adolescents.
- The weak pharmaceutical product management compromises the ability to supply medicines necessary to satisfy the demand for obstetrical and neonatal out-patient consultations and emergencies. Only two HFs (one in Ancash and one in Huancavelica) have sufficient availability of medicines for proper health care and recovery.

ORGANIZATION FOR HEALTH CARE DELIVERY

- Only 53.3% of HFs fulfill the criteria of evaluation of the organization for referrals and counter-referrals that favor timely and comprehensive medical care in the HFs of each network depending on its categorization and response capacity. Only 46.7% of the HFs makes transfers of patients in a timely and safe manner.
- Observation shows that 73% of the HFs has a formal and permanent system for information gathering, processing and analysis. The differences between the sites are not significant; nevertheless there exists an important 27% of HFs that still do not have this system implemented in all their processes.

- Limited coordination of the health care services with their surroundings, sectors and key actors of civil society and the organized community. The perception of the health care personnel with respect to the programming of interventions is aimed at its development in coordination with the Micro-Network, Network and DIRESA (52.4%), together with the HF team (28.2%) and in coordination with the district authorities (26.2%).

HUMAN RESOURCES (HR)

- In the diagnosis of human resources management, exploring its availability and training, it was observed that in Ancash and in Huancavelica it stood at 70.8%, which rates this component of the degree of application of the PLGHI as “in process.”
- The performance and efficiency of human resources is weak for the achievement of health objectives given that to date there is no real diagnosis of the HR gaps and there is no proposal for innovation of the remuneration policy for HR.²⁸
- Some 20% of human resources in HF have not been trained in Comprehensive Health Care subjects required to implement the actions in the PLGHI.

PROVISION OF HEALTH CARE SERVICES

- Limited response to the health requirements and demands of the population. In the Ancash region, 50% of HFs does not have an updated directory of users of the services by sector in the area of influence. The absence of this sector information does not allow the tracking and control of children for the monitoring and evaluation of CCM.
- The delivery of the comprehensive health care package offered to the boys, girls, adolescents and pregnant women is not registered in the HC, which prevents the tracking of each patient in the HFs.
- None of the HFs in either region disseminates the portfolio of outpatient consultation services, and obstetrical and neonatal emergencies, despite the fact that several of the HFs perform these activities, which diminishes the demand for care because of ignorance.
- The perception that only 67% of health care services for adolescents were very adequate or adequate indicates to us that there is difficulty in the provision of services in this life cycle in both regions.

FINANCING

- The average population affiliated with the SIS in the districts of Ancash is 91%, but in Huancavelica this figure is only 73%, which makes the return of financing to the HFs difficult.
- In the areas of intervention in Huancavelica, there is a high percentage of health care services records rejected by the SIS (11% on average), which is an indicator of the deficiency in the processes of completion and quality control of the information due to an insufficient dissemination of the criteria for completion of the records, lack of permanent monitoring in these areas, and the absence of an auditor for the SIS that would permit reversing these deficiencies.

²⁸ Considering that the personnel that serve in areas of high risk because of geographic and cultural accessibility and because of the absence of another source of health care, must be privileged in their remunerative level and other monetary incentives that compensate the effort deployed in the health care provided to those populations.

- In both regions, the reimbursement of the SIS to the HF for the development of the interventions included in the LPSIG and the PpR is limited.
- Limited aiming of the budget allocated by the Municipal Incentives Program to complement the interventions for maternal-neonatal health and the reduction of CCM.
- The implementation of public spending in both regions is not commensurate with the achievement of institutional goals, which evidences difficulties in implementing the disbursements for the fulfillment of the interventions related to the PLGHI.

MULTI-SECTOR COORDINATION

- In Huancavelica, 22.2% of the HFs strengthen the spaces for district coordination and coordination, whereas in Ancash this percentage has increased to 66.7%.
- In Huancavelica, 66.7% of HFs incorporated actions of health promotion in coordination spaces, whereas in Ancash this figure was 50%. This limits the ability to determine the gaps and implement actions that lead to improved interventions aimed at reducing chronic malnutrition and at neonatal maternal health.

4.2 GUIDELINES FOR THE TECHNICAL ASSISTANCE PLAN

The reduction of CCM and the improvement of maternal and neonatal health in Ancash and Huancavelica through the implementation of the PLGHI require the strengthening of the health care services to improve health care coverage, and its quality and efficiency.

The following guidelines are inputs to offer technical support in the resolution of the critical processes identified in the evaluation of the performance of the HFs. These constitute the starting point for the preparation of regional and/or local technical assistance plans.

Technical assistance requires having teams of specialists with strategic thinking abilities for the proposal of alternatives that would allow improving the implementation of interventions aimed at the reduction of CCM and the improvement of maternal and neonatal health, promoting participation in spaces of inter-sector and inter-institutional coordination.

The technical assistance plans for each region and locality must be developed taking the following into account:

- Strengthening the development of the capacities and competences of the health team to implement the health interventions aimed at the reduction of CCM. This implies a strong coordination between the productive processes of the health care services with those related to the training of human resources, as well as of common efforts to incorporate these two components in the MAIS-BFC.
- Support for the organization of the health care services to aim them at comprehensive care for pregnant women, girls and boys and that would lead to the improvement of maternal-neonatal health and the reduction of CCM.

- Development of advocacy mechanisms at the regional and local levels that would allow inserting comprehensive interventions aimed at the reduction of CCM and maternal and neonatal mortality in the District Development Plan.
- Assistance to the technical teams of the Health Networks in aspects of strategic management to ensure uninterrupted supply of quality medicines to the primary care HFs.
- Advice to the health teams of Networks and Micro-Networks in the alignment of PIM resources to aim them at the improvement of HF response capacities and of institutional performance to facilitate the care of obstetrical and neonatal emergencies that would allow fulfillment of protection of maternal-neonatal health and reduction of CCM.
- Assistance in the process of implementation of strategies that would allow the improvement in reimbursements of the SIS, giving priority to areas with low-income population and difficult access to health care services.
- Strengthening the processes of monitoring, supervision and evaluation of the performance of the HFs based on a diagnosis in each region, and implementation of a model in the project areas identifying the tracer indicators oriented to maternal and neonatal health care and the reduction of CCM.
- Incentive for the proposal of a plan for active and obligatory participation by the health teams of the Regional Directorates and Health Networks in the project intervention area in spaces of agreement, monitored by the Office of Human Resources of the Regional Directorates of Health with the purpose of placing in the regional and district agendas the need to renovate the infrastructure and equipment of the HFs in primary health care.
- Promotion of the implementation of co-management mechanisms to approach the health care needs of the population, in a way that allows the exploration of new management models for health care services with a territorial approach, considering the intervention of private enterprise in the delivery of public health care services aimed at the care of maternal-neonatal health and the reduction of CCM.
- Promotion of mechanisms for political advocacy with local and regional governments whose results are expressed in the allocation of greater resources and investment in favor of child nutrition, maternal-neonatal health care and the promotion of sound public policies that result in the modification of lifestyles within the framework of healthy environments.

The guidelines for technical assistance proposed for the implementation of the LPSIG in the project areas are the basis for the design of actions and activities at the regional and local levels. They also provide direction for the inclusion of activities that are indicated in the “Coordinated Nutritional and

Maternal Neonatal” strategic program of the PpR, which are monitored monthly by the Micro-Network, Network, DISA, and at the national level in parallel with the implementation of budgetary spending at the regional level.