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Pathfinder INTERNATIONAL

Improving the Health of Peruvians

(Cooperation Agreement: CA 527-A-00-04-00109-00)

Joint Project with the Ministry of Health, Regional Governments, Local Governments and civil society

Final Report

(2004-2007)

Lima, 2007

ACKNOWLEDGEMENT

To regional, local and community governments, officials and technical teams of the Ministry of Health, other public and private institutions, human teams at all levels and to the organized civil society, who with their commitment, enthusiasm and contributions made possible the development of the Project. The improvement in health service delivery quality and the promotion of healthy communities for achieving human development today is the result of joint and coordinated work that was carried out in different activities.

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PRESENTATION

The Project "Improving the Health of Peruvians" was implemented between October 2004 and September 2007 through a Cooperation Agreement (CA 527-A-00-04-00109-00) entered into by the United States Agency for International Development, USAID, and Pathfinder International. Its goal was to contribute to the reform of the health sector regarding service quality management, health human resource policy and the promotion of healthy habits in people and communities.

The project was developed within the framework of the decentralization of health functions started by the Peruvian Government. As a result, technical assistance was directed at coordinating health and regional and local development, encouraging the involvement of citizens in the implementation of policies in favor of human development.

The intervention scope comprised low-resource populations of seven deprived regions: Huanuco, San Martín, Junín, Pasco, Ucayali, Ayacucho and Cusco, defined as priority areas by USAID based on their poverty indicators and social vulnerability, and among other things, for being coca leaf growers.

This document summarizes the activities and results of the different strategies. Opinions set forth correspond to the project's technical team and do not necessarily reflect USAID's points of view.

ACRONYMS

ACS	Health Community Agents
ACLAS	Local Health Care Committees Association
ADAR	Local NGO located in Iquitos (Loreto)
AGROVIDA	Local NGO located in Trujillo (La Libertad)
AIEPI	Comprehensive Care of Prevalent Diseases in Infants
AMARES	Local NGO
AMRESAM	Association of Municipalities in the San Martín Region
APAFA	Parents Association
APROPO	Local NGO. Promoting free responsible sexuality
ASPEFAM	Peruvian Association of Medical Schools
ASPEFEEN	Peruvian Association of Nursing Schools
ASPEFOBST	Peruvian Association of Obstetrics Schools
BCC	Behavior Communication Change
CA	Cooperation Agreement
CAFME	Accreditation Committee of Medical Schools
CATALYST	USAID Project-Consortium lead by PI, implemented in 11 countries
CCLs	Local Coordination Council
CDC	Competence Development Center
CEP	Nurses School of Peru
CERITS	Referral Center for People Infected by Sexually Transmitted Diseases
CGD-RHUS	Health Human Resource Development Management Committee
CIE	International Disease Classification
CLAP	Latin American Center of Perinatology and Human Development
CLAS	Local Committees of Service Administration
CMI	Comprehensive Control Table
CMP	Peruvian Medical Association
CND	National Decentralization Council
CO	Organizational Atmosphere
CONAREME	National Medical Internship Committee

CONEAU	Quality Evaluation, Accreditation and Certification Committee for Higher Education
CONEI	Institutional Educational Council
COP	Peruvian Obstetricians Association
COTEDI	District Technical Committee
CRECER	Coordinated Infant Nutrition Program
CRGDS	Regional Health Development Management Committee
CRS	Regional Health Committee
CRSJ	Regional Health Council Junín
CTO	Cognizant Technical Officer
CS	Health Center
CTR	Regional Technical Committee
CTR-RHUS	Regional Human Resource Committee
CTRGC	Regional Technical Committee for Quality Management
DAC	Comprehensive Health Care Directorate
DAIS	Comprehensive Health Care Directorate
DECS	Health Quality Executive Directorate
DEVIDA	National Committee for Development and Life without Drugs
DGSP	People's Health General Directorate
DIGEMID	General Directorate of Medicine, Supplies and Drugs
DIGEPROMSA	General Directorate for Health Promotion
DIRESA/ DISA	Regional Health Directorate
DL	Law Decree
EE.SS	Health Facility
ENESR	National Strategy for Reproductive Health
EGC	Quality Management Team
EGES	Strategic Health Management Team
EMOB	Obstetrical Emergency Program for Health Services
EMS	Healthy Municipality Strategy
ENAE	National Nursing Examination
ENAM	National Medicine Examination
ENDES	Demographic Survey of Family Health
ENSSR	Sexual and Reproductive Health Strategy
EPS	Permanent Health Training
EPSyD	Health and Development Promotion Schools

EsSalud	Health Social Insurance of Peru
ETGC	Technical Team for Local Quality Management (ETGLC)
ETGC	Technical Team for Quality Management
FAIMER	Foundation for Advancement of International Medical Education and Research
ETL	Local Technical Team
FIB	Basic Infant Functions
FIE	Essential Infant Functions
FII	Intensive Infant Functions
FIP	Primary Infant Functions
FF.AA.	Armed Forces
FF.PP.	Police Forces
FON	Obstetric and Neonatal Functions
FONB	Basic Obstetric and Neonatal Functions
FONE	Essential Obstetric and Neonatal Functions
FONI	Intensive Obstetric and Neonatal Functions
FONP	Primary Obstetric and Neonatal Functions
FORO SALUD	Local NGO
GAMHESA	Blood Brothers Mutual Help Group Association
GDS	Social Development Management
GICES	Quality Initiatives in Higher Education Group
GR	Regional Government
HCMP	Maternal Perinatal Clinical Record
HSH y TS	Men who have sex with men and Sex Workers
IDREH	Human Resource Development Institute
IEPSyD	Health and Development Promoting Educational Institutions
IEC	Information, Education and Communication
IES	Educational Institutions
INPPARES	Peruvian Institute for Responsible Parenthood, local NGO
IPC	Consumer Price Index
Juntos	National Program for Direct Support to the Poorest
MAIS	Comprehensive Health Care Model
MCC	Continuous Improvement in Quality
MINED	Ministry of Education
MINSA	Ministry of Health

MOCAMP	Quality Monitoring of Maternal Perinatal Care
MOF	Organization and Functions Manual
MP	Maternal Perinatal
MR	Micro-network
MS	Healthy Municipalities
MSH	Local NGO
MT	Thematic Committee
MT_RHUS	Thematic Committee on Health Human Resources
MUNIRED	Municipalities Network
NBME	National Board of Medical Examiners
LEEC	Experimental Laboratory for Evaluating Clinical Competences
NCL	Work Competence Regulation
ODL	Local Development Organizations
OGEI	General Statistics and Data Processing Office
OGGRH	General Human Resource Management Office
OLSIS	Local Comprehensive Health Insurance Office
OPI	Investment Project Office
OPS	Pan-American Health Organization (PAHO)
OTL	Local Technical Office
PAC	Annual Training Program
PAE	Annual Education Program
PARSALUD	Local NGO
PASARE	Reproductive Health Support Project
PCIE	Curricular Project for Educational Institutions
PDA	Alternative Development Project
PCMI	Mother Child Training Program
PDI	Local NGO
PECO	Continuous Education Program
PED	Strategic Development Plan
PEI	Educational Project
PEPE	Permanent Nursing Training Program
PER	Regional Education Program
PF	Family Planning
PHEA	Plan, do, study, act

PMCC	Continuous Quality Improvement Projects
POA	Annual Operative Plans
PI	Pathfinder International
PPD	Participative District Budget
PPR	Participative Regional Budget
PS	Health Center
PRCE	Coordinated Regional Education Program
PRCS	Coordinated Regional Health Plan
PRISMA	Local NGO
PRODES	Local NGO
PROGRESA	Health Management Program
PROMSA	Health Promotion
PUCP	Pontifical Catholic University of Peru
RC	Referral and Counter-referral
RD	Director's Order
RG	Regional Government
RI	Intermediate Result
RHUS	Health Human Resources
RM	Minister's Order
RN	Newborn
RNPM	National Network for Women's Promotion
ROF	Regulation on Organization and Functions
RPD	Reflection on Daily Practice
RRHH	Human Resources
RSE	Social Business Responsibility
SAIDA	Comprehensive and Differentiated Care Services for Adolescents
SECORE	Regional Coordination Secretariat
SEDES	Departmental Health Service
SER	We Know, We Listen, We Answer
SERUMS	Rural and Peripheral Urban Health Service
SGC	Quality Management System
SIGA	Administrative Management Information System
SINADEPRO	National System for Professional Development of Obstetricians
SINEACE	National Evaluation, Accreditation, Certification System for Educational Quality

SIP	Perinatal Data Processing System
SIP 2000	Perinatal Information System
SIS	Comprehensive Health Insurance
SISMED	Medicines, Supplies and Drugs System
SISTCERE	Certification and Re-certification System
SNP	Contractual Service
SO	Strategic Objective
SRC	Regional Quality System
SSR	Sexual and Reproductive Health
UGEL	Local Educational Management Unit
UNCP	Peruvian National University del Centro
UNHEVAL	Peruvian University Hermilio Valdizán
USAID	US Agency for International Development
VRAE	Valley of the Apurimac and Ene Rivers

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Final Report

A. EXECUTIVE SUMMARY

The Cooperation Agreement between the United States Agency for International Development (USAID), and Pathfinder International was developed between 2004 and 2007. The purpose of the Project was to provide technical assistance to 7 regions in order to improve the health conditions of the most deprived populations through local and regional policies for health quality and human health resource management, as well as for promoting healthy habits, within a favorable political context due to decentralization in the health sector promoted by the State.

The Project is registered within Strategic Goal 11 of the USAID Local Mission: "Improving the Health of Peruvians" and covered 7 regions: Ayacucho, Cusco, Huanuco, Pasco, Junin, San Martin and Ucayali, these being considered priority areas according to their poverty indicators and social vulnerability because they within or near coca-growing areas.

Upon conclusion of the Catalyst Project (2002-2004), followed by the Cooperation Agreement, the development balance of the health sector was favorable. The health establishments had noticeably increased the coverage of their services which made critical health indicators, such as child mortality rate and maternal mortality rate, favorably change; however, there were still great barriers to overcome for effective improved health for Peruvians at risk, among them:

- Poor quality, inefficiency, under use and unequal access to health services.
- Health sector policies and programs insufficiently sensitive to health needs and to cultural and social economic conditions of the population of the regions.
- Insufficient knowledge on the part of the population about prevention of high risk habits.

The Cooperation Agreement addressed its activities towards the elimination of these barriers through the creation of a Health Quality Management System, the development of the Health Human Resources Policy and the implementation of actions for promoting Healthy Habits and Health Communications.

The following are some of the Agreement's main products by strategic product:

Quality Management System

- Preparation of Coordinated Regional Health Plans in Junin, Pasco and Cusco.
- Preparation of the Coordinated Regional Educational Plan in Huanuco.
- Design, preparation and approval of maternal perinatal quality standards through Minister's Order 142-2007/MINSA, of compulsory use in MINSA health facilities.
- Design and preparation of infant quality standards.
- Design, preparation and approval of the Regulation and the List on Accreditation Standards for Health Facilities through Minister's Order 703-2006/MINSA, updated by Minister's Order 456-2007/MINSA of compulsory enforcement at all health facilities in the country.
- Implementation and dissemination of a Continuous Quality Improvement culture in health facilities of the 7 project intervention regions.
- Neonatal and Obstetrics Emergency Training Manual, EMOB (Spanish and English), approved by the Gynecological and Obstetrical Association and the Pediatrics Association.
- Quality Information Systems
    - Information System on Neonatal and Obstetrics Functions (FON), approved by MINSA (Minister's Order 1001-2005/MINSA) which makes its use compulsory in all the country as a routine instrument for the evaluation of the resolving capacity of health facilities at all levels. The FON system is also used by the Ministry of Economy and Finance as a source of information for assigning the health budget for the regions.
    - Accreditation Information System of Health facilities through Accreditation Application V-1.0.
    - Updating of the Prenatal Information System and its application in all the country, approved by Minister's Order No. 008-2000-SA/DM
    - Certification and Re-certification Information System of the Peruvian Medical Association.

Health Human Resource Policy

- Development of Initiatives for the improvement of health human resource education:
    - Designing of the Initiative Group for Higher Education Quality (GICES)

- Contribution to the preparation of bill and enactment of Law No. 28740 on the Creation of the National Evaluation, Accreditation and Certification System on Educational Quality (SINEACE), May 2006 and the SINEACE Law Regulation (7/10/2007).
- National Medicine Exam (ENAM) acknowledged by Minister's Order No. 620-2006/MINSA and put into practice in the 22 medical faculties, members of ASPEFAM. For the National Committee of Medical Internship (CONAREME, the ENAM is considered a requirement for the Medical Internship program.
- Creation of the CAFME by Law No. 271548 and Accreditation of 23 of the 29 faculties and medical schools in the country.
- Basic Curricula addressed at competences for the Nursing and Obstetrics Schools and Faculties.
- Graduate Profiles by competences of the nurse and obstetrician.
- National Nursing Examination (ENAE) approved by ASPEFEEN.
- Quality Standards for the Accreditation of Nursing and Obstetrics Faculties and Schools. Of 47 Nursing Faculties and Schools in the country, 44 have finished their self-evaluation and 30 have already had external evaluation.
- New model of Medical Re-Certification.
- National System of Periodic Nursing Certification.
- Permanent Education in Nursing Program (PEPE).
- Continuous Education in Obstetrics Program (PECO).

- Development and improvement in Health Human Resource Competences through:

- 5 Competence Development Centers CDC-Hospitals rated by IDREH as Teaching Centers for Internships in Neonatal and Obstetric Emergencies, and 8 CDC - Hospitals currently being rated.
- 4 primary health care Centers rated as CDC-Micro-network.
- Trained and qualified tutors for CDC-Hospitals and CDC-Micro-network.

- Development of a New Labor Regulatory Framework that includes:
- Profile of work competences and Labor Competence Regulations of the prioritized competence units in the following areas: child, pregnant women and management, for facilities category 1-2, Care Level I; and evaluation instruments of working competences: 15 checklists and 10 questionnaires.
- Occupational Profile and Labor Competence Regulations in the following areas: person (child, adolescent, pregnant women and the elderly), family, community and management approved in Huanuco (Director's Order No. 272-07-GR-HCO/DRS-DG-OEGDRH-DESP of May 2007).
- Management agreement (July 2007) between the Regional Government and the local governments of Amarilis and San Francisco de Cayran (Huanuco), to improve work competences of health human resourceS in the mother-child area. Expansion (September 2007) of the Management Agreements to eight districts comprised in the CRECER Plan.

- Improvement of working conditions, motivation and commitment through incentives based on staff's performance and the incorporation of staff well-being service as part of the comprehensive human resource management.

- Improvement of working relationships based on respect, by measuring the organizational climate and the Implementation of solutions according to the possibilities of the San Martin and Huanuco DIRESAs.

Health Promotion

- Advocacy in favor of the following regulations:

  - MINSA's policy on "Decentralization of the Health Function at a local level – Pilot Projects", which takes into account Health Promotion as a key element in primary health care to be decentralized.
  - Regional Ordinance No.002-2007-CR-GRH of the Huanuco Region which approves the Certification of Minimal Regional Standards of Healthy Towns.
  - Executive Regional Order No. 115-2007 GRJ/PR of the Junin Region which establishes health promotion and culture as a regional priority, as well the Implementation of the Minimum Regional Standard Certification of Healthy Towns for the promotion of Social Well-being and Development in the Region.

- Sensitization and Advocacy of local leaders and authorities for organizing and implementing the Health Promotion Strategy:

  - Implementation of 52 Local Development Offices, ODL, as coordinating bodies of PROMSA activities for institutions, authorities and community.
  - Implementation of 52 Local Technical Teams, ETL, as technical support groups for ODL management.
  - Organization and acknowledgement of 504 Neighbor Community Associations.
  - Conformation of 60 social networks.
  - Enactment of 131 Municipal Public Policies to make effective their Local Development Plan.
  - Preparation of 835 Community Development Programs.
  - Preparation of 305 Family Programs to be acknowledged as Healthy Families.

- Regional Meetings in Huanuco, Ucayali and Pasco to exchange PROMSA experiences and health communication and strengthen the relationship between the Local and Regional Governments.

- Incorporation into the municipal policy agenda the design of Healthy Town projects in the Framework of the Regional (PPR) and District (PPD) Participative Budget:

- Junin: Project, "Strengthening Capacities of the Local and Regional Technical Teams for Health Promotion in the Region" approved in the Regional Participative Budget, (337 200 nuevos soles)
- San Martín: Project, "Promoting the Participative Social Development in the District of Juan Guerra", (30 000 nuevos soles).

- Correspondence Course: Healthy Towns and Schools with the participation of 5,160 people from 55 provinces of the 7 regions taking part in the Project.

- Healthy Communities: strategy carried out in 689 communities from 72 districts, of which 32 belong to areas of the Alternative Development Program, PDA.

- Between 2005 and 2007, Healthy Habit Indicators showed a noticeable higher increase than the 20% established in the Intermediate Result 2 indicator: "Population practicing healthy habits."

Health Communication

- Communicators network of the Amazon region. Technical assistance (requested by DEVIDA) for training of communicators networks of Ucayali (Pucallpa and Aguaytia), Ayacucho (Huamanga and VRAE), San Martin (Tarapoto) and Huanuco (Tingo Maria) in:
  - Communications Specialization Course: 110 communicators participated who represent 90% of the total of these network members.
  - Improvement of the Website, through an agreement with PRISMA.

- Seven Networks of Radio Program Correspondents. San Martin, Cusco and Huanuco were the most successful.

- Seven Communication Networks, consisting of communicators, journalists, health personnel and students from the faculties of Social Sciences and Communications.

- Training in Communications

  - Correspondence Course on "Health Communication"
  - Specialization Program in Health Communication for communicators
  - Internship in Radio Marañon aimed at the owners of radio stations

- Communication Products

  - Radio Programs (radio dramas based on motivations)
    - Huanuco: Program: "In confidence" ("Between you and me") (formerly, "Consultorio en la Radio" ("Doctor's Office on the Radio") of the Luz y Sonido radio station, aired Tuesday and Thursday from 10am to 12m.

- Ucayali: Program "Surcando al Progreso" ("Moving Ahead") from Del Progreso radio station.
- Junín: During the summer of 2007, the program "Reconstruyamos juntos Chanchamayo" ("Rebuilding Chanchamayo together") was produced to support flood victims, once the emergency was over, it was named "El cambio esta en uno" ("The change is in each of us").
- Cusco: Program "Redes" ("Networks") of Universal radio station (conversation with women).

- Radio spots, on:
  - Medical re-certification in the seven regions.
  - Maternal health and institutional childbirth in Ayacucho, Cusco and Huanuco.
  - Healthy practices: hygiene, communication with schoolchildren and prevention of teenage pregnancy and prevention of child labor in Ayacucho (Iguain), Cusco (Combapata) and Pasco (Oxapampa) and San Luis de Shuaro.

- Television reports:
  - Report on healthy schools in Huanuco
  - Reports on the medical Re-certification: 3 reports in Huanuco and 2 in Cusco.

- Health communication campaign based on motivators (Ucayali)

- Video "If we had only" on healthy and safe pregnancy to promote a change of behavior in pregnant mothers, their relatives, community and health staff.

- Bulletins
  - San Martín (Juan Guerra), Junín (San Luis de Shuaro), Ayacucho (Iguaín), Cusco (Combapata) and Pasco (Oxapampa): Bulletins on Healthy Towns which included healthy practices on hygiene, identity, breast feeding, pre-natal check-ups, institutional childbirth care, among others.
  - On-line bulletins. Two in each region: Ayacucho, Cusco, San Martín and Junín in support of the activities of the Regional Health Board of the Medical Association (periodic certification) and of local governments.

B. BACKGROUND

Within its cooperation strategy with the Health Sector of Peru, the United States Agency for International Development has a long tradition of cooperating with the Ministry of Health to improve health and quality of life of the most deprived Peruvians. Such support is aimed at strengthening service delivery, at the relevance and effectiveness of professional training systems, health administration and management. In this sense, after a lengthy and successful experience of Project 2000[1] (1995 – 2002), whose main component was the Maternal-Infant Training Program (PCMI), the Catalyst Project[2] followed (200-2005), globally designed (in 11 countries[3]) to reduce maternal and infant mortality through the increase in the use of the services of family planning and sustainable quality reproductive health, at the same time encouraging healthy practices through clinical and non-clinical programs.

At a local level, the Catalyst project responded to the needs of each beneficiary country of the project, adapting itself to their particular needs, resources and development level. In Peru, a variety of activities were implemented, some in the local sphere and others focused on seven regions, defined as priority regions by USAID based on their poverty indicators and social vulnerability for being coca leaf growing areas. One of these activities was the preparation of Health Coordination Regional Plans, PRCS, as important management tools, which were developed in mutual consensus among the Regional Governments, Local Governments, (provincial and district), different government sectors, civil society institutions and the

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[1] *During the period between 1995-2002, the Ministry of Health with the technical financial support of USAID, successfully developed the **2000 Project** throughout 12 leading regional health centers with the purpose of improving the health and nutritional care of infants and women in their reproductive stage, through the following :*

a) increasing access to services of maternal and infant care

b) reducing obstacles (financial, cultural and informative) for access to maternal-infant health care in 90 facilities of the Ministry of Health, and

c) Improvement in quality and efficiency of the organization and the delivery of maternal and pre-natal health care services.

The main component of this project was the Maternal-infant Training Program (PCMI) in order to provide training in maternal infant health care throughout the regional CDC.

[2] *From October 2000 to September 2005, MINSA, with technical and financial support from USAID, through a consortium of five institutions headed by Pathfinder International, implemented the Catalyst Project and thus contributed to achieving the objective of the local USAID Mission of "expanding sustainable opportunities for the improvement of the quality of life of Peruvian People through institutions and democratic procedures". USAID Peru's concern was focused on critical health problems such as HIV/AIDS, malaria, tuberculosis, malnutrition, maternal mortality, unwanted pregnancies. The emphasis was aimed at supporting preventive changes in habits towards healthier forms, as well as toward a reform of the sector's policies.*

[3] *Bolivia, Cambodia, Egypt, Indonesia, India, Laos, Nepal, Pakistan, Peru, Rumania and Yemen.*

community. Aside from the Plans, Catalyst provided technical and financial assistance to the Ministry of Health and non-governmental organizations to develop actions related to:

- Comprehensive post-abortion care
- Accreditation of health centers and institutions which train health professionals; as well as periodic certification of medical professionals, obstetricians and nurses
- Improvement of health conditions of the population sector at risk
- Diversification of sources for birth control methods and development of Corporate Social Responsibility strategies
- Optimal Birth Spacing
- Improvement of health services for young people
- Gender based violence

Progress made in each of these activities[4] showed that a comprehensive model of coordination and inter institutional bonds with the regional and local governments and with

[4] ***a) Comprehensive post-abortion care*** *(within the improvement framework of EMOB services in order to reduce maternal mortality) in 306 hospitals and health centers of the country. At a community level, campaigns were launched to detect alarm signs and to design several action plans in order to reduce teenage fertility and gender-based violence as forerunner of abortion.*

b) Accreditation *of health centers and institutions which train health professionals, as well as health facilities.; this should also include* ***periodic certification*** *of health professionals through a joint working experience with MINSA and eight other associated institutions (ASPEFAM, ASPEFEEM, ASPEFOBST, CAFME, Medical Association of Peru, Obstetrics Association of Peru, Nursing Association of Peru, and GICES). In mid 2000, 19 out of 28 Faculties of Medicine had been accredited and the National Medical Exam had been validated and used in several faculties. National Standards were approved for Nursing and Obstetrics Training Schools, qualification profiles for nursing and obstetrics were developed, as well as the basis for an obstetrics curriculum. 25 Schools of Obstetrics and 48 of Nursing had completed their own evaluations and were expecting their external peer evaluation. The periodic certification procedures had been implemented in the medical profession and were still pending in Obstetrics and Nursing.*

c) Improvement *of health services in 7 regions through training of RH. and FP. providers, post-abortion care, EMOB, health administration and management, among others, setting-up of regional CDCs, Health administration Program PROGRESA (in partnership with PHRplus and Policy Project), selection of Quality Teams and Health Management Committees.*

d) Diversity of birth control sources and Corporate Social Responsibility. *Following a social marketing strategy, APROPO launched their condom OK. Inpares, in conjunction with the pharmaceutical industry, created a network of suppliers, Red Plan Salud, made up by over 500 Obstetricians in 20 districts of Lima, in order to provide services and supplies for RH.and FP. 54% of the network's customers had previously been attended by the public sector. Catalyst implemented Social Corporate Responsibility activities with Agrícola Chapi, Amanco, BTL Pharmacies, Camposol, Corporación Los Andes, Dan Per, InkaFarma and mining industries such as Tintaya and Yanacocha, so they could offer their workers assistance in sexual and reproductive health.*

e) Optimum Pregnancy Spacing*, in order to disseminate the message that the optimal spacing between births is ideally 3 to 5 years as per health services of the NGOs ADAR (Loreto) and AGROVIDA (La Libertad)*

f) Expansion and Improvement of Health services for Young People. *Online counseling for Young people on STD and RH through APROPO ("nosedesexo.com"), which received over 250 thousand orders within two years. Sale of contraceptives and antibiotics for the treatment of Sexually Transmitted Diseases among young people 18 and 29 years old in Peruvian cities; means of communication on behavioral changes (BCC) and telephone assistance provided by expert counselors.*

g) Gender based Violence. *Through activities undertaken toward social awareness on gender violence implications, so as to prevent and reduce it, in the areas around Lima and other rural areas of Cusco, in association with the NGOs Manuela Ramos and Amauta.* .

the communities and individuals, is effective for improving health management, developing preventive activities and promoting the use of health services.

On completing Catalyst, the above mentioned activities showed different stages of progress and its expansion was also uneven by region. To consolidate them and extend them both geographically and technically, a bilateral agreement was signed between the local office of the United States Agency for International Development, USAID, and Pathfinder International which was concluded as Cooperation Agreement No. CA527-A-00-04-00109-00. In the framework of this agreement, Pathfinder developed the Project "Improving the Health of Peruvians" to contribute to the fulfillment of **Strategic Objective 11 of USAID "Improved health for Peruvians At-Risk".**

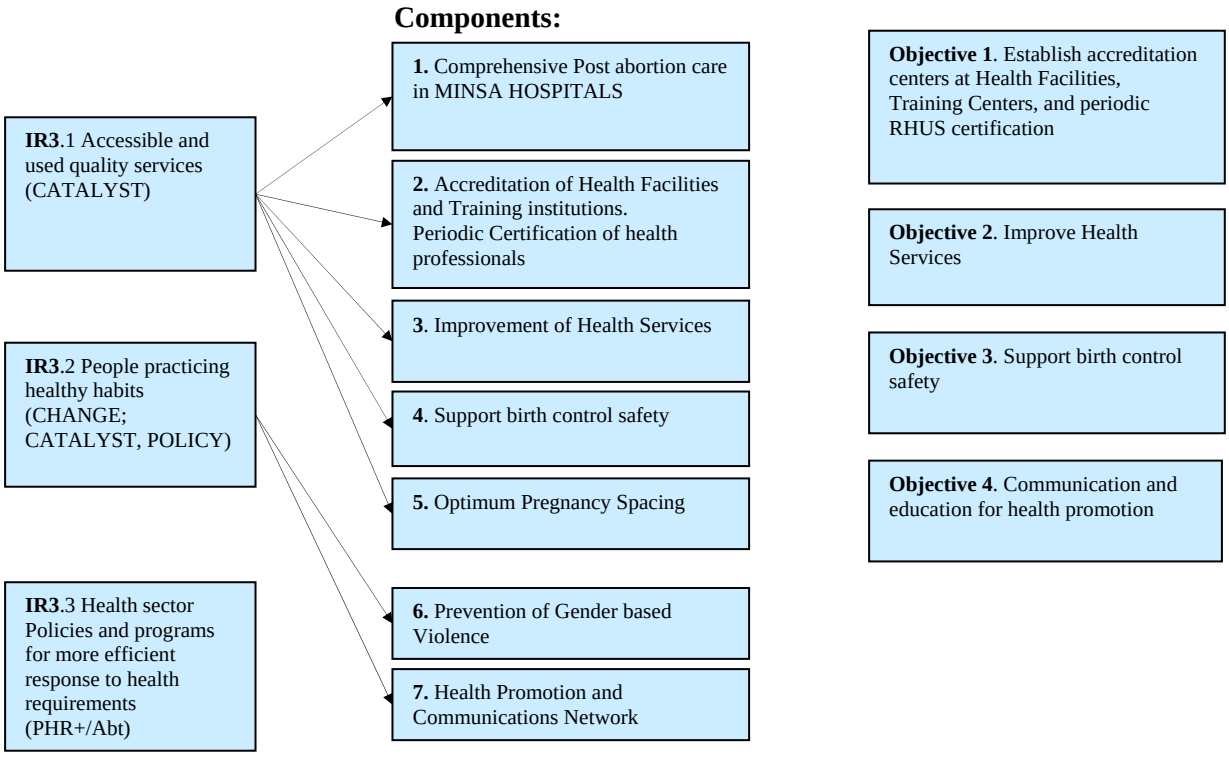
The transition of Catalyst towards the Cooperation Agreement is illustrated in Diagram 1.

Graphic 1: Transition of Catalyst to the Cooperation

USAID SO11: To Improve health of high risk Peruvians in five regions of the upper jungle and in the metropolitan area of Lima

CATALYST SO: To reduce maternal and infant mortality by increasing the quality of PF y SR. and promoting healthy practices through clinical and non-clinical programs.

Cooperation Agreement: To improve the quality of health services, to support the reforms of the health sector and promote healthy habits among individuals and communities in seven prioritized regions



C. THE COOPERATION AGREEMENT

In the dawn of the new millennium, the progressive and systematic social-economic growth of the country as of the second half of the '90's was reflected in strong macro-economical indicators (such as the Consumer Price Index, CPI and the dollar exchange rate which remained stable and the monetary reserves which increased, among others). However, these achievements were not clearly reflected in an improvement of living conditions of the large majority of Peruvians. For example, the Rate of Human Development of the country, instead of increasing decreased from 0.620 in 2000 to 0.590 in 2003[5]. At the same time, a huge imbalance in the distribution of the health sector's resources continued (facilities, professionals, equipment and products) concentrated in urban areas (particularly in Lima). This favored better health care quality in the cities, while the populations of the outlying and rural areas remained unattended or only partly attended.

The recent decentralization strategy whose aim is that the management of different services, especially those of health and education, would befall on the respective local and regional administrations, provides a favorable framework for the development of the Agreement activities that seek to: i) strengthen health institutions improving the quality of services and the effectiveness of the administration systems; ii) strengthen educational institutions which train health professionals and the professional associations which supervise professional activity, and iii) train the population of communities in the practice of healthy habits and lifestyles to contribute to their well-being and better health.

The geographic intervention sphere of the project consists of seven regions (San Martin, Ucayali, Huanuco, Pasco, Junin, Cusco and Ayacucho), considered priority areas by the local USAID mission, basically because of its high levels of maternal and infant mortality and child and adult morbi-mortality due to causes that can be prevented and to their social fragility in face of the dangerous effects of coca leaf growing and processing. The goal of the project was to "…*increase the quality and efficiency of health services through the building of ties with the public sector, private sector and non-government organizations*." The Strategic Objective of USAID (SO11) of "Improving the Health of Peruvians" (Diagram 2) would be measured by two Intermediate Results (IR):

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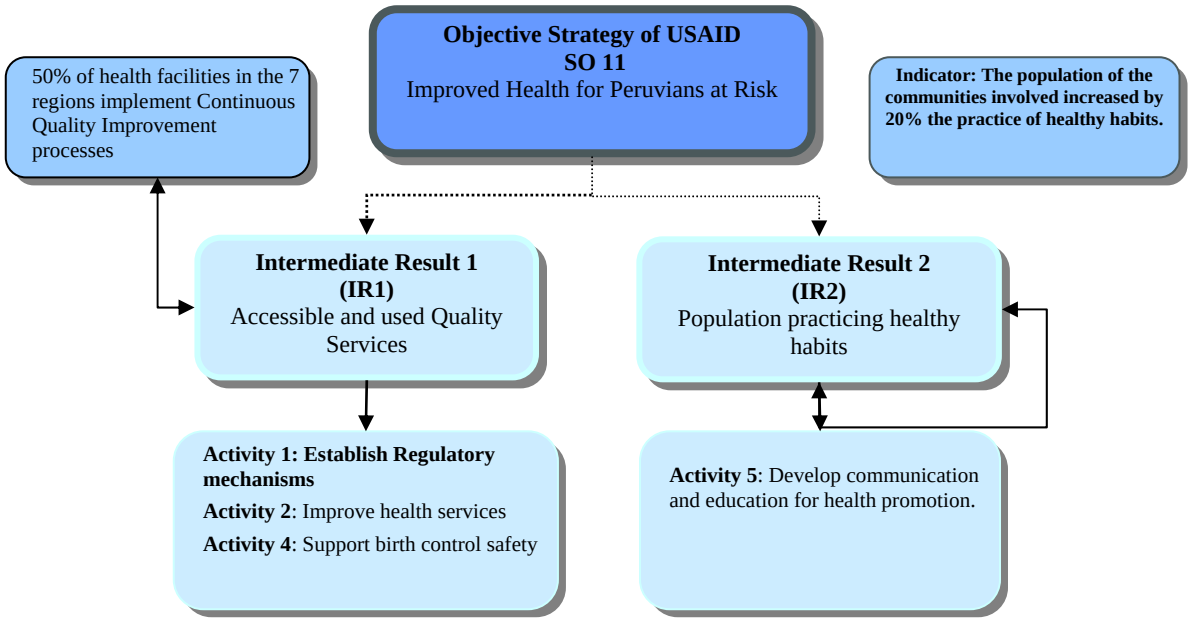
[5] *The United Nations Development Program, UNDP, measures poverty through the Human Development Index, HDI, which is a compound indicator that measures the average advances of a country, locality or specific administrative political division, based on three basic dimensions of human development:*

- *A long and healthy life (measured by life expectancy at birth)*
- *Education (evaluated through the adult literacy rate and the gross rate of school registration in primary, secondary and higher education), and*
- *The level of decent life (measured by the Gross Domestic Product, GDP, per capita in American dollars).*

Intermediate Result, IR 1.- Accessible and used quality services.
Intermediate Result, IR 2.- Population practicing healthy habits

Table 2: Cooperation Agreement: Improving the Health of Peruvians



Three activities contributed to the achievement of Intermediate Result 1: "Accessible and used quality services"

Activity 1.- Establish Regulatory Mechanisms for the creation and/or strengthening of a) an accreditation system of educational institutions, universities and higher institutes, which train health professionals, b) an accreditation system of health facilities (hospitals, health centers, health posts and private clinics) and c) a system of periodic certification of health professionals (doctors – general and specialists-, nurses and obstetricians).

Activity 2.- Improve the quality and efficiency of the health services in MINSA health facilities in the seven regions which are USAID priority areas.

Activity 4.- Diversify birth control safety extending method supply sources through the expansion of the commercial sector, promoted by two NGOs specialized in reproductive health: APROPO and INPPARES.

APROPO
PROMOVIENDO SEXUALIDAD RESPONSABLE EN LIBERTAD

Inppares
Promueve salud y desarrollo

The fifth activity of the Agreement contributed to Intermediate Result 2 "Population practicing healthy habits":

Activity 5.- Develop communication and health education activities for health promotion, through improvement of healthy habits practiced by individuals and communities and the strengthening of healthy Educational Institutions or Health Promoting Schools.

Each activity consists in several secondary activities that varied during the carrying out of the Project to adapt themselves to the regional reality, specific requirements and needs of beneficiaries and the progress being achieved in the field (See original and adapted activities and secondary activities at the end of this chapter, Tables 5 and 6).

During the last execution stage of the Agreement, the combination of activities and secondary activities, were organized to reach certain Strategic Products, in addition to the two Intermediate Results which mutually complement one another and individually contribute to the achievement of the universal goal of the project, which it to improve the health of the population in the seven regions, Diagram 3.

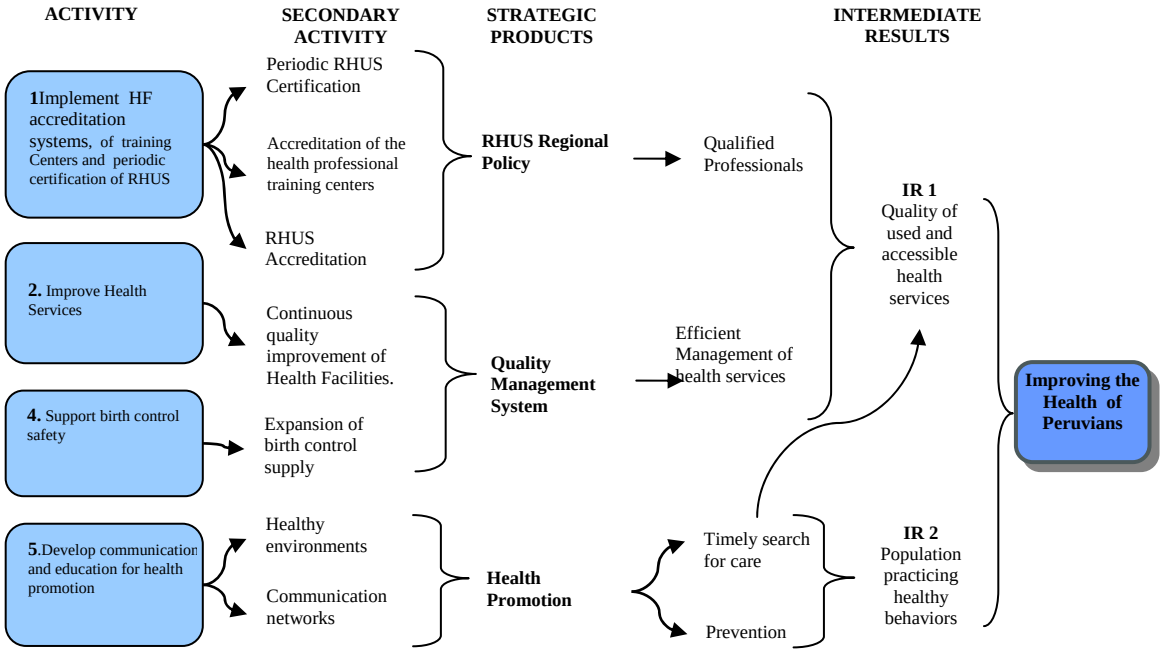
Strategic Products, which are studied separately (activities and achievements) in the following chapters of this report are:

Strategic Product 1: Quality Management System. Its final purpose is an efficient management of health services from the central level up to the local level.

Strategic Product 2: Regional Policy on Health Human Resources whose objective is for the health system to provide competent professionals.

Strategic Product 3: Health promotion through the promotion of healthy environments (towns, communities, educational institutions, neighborhoods and healthy families, among others) and of health communication networks which contribute to making more appropriate environments for the development of peoples' everyday lives.

Diagram 3: Cooperation Agreement: Activities and secondary activities according to Strategic Products and Intermediate Results



D. INTERMEDIATE RESULTS

***INTERMEDIATE RESULT 1:* "Accessible and Used Quality Health Services"**

The following indicator was proposed for measuring this intermediate result: "50% of health facilities develop continuous quality improvement processes in the framework of a Quality Management System".

Upon conclusion of the project, this indicator was improved upon in the seven regions intervened, as 62% of health facilities were developing continuous quality improvement processes, (see Table 1). In point of fact, as a result of quality management activities, out of 1,382 health facilities located in the seven regions, 857 were developing projects (designed by health service providers themselves) to improve quality standards identified as weak or deficient during an initial measurement. Continuous improvement projects contain different activities tending to favorably influence on the weak standard for a certain period of time after which a new measurement will account for the effectiveness of activities set forth in the project. If after a second or third measurement the standard has not yet reached an acceptable level, the improvement process continues with a new project after the other, until the desired standard(s) level is achieved.

Per type of continuous improvement project, more than half (54%) had the objective of raising primary maternal perinatal standards, 29% were addressed at making progress in the achievement of quality standards for first level facilities, 9% sought to raise the level of primary infant standards and only 6% were addressed at obtaining better basic and essential maternal perinatal standard levels. However, these represented 82% and 90% of health facilities that should comply with such standards. Table 1.

To illustrate the nature of the projects, the following is a brief description of each according to the standard they sought to improve:

1) **Project for improving Quality Standards for First Level Health Facilities**. In this group, the most common projects were addressed at improving standards in: a) effectiveness, (cutting down waiting time, promotion of institutional childbirth delivery, improvement of registry of clinical records and compliance of referral and counter-referral according to regulations and protocols, among others), b) Respect to user standards (implementation of operative mechanisms for listening to service users), c) social involvement standards (improvement of community referral and counter-referral system), and d) external user satisfaction standards

Table 1: Continuous Quality Improvement Projects

Networks, Micro-networks, Health Facilities. and Continuous Quality Improvement Projects (PMCC)	Total	Regions						
		Ayacucho	Cusco	Huánuco	Junín	Pasco	San Martín	Ucayali
Total Number of Networks [1]	**37**	**7**	**4**	**3**	**6**	**3**	**10**	**4**
Total Number of Micro-networks (MN) in the regions [1]	**195**	**30**	**38**	**29**	**26**	**14**	**43**	**15**
Micro-networks in the intervention area	127	4	30	28	23	11	22	9
% in relation to the total number of MN in the regions	**65%**	**13%**	**79%**	**97%**	**88%**	**79%**	**51%**	**60%**
Micro-networks in the intervention area with MCC projects	111	4	29	28	22	10	11	7
% in relation to the total number of MN in the intervention area	**87%**	**100%**	**97%**	**100%**	**96%**	**91%**	**50%**	**78%**
Total Number of Health Facilities in the regions [1]	**2,197**	**406**	**284**	**242**	**461**	**258**	**355**	**191**
- Health Facilities in the project's area of intervention	1,382	47	208	228	393	195	176	135
% in relation to the total number of facilities in the regions	**63%**	**12%**	**73%**	**94%**	**85%**	**76%**	**50%**	**71%**
- Health Facilities in the intervention area developing MCC projects	857	22	161	216	278	108	49	23
% in relation to the total number of facilities in the intervention area	**62.0%**	**46.8%**	**77.4%**	**94.7%**	**70.7%**	**55.4%**	**27.8%**	**17.0%**
Health Facilities in the Project's intervention area with PMCC per type of project [2]								
For First Level	334	2	26	151	71	36	46	2
Primary Maternal Perinatal (FONP)	613	13	112	175	236	72	4	1
Primary Infant (FIP)	121	20	7	36	13	34	0	11
Basic Maternal Perinatal (FONB)	41	0	33	7	1	0	0	0
Essential Maternal Perinatal (FONE)	2	0	2	0	0	0	0	0
OTHERS (Combination of two standards)	42	0	0	5	34	3	0	0
Total MCC Projects by Quality Standards at Health Facilities in the intervention area	**1,238**	**38**	**244**	**526**	**345**	**48**	**7**	**30**
Quality Standards for First Level Health Facilities	361	2	27	211	100	16	3	2
Primary Maternal Perinatal (FONP)	671	14	169	251	194	22	4	17
Primary Infant (FIP)	109	22	7	49	13	7	0	11
Basic Maternal Perinatal (FONB)	51	0	37	10	4	0	0	0
Essential Maternal Perinatal (FONE)	4	0	4	0	0	0	0	0
OTHERS (Combination of two standards)	42	0	0	5	34	3	0	0
Projects at a DISA, NETWORK and Micro-Network Level	**28**	**0**	**1**	**11**	**5**	**9**	**2**	**0**

[1] *According to MINSA's database updated in January 2007*
[2] *The same facility was counted more than once because it was developing more than one project*

2) **Projects for improving Primary Maternal Perinatal Standards (FONP)**. Regarding continuous improvement of FONP standards, most projects were designed to improve process standards and indicators, rather than structure and result standards and indicators. Thus, you can find projects related to the application of the partogram at health facilities; reduction of home childbirth deliveries; strengthening of information, communication and education on childbirth with cultural adaptation; referral of newborns in emergencies; cutting-down waiting time for pregnant women care; strengthening of community involvement in mother-child care, among others.

3) **Projects for improving Basic Maternal Perinatal Standards (FONB)**. Continuous improvement of basic maternal perinatal standards at facilities that carry out basic obstetric and neonatal functions was addressed at the improvement of process and result standards and indicators. Among the first, we can highlight projects for expanding coverage of lab test service for all pregnant women; improvement of health service provider competences; pregnant women care through waiting houses, recruitment of pregnant women in their first quarter; reduction of pregnancy among teenagers, etc. Among the latter, there are projects that seek satisfaction of pregnant women on care received and reduction of home childbirth deliveries in the intervention scope.

4) **Projects for improving Essential Maternal Perinatal Standards (FONE).** Standards that need to be improved at facilities that carry out essential obstetric and neonatal functions are: a) prenatal and childbirth care (strengthening of care quality in Gynecological-Obstetrics Services, improvement of quality in obstetric and neonatal care and improvement of recruitment and comprehensive care of pregnant women who are victims of violence, among others). b) care standards for newborns with low APGAR and pediatric patients with serious malnutrition, and c) users' satisfaction standards.

5) **Projects for improving Primary Infant Standards (FIP).** Primary infant standards whose improvement is sought by projects developed by facilities in the intervention area are of structure (reorganization, implementation, refurbishing of place for newborn care at the facility; promotion of community involvement in mother-child surveillance, surveillance of health in children in the family and the community), of process (comprehensive care program prepared according to MINSA's technical regulation, evaluation of child abuse, referral of children to more complex facilities if required), and of results (improvement of child care with AIEPI methodology and improvement of comprehensive care of children under 5 at health posts).

As can be seen on Table 1, the indicator Intermediate Result No. 1 did not have the same achievements in all regions. The 50% goal was surpassed in Cusco, Huanuco, Junín and Pasco, the Huanuco region standing out, where nearly 95% of facilities developed continuous quality improvement projects; while in Cusco 77% of them were involved and in Junín, 71%. In these four regions, standards that needed to raise their levels through projects were basically those that had to be practiced at facilities with primary obstetric and neonatal functions.

The other regions, Ayacucho, San Martín and Ucayali experienced a series of limitations during the development of the project that negatively affected compliance of IR indicator No. 1.

From lessons learned up to the conclusion of the project, you can say that the implementation of continuous quality improvement projects has enabled to:

- Re-direct purchase of supplies and goods through SIGA (Integrated Administrative Management System), review SISMED's request for medicines and guide scheduling of purchase of supplies.
- Improve knowledge of regulations of the Referral and Counter-referral System.
- Improve recruitment system to SIS affiliations.

- Comprehensive child care regulations should be complied with systematically.
- Lab test standards should be complied with to improve lab operation as a result of procurement of products foreseen in comprehensive care regulations for pregnant women and children.
- Coordinate work at MN head offices with peripheral facilities.
- Link PROMSA, HR activities and the various sanitary strategies.
- Identify staff training needs through self-evaluation of standards and direct staff training according to their needs.
- Measure the effectiveness on the use of SIS resources through the evaluation of standards linked to a certain product.
- Identify gender and child-based violence problems by measuring standards in pregnant women and children.
- Guide human resource policies through motivation of staff with incentives to make progress in the PMC implementation.

***INTERMEDIATE RESULT 2:* "Population practicing healthy habits".**

Measured through the indicator: "The population in intervened communities increased the practice of healthy habits by 20%".

Selected healthy habits were in relation to infant health, maternal health, reproductive health and housing. These indicators were measured twice in four regions (Junín, Huanuco, Pasco and San Martín), out of the seven prioritized by USAID, as health promotion activities, PROMSA, had been focused there. The measurement corresponds to a representative sample of 26 districts in these regions and 202 communities (see the distribution by region on Table 26 in Chapter III). In all of them, a base measurement of indicators was carried out and another one at the end of the project. Table 2.

Table 2. Variation of healthy habits indicators in communities of the project that do not belong to the Alternative Development Program, PDA

Indicators	Junín		Huanuco		Pasco		San Martín	
	2005	2007	2005	2007	2005	2007	2005	2007
Infant health indicator								
• % of children with birth certificate	32.0	78.1	50.0	67.0	69.8	89.3	67.0	85.4
• % of children with updated CRED cards	56.7	65.6	59.0	70.0	49.0	65.0	56.3	67.1
• % of children with vaccinations up to date	56.1	65.3	59.0	69.0	49.0	62.0	54.2	67.1
• % of children under 6 months old exclusively with maternal breastfeeding	90.1	92.1	93.0	98.0	93.0	95.0	91.7	95.7
Reproductive health indicators								
• % of pregnant women with prenatal control	73.0	91.0	64.0	79.3	65.0	82.0	72.0	88.0
• % of women with institutional and/or professional childbirth care	46.0	65.0	45.0	57.0	56.0	78.0	60.0	67.0
• % of fertile-aged women that know when their fertile period occurs	17.9	25.0	18.8	23.0	15.4	22.0	18.0	22.5
• % of fertile-aged women that use birth control method	65.0	68.0	63.0	61.6	68.0	70.8	68.5	69.1
◦ Modern method	42.0	39.0	40.2	37.8	50.0	48.0	48.0	50.0
◦ Traditional Method	23.0	29.0	22.8	23.8	18.0	22.8	20.5	19.1
Housing indicators								
• % of families that drink boiled or chlorinated water	72.5	91.0	67.0	71.6	82.0	92.7	48.2	65.0
• % of families with bathrooms connected to a network or latrine	45.0	75.0	56.9	84.4	57.0	88.0	65.0	99.0

As can be seen on Table 2, a large number of healthy habit indicators showed an increase above 20% between 2005 and 2007. Broken down results show that regarding infant indicators, the greatest progress was made in the percentage of children with birth certificates, which increased in all regions at an average of 30%, but in Junín, the increase was of 143% (from 32% to 78%). The increase in the number of children with an updated growth and development card, CRED, is also significant. This implies, as shown by the figures, that these children have all their vaccine shots up to date.

In relation to reproductive health indicators, an increase is also shown in all indicators. The ones that increased the most were the prenatal control and institutional childbirth care indicators. Out of the four regions considered, these two indicators were lower in Huanuco and higher in Junín and San Martín. Nevertheless, prenatal control carried out by health staff as well as institutional childbirth care registered in the communities of the intervention area of the project in all the regions were sometimes higher than in all the regions as a whole. According to data provided by ENDES, this will continue in 2006. This is shown on Table 3 for the seven regions.

Table 3. Global Indicators in maternal infant health and housing in the seven regions of the project

Indicators*		Infant Health	Reproductive Health						Housing	
		Infant Mortality Rate (per thousand)	Global Fertility Rate	Teenage Fertility (% pregnant or with children)	% of modern BCM. United Women	% of prenatal care by health staff	% of institutional childbirths	Maternal mortality ** (Number of MM)	Access to safe drinking water	Access to network connected toilets
Peru	**2,000**	**43**	**2.9**	**13.0**	**50.4**	**83.8**	**57.9**	**655**	**72.3**	**51.1**
	2,006	**27**	**2.6**	**12.2**	**47.6**	**91.5**	**71.6**	**485**	**74.3**	**55.4**
Huanuco	2,000	63	4.3	19.5	46.0	65.6	28.3	38	48.6	18.8
	2,006	n/i	3.4	15.4	43.3	77.9	52.9	27	42.3	22.1
San Martín	2,000	49	3.0	21.1	57.5	83.3	45.8	25	62.1	37.3
	2,006	n/i	2.8	26.3	49.2	87.5	70.6	15	60.9	47.4
Junín	2,000	43	3.2	19.4	43.5	78.2	46.0	30	78.6	43.2
	2,006	n/i	3.0	9.2	48.8	88.7	63.4	20	69.8	44.2
Ayacucho	2,000	50	4.2	21.3	33.1	80.9	47.2	27	47.6	20.-3
	2,006	n/i	3.6	17.4	36.1	88.4	70.6	26	64.7	24.4
Pasco	2,000	58	3.3	13.4	50.4	72.8	50.7	7	61.7	28.4
	2,006	n/i	2.9	-18.2	57.4	85.4	69.3	10	62.6	34.2
Ucayali	2,000	52	3.2	27.0	58.9	72.9	46.3	9	32.1	23.8
	2,006	n/i	3.9	-23.0	51.5	78.4	73.7	13	39.9	37.4
Cusco	2,000	84	4.0	17.2	43.8	95.1	39.4	53	71.8	29.2
	2,006	n/i	3.2	13.9	38.8	98.0	62.0	20	77.7	35.7

Source:

* *For all indicators, INEI: ENDES 2000- Continuous ENDES 2004-2006*

** *For maternal mortality: National Sexual and Reproductive Health Strategy*

n/i No information

The use of birth control methods among united women reveals modest increases in the four regions, in tune with the national trend registered by continuous ENDES, which, as seen on Table 3, shows a stoppage in the increase on the use of methods in the country.

The more stable indicator, at a low level during the project's execution period, is the knowledge of the fertile period that has gone up in all the regions. This is an indicator that is difficult to move, not only in communities but also at a national level as shown by data from ENDES[6]. In point of fact, out of the total number of women in their fertile age in the country,

[6] *INEI,. continuous ENDES 2004-2006. Main Report, 2007*

only 37% correctly identified the period with greater risk of becoming pregnant, while 63% did not specify the time or did not know what was the time of highest risk for a woman to get pregnant when having unprotected intercourse. Among method users, only 60% answered that the time of highest risk for getting pregnant was halfway through the menstrual cycle. The number of wrong answers about the cycle's fertile period indicates that 40% of users apply this method incorrectly.

In addition, the health communication activity gave quite interesting results on the conformation of groups to disseminate healthy habit promotion messages and contents. Thus, seven Radio Program Correspondent Networks were created and seven Inter-institutional Communicator Networks.

During the third year of the project, in which healthy habit promotion activities were kept in different scenarios (and progress was evident in the communities intervened as shown by figures on Table 2), new indicators were proposed for Intermediate Result 2, as follows:

Indicator 1: Two Regional Certification Systems for minimum standards at healthy towns for promoting healthy habits in the framework of health decentralization
Indicator 2. A sustainable health communicator network to promote changes in habits based on motivators

Upon conclusion of the project, health promotion activities switched from working with local (district) and community governments to a strategy that coordinated actions of the regional government, local government (province and district), community organizations and the population, under the form of **Management Agreements** (See Section F of this chapter). Thus, the project has contributed to creating awareness among the authorities and the public that life quality and well-being of people is everyone's job and does not require large economic resources but rather a social communication strategy to help create healthy citizens and that individuals do not only have rights but also duties towards themselves, their family and their community.

In respect to the certification of healthy towns, the following are the project's achievements:

***Indicator 1** Two Regional Certification Systems for minimum standards at healthy towns for promoting healthy habits in the framework of health decentralization:*

- *Regional Regulations:*
    - *Junín:* Regional Executive Order No. 115 (08/02/07) of the Technical Regional Committee for Health Promotion and Culture, signed by the Regional President, establishes health promotion and culture as regional priority and makes possible the implementation of the Healthy Town strategy.
    - *Huanuco*: Regional Ordinance No. 002-2007-CR-GRH of March 26th, 2007, approves the Regional Policy for the Implementation of Healthy Towns Strategy

- *San Martín*: The Regional Health Program includes the certification of social development, economic and environmental standards, including Healthy Towns certification

- *Implementation of policies*

  - Three regions (Junín, Huánuco and San Martín), count with a regional policy and have implemented their PROMSA Policy, including minimum regional standards for the Certification of Healthy Towns.

***Indicator 2*: A sustainable health communicator network to promote changes in habits based on motivators.**

- Seven communication Networks that operate in permanent exchange in disseminating health and healthy habit messages among the different audiences. Networks group communicators, journalists, health staff, teachers and students from the Social Sciences and Communication Sciences faculties and radio stations of the private sector[7] and contribute to an interconnected work among the health sector, civil society and the media.

- Seven Radio Program Correspondent Networks (one in each region)

- Preparation of health communication products (spots, videos, printed and virtual newsletters and three-leaf brochures, etc.) based on motivators to promote: child care, growth and immunization, prenatal and childbirth care and basic hygiene and water consumption habits, among others.

[7] *Luz y Sonido Radio Station in Huanuco; Uno Radio Station in Chanchamayo, Junín; del Progreso Radio Station in Ucayali; Salcantay and Universal Radio Stations in Cusco; PRODEMU Radio Station in San Martín;and Atlantis Radio Station in Ayacucho*

E. COORDINATED REGIONAL HEALTH AND EDUCATION PLANS

Regional Governments prepared their Regional Development Plans to direct their work towards the balanced and sustainable achievement of their villages. Those plans had as priority the attention given to health and education problems which urgently needed to be addressed in an comprehensive way and for which it was necessary to coordinate strategies and methods. In 2003, the Catalyst project provided technical assistance to the Huanuco region in preparing its Coordinated Regional Health Plan and its Coordinated Regional Education Plan, a first and illustrative experience on which the design of the Cooperation Agreement was based; through this Agreement, technical assistance was extended to other regions to carry out similar regional plans. In this second stage, health plans included the creation of a Quality Management system, the efficient, timely and appropriate administration of the Health Human Resources[8] and a combination of activities to promote the use of healthy habits through the involvement of the entire society.

The coordinated regional health plans contain a regional vision, coordinated priorities, strategic goals, and an agenda of public policies and profiles of regional projects. The legitimacy of the plans comes from some of its qualities:

Participative: Institutions and local and regional social actors took part.

Decentralized: The input for the plans came from all the provinces, and in Pasco, from the districts.

Coordinated: The Coordinated Regional Plan is the result of an agreement on priorities, willingness, interests, expectations and resources.

Regional: It is the political, strategic, guiding and regional leadership level.

Focus on Human Development: Seek to improve the quality, organization and distribution of human, physical and financial resources in health and education.

For preparing plans, a technical team was set up in each region, which was in charge of designing the methods, instruments and organization of activities. The plan's technical team drew up documents for a participative, coordinated and decentralized management.

[8] *Coordinated Regional Health Plans in Huanuco, Pssco, Cusco and Junín. Coordinated Regional Education Plans in Ucayali, Pasco and Huanuco*

The sustainability of the drawing-up of coordinated plans is based on five stages:

1. Creation of a favorable environment which includes: a) the organization (consolidation of the Health Regional Council, creation of the Regional Planning Committee, Regional Communication Committee and teams of provincial facilitators) as a key step to technical sustainability of the process and b) the strategic analysis of social actors; interaction among them and local sensitization efforts. This stage ended with the subscription of a First Agreement or Social Agreement, which consolidated the commitment of social actors in participating in all the activities involving the preparation of the regional health and education plans.

2. Evaluation or Analysis of health/education which includes a profile of the health care system, provincial self-evaluation and a final regional evaluation.

3. Creation of the regional plan with a strategic approach which includes the analysis of the capacities of the social actors, the development of the regional vision and the identification of scenarios, as well as the definition of objectives and strategies, programs and projects. This stage ended with the subscription of the Second Agreement or Social Agreement which approved the health plan and undertook commitments for its implementation.

4. Implementation of the regional plan through the organization of teams into "Thematic Committees" or "Regional Technical Committees" responsible for the implementation of plan strategies and preparation of participative budgets.

5. Monitoring of the plan's implementation process and evaluation of the results obtained through periodic measuring by indicators, analysis of their results and their use as input for decision-making on prioritized health and/or education problems.

Based on the Coordinated Regional Health Plans, Pathfinder International provided technical assistance to set up Quality Management Systems, implement Health Human Resource Policies and the strategy for Health Promotion through Healthy Towns and health Communication.

Coordinated Regional Health Plans which have been produced (see Annex 1):

- Coordinated Regional Health Plan of Huanuco (2003-2006), approved on April 25th, 2003, through a Commitment document and perfected as Regional Ordinance of October 19th, 2007.

- Coordinated Regional Health Plan of Junin, approved on April 29th, 2005, authorized by Regional Ordinance on August 31st, 2005.

- Coordinated Regional Health Plan of Cusco, approved on October 11th, 2005.

- Coordinated Regional Health Plan of Pasco, approved on October 25th, 2005.

- Coordinated Regional Health Plan of Huanuco (2008-2015)[9], (up-date of the previous plan) prepared by the Thematic Planning Committee of the Regional Health Board, CRS, using the methods of the Comprehensive Management Table, CMI, (Balance Scorecard)[10].

Coordinated Regional Education Plans which have been produced (see Annex 2):

- Coordinated Regional Education Plan (2003-2021), approved through Regional Board Agreement No. 136 – 2003 CR – GRH, December 22nd, 2003.
-
- Regional Educational Project of Ucayali, based on the Coordinated Regional Plan of Education, approved on April 29th, 2005.

[9] *This proposal shall be approved by the Regional Health Board and sent to the Regional Government for its approval. On October 19th, 2007, the regional Board of the Regional Government approved the expansion of the Coordinated Health Regional Plan and the Regional Health Board was put in charge of its completion. Upon conclusion of the Agreement, the Thematic Planning Committee has submitted a consensus proposal to the CRS. Some difficulties delayed the work, for example, the non-permanent presence of directors and officials of the Regional Government and DIRESA and delay in the definition of some indicators and goals. However, the region has a new management instrument which incorporates a modern management tool (CMI), with an integrated approach for easy dissemination and measuring.*

[10] *It contains ruling ideas, strategic objectives in perspectives: society-users, financial, internal processes and learning-growth, which have been displayed in the Strategic Map which enables giving a balance or equilibrium and easily communication of the methodology to be followed. Each of the strategic objectives contains indicators, goals and initiatives.*

F. MANAGEMENT AGREEMENT BETWEEN THE REGIONAL GOVERNMENT OF HUANUCO AND THE DISTRICT MUNICIPALITIES OF AMARILIS AND SAN FRANCISCO DE CAYRAN

1. Design

Health care priorities require the development of coordinated strategies –at national, regional and local level- for addressing chronic malnutrition and the maternal - neo-natal mortality which have been defined as State Policies in the country and by geographic breakdowns. According to the order from the Ministry of Health, in all of them, technical and financial assistance should be focused on the groups of women who are in a fertile age and children under 5 who live in poverty and extreme poverty, as well as on the families who are in a socially vulnerable or at risk situation. In this sense, the Management Agreement is an instrument which enables the improvement of sanitary results of local, district and community environments, joining efforts of the regional and local actors in fulfilling of previously established commitments, goals and indicators.

Authorities and public officials of the Regional Government of Huanuco – through the Social Development Management and the Regional Health Office – and Municipalities of the districts of Amarilis and San Francisco de Cayran, with technical assistance from Pathfinder International, developed activities which enabled the subscription of a Management Agreement, whose purpose is to improve health levels and quality of life of the populations of both districts. The Agreement is registered in the decentralization and transfer process of the health function to local governments; and it becomes a tool which guides the performance of the parties for the achievement of concrete and coherent sanitary results in tune with health requirements of those populations. Several of the performance indicators designed measure the achievement of the Management Agreement, the same which upon completion of the Project is in its Implementation stage.

2. Management Agreement Preparation Process

- **Coordination and sensitization for the subscription of the Management Agreement**

Based on the regulations issued by the Ministry of Health on the decentralization process[11], meetings were held at the beginning of May, 2007, with Social Development Management officials and the Regional Health Office of the Regional Government of Huanuco to evaluate the possibility of signing *Management Agreements between the Regional Government and each of its towns.*

[11] *RM No. 366-2007/MINSA. Technical Document "Development of health function at Local Governments*"

At the end of that month, the meeting counted with the presence of representatives of the MINSA Planning Office, USAID and Pathfinder International and, as guests, personnel from the Regional Government of Pasco. Pathfinder International was put in charge of preparing a preliminary version of the Management Agreement, specifying the steps and documents for its Implementation, and requesting its technical[12] assistance.

❖ **Drawing-up of the preliminary document of the Management Agreement**

Several meetings of the Technical Team were held to review the preliminary version of the Agreement, at the same time the Social Development Management had meetings with the mayors and management teams of the District Municipalities of Amarilis and San Francisco de Cayran, who supported the initiative.

In July 2007, the technical aspects of the Management Agreement were ready, as well as the documents and processes for its Implementation.

3. Subscription and approval of the Management Agreement

On July 13th, 2007, after a last review of the aspects considered in the Management Agreement, the President of the Regional Government, the General Director of the Regional Health Office, the Mayor of the District Municipality of Amarilis and the Mayor of the District Municipality of San Francisco de Cayran signed the Management Agreement, thereby approving the commitments established therein. (See Annex 4) and which refer to, among others, the enforcement of the indicators indicated on table 4.

Table 4. Maternal infant and housing indicators with prioritized care as per the Management Agreement between the Regional Government of Huanuco and the District Authorities of Amarilis and San Francisco de Cayrán

Nº	Indicator
1	% of pregnant women being monitored (6 visits or even more during the current pregnancy)
2	% of pregnant women with child birth deliveries at health centers with FONB OR FONE
3	% of young people in Educational Centers who are aware at which stage of the menstruation cycle it is more likely to become pregnant
4	% of medical staff at health centers I-1 and I-2 of the Micro-network with work competences in the care of Child and Pregnant women and new mothers
5	% of health centers with available normal stocks of birth control methods : injections, pills and condoms
6	% of children under 3 with an updated CRED card
7	% of homes with children under three who drink boiled or chlorinated water
8	% of homes with latrine or sewage connected to a network, where children under three live
9	% of children with birth certificates within the month or the month after their birth

[12] *Please see Annex 3*

AHORA

17 de setiembre de 2007

Más distritos se suman a la experiencia Acuerdos de Gestión

Los distritos de Panao, La Unión, Pachas Obas y Pampamarca se sumaron a la firma de "Acuerdos de Gestión" cuyo objetivo es contribuir con la disminución de la mortalidad materna y la desnutrición crónica infantil, que constituyen dos de los problemas sanitarios priorizados en el departamento de Huánuco.

El documento, según los promotores, busca alinear de manera coherente los objetivos, estrategias y metas del Gobierno Nacional, Regional y las Municipalidades distritales en el cumplimiento de metas que den cuenta del esfuerzo de cada institución.

La Gerencia de Desarrollo Social del Gobierno Regional convocó a los 21 distritos pilotos del plan "Crecer" para que los gobiernos locales conozcan los avances y resultados que se vienen dando en los distritos de Amarilis y San Francisco de Cayran, tras la firma de los Acuerdos de Gestión.

Uno de los resultados presentados por ambos distritos es la línea basal de los indicadores: Niñas y niños menores de tres años que cuentan con tarjetas de crecimiento y desarrollo, consumo de agua segura en sus hogares y uso servicios de desagüe de la red.

El acto contó con la presencia del responsable de la Estrategia CRECER, Iván Hidalgo Torres, quien luego de conocer los resultados de los procesos de los distritos de Amarilis Y Cayran, felicitó y reconoció al presidente del Gobierno Regional por ser el primer departamento que articula para dar marcha la estrategia CRECER.

"Les he visto empoderados y liderando este proceso, los alcaldes de Amarilis y Cayran hoy dieron una clara demostración. Este trabajo va servir de ejemplo para los demás departamentos el país va aprender de lo que aquí se viene haciendo para implementar la estrategia Crecer", manifestó Hidalgo Torres.

Por su parte, Jorge Espinoza Egoavil, presidente del Gobierno Regional Huánuco, reafirmó su compromiso de trabajo por los necesitados. Asimismo, agradeció a la Agencia de los Estados Unidos para el Desarrollo Internacional USAID a través de Pathfinder International por la asistencia técnica.

Los alcaldes firmantes a la expansión de los Acuerdos de Gestión fueron: Cayo Rojas Rivera (Pachitea), Fortunato Ramos Lavado(Dos de Mayo), Bernardino Cahgua Cieza(Obas), Wilder Gómez Penadilo (Pachas) Orlando Herrera Calixto (Pampamarca).

4. Operation of Technical Teams in charge of the Management Agreement

For the Implementation of the Management Agreement, technical teams were organized: Management Committee, Technical Team for Monitoring and Information Areas. Regulations and Proceedings were drawn up for the Management and Monitoring of the Management Agreement, the Work Plan for the preparation of the Baseline and tools (validated in similar experiences) to put the undertaken commitments into practice. (Refer to Annex 5 for the drawn-up documents, functions of the technical teams and the respective Executive Orders).

5. Determination of the Management Agreement Indicator Baseline

The first commitment was the mapping of a baseline of the situation of the indicators which was carried out by the technical teams with technical assistance from the Project. There are three sources of information: Statistics of health and educational facilities (indicators 1, 2, 5 and 9), surveys to adolescents and interviews to selected homes from both districts (indicators 3, 4, 6, 7

and 8). Each indicator had a simple design, which established the size of the sample and the documents to be used.[13]

The staffs from the participating institutions and community agents were in charge of the collection of information; this was an enriching joint work experience between state organizations and the local community.

6. Definition of the Indicator Goals and Intervention Proposals

Concurrently with the measuring of the indicators starting point, the goals to be achieved in 2008 and the strategy to obtain them were defined; these included activities, officials and schedules, defined with the Management Committee and the Monitoring technical team.

7. Results

- The Implementation of Management Agreements in regional and local areas is a contribution from the Project and marks the beginning of the enforcement of this development strategy in the country. Therefore, each activity and process followed in its Implementation was taken as a learning process by the participants. The balance of achievements is highly positive and emphasizes the commitment and coordinated work of different administration levels: the Regional Government –through the Social Development Management and the Regional Health Directorate-, Local Governments –through District Municipalities- and the community in general.

- Coordinated work by the Regional Government and District Municipalities, which is the essence of the Management Agreement, is fundamental to improve the population's health level and quality of life. The local teams have gradually accepted that the sanitary results are also their responsibility and that this task is not only that of health facilities, but also extends to the family and community.

- In carrying out the survey for measuring the base line, the participation of the community agents has been fundamental to enable greater access to homes because of their thorough knowledge of the areas and families interviewed.

- Regarding indicators, the baseline has enabled the correction of the long-standing limitation of additional information in official statistics, showing the real level of those indicators in districts and communities. This has enabled specific involvement with the purpose of closing the gaps between the standard and the indicator, based on the joint work of local authorities and the community.

- The experience of the Management Agreement should continue in 2008 with the Implementation of the intervention plans, for which the continuance of the Management

[13] *Information gathering record sheet in Annex 6*

Committee, Technical Monitoring Team and the Areas responsible for each indicator is necessary.

8. Lessons Learned

- The participation and commitment by regional and local authorities is a central aspect which has enabled the successful construction of experience, and is a good alternative to institutionalize and continue the experience in the search of improving sanitary results.

- This strategy has helped reveal the lack of necessary and reliable information on local indicators. The baseline work has given way to an improvement and up-dating of the Perinatal Information System and the SISMED Software at health facilities of the Amarilis Micro-Network. However, this is a pending task that the Regional Health Office and the District Municipalities should develop in order to obtain quality information on sanitary issues considered as priorities in their spheres.

Table 5. Original Cooperation Agreement by Activities and Sub-Activities

Average Result	Activity	Sub-activity
RI 1: Accessible and Used Quality Health Services	*1. Establish Regulatory Mechanisms*	1. Improve education quality of students attending Medicine, Nursing , and Obstetrics Schools, by developing professional standards and accreditation mechanisms
		2. Promote the creation of an autonomous national entity for evaluation and certification of health training professions in Higher Education institutions
		3. Develop high quality standards for health facilities and strengthen supervision in pilot areas
		4. Create a national accreditation system for public and private health facilities
		5. Strengthen certification and periodic re-certification carried out by the Professional Associations of medicine, nursing and obstetrics
		6. Create a national organization for periodic re-certification of Peruvian health professionals
	2. *To improve health services in prioritized regions*	7. Improve medical and preventive health care for maternal, perinatal and infant health and infectious diseases.
	4. *To diversify the supply sources of Birth control methods*	9. Create within the private sector alternative sources of supply of FP products and reproductive health services
		10. Train and provide material to the pharmaceutical staff to enable them to disseminate information on STD and FP
		12. Enlarge the contraceptives social market within the private sector and encourage MINSA's customers to acquire their supplies from the private sector and less from the subsidized public sector
RI 2: Population practicing healthy habits	5. *Communication and Education for Health Promotion*	13. Develop strategies and activities in order to encourage healthy habits in municipalities, communities and families
		14. Implement health promotion programs in prioritized regions to encourage their participation in activities such as "Healthy Schools" and "Healthy towns"
		15. Design and implement education and communication strategies to increase awareness on reproductive health, health rights and increase the use of health services
		16. Strengthen capacity of Communication Departments in Peruvian Universities to support communication activities relevant to health and habit changes.
		17. Strengthen the capacity of the Ministry of Health in order to achieve an effective health promotion
		18. To support the local communication networks as well as relay stations to improve health communication activities and habit changes focused on the community

Table 6. Original Agreement of Cooperation by Activities and Sub-Activities

AVERAGE RESULTS	INDICATOR OF AVERAGE RESULT	STRATEGIC PRODUCT	ACTIVITY	SUB-ACTIVITY
RI 1: Accessible and Used Quality Services	50% of Health Facilities implement MCC procedures within the framework of the Regional Quality Management System	Regional Quality Management System	1. Regulatory quality Mechanisms	1.1 Strengthen MCC procedures in schools and faculties that train health science professionals.
				1.2 Provide the foundation for a system which will ensure the quality of higher education at National and Regional levels.
				1.3 Facilitate the implementation of mechanisms to regulate the quality of health care at regional level.
			2. Improve Service Quality provided at MINSA's Health facilities in prioritized regions.	2.1. Develop a quality management processes in health facilities in the network and micro networks involved, especially for maternal, perinatal and infant healthcare.
			3.Diversification of MAC supply sources	3.1.Create alternative supply sources of family planning products and reproductive health services in the private sector.
		Regional Human Resource Policy	4. Management Strategy (EGES) of Human Resources	4.1 Develop Regional Health Human Resource Systems
RI: 2: Population practicing healthy habits	20% of families in the visited districts carry out healthy practices	Healthy settings	5. Develop strategies to promote healthy habits in the Regions, Municipalities, communities, schools and families within the districts involved.	5.1 Promote regional health policies and health promotion projects at the level of the 7 regions
				5.2 Implement a health promotion program in the territory that encourages the participation of the population involved.
		Health Communication Network for habit changes and follow-up supervision of service quality	6.Coordinate a strategy of communication networks to educate the regional and local population in health promotion	6.1 Design educational communication campaigns for the promotion of habit changes for self healthcare and the use of maternal, perinatal and infant health care services as a lawful right.
				6.2 Strengthen capacity of DIRESAs, and of local governments, in order to promote informed Health Promotion Actions
				6.3 Strengthen the capacities of the country's communication faculties to implement health communication contents for habit changes.
				6.4 Strengthen local communications networks and actors to improve their health communication strategies to bring change in habits and ensure a follow-up of service quality provided.

I. STRATEGIC PRODUCT 1: QUALITY MANAGEMENT SYSTEM AT DIRESA

1. QUALITY DEVELOPMENT IN PERU

Concern for improving health service quality in the country became more evident since 1996 when the Ministry of Health started issuing ministerial orders approving the "Hospital Accreditation Manual"[14], the "Guideline for the application of the Hospital Accreditation Manual"[15] and, in 1998, the "Regulations and Procedures for Accreditation of Health Facilities and Support Medical Services"[16]. In 2001, the document "Quality Management System"[17] was approved, which established the principles, policies, objectives, strategies and components of such system. With these management instruments, 300 external examiners and seven accrediting bodies (agencies, institutions) were certified. The result was that in 2002, there were nine accredited hospitals (five private clinics, the Peruvian Air Force hospital and three social security hospitals). This process was essentially based on structure standards as at that time, the regulatory health system framework did not encourage suppliers to seek accreditation.

On the other hand, in 1993, USAID through the Reproductive Health Support Project, (PASARE)[18] developed by the MSH, implemented standards on different aspects of reproductive health care, counseling, technical competence, IEC, adequate organization of services, management and support services. Based on these, continuous reproductive health improvement projects were developed that involved the entire facility. This forced the other services (dentistry, pharmacy) to change too. In 1998, the MINSA and USAID 2000 Project [19] developed basic standards for maternal perinatal care quality and accredited eighty maternal perinatal hospital services. Monitoring carried out two years later determined that only 12 of these hospitals complied with those standards.

The ongoing accreditation process was designed based on lessons learned on the experiences described, which showed that:

- Accreditation should be implemented as a process within the Quality Management System
- Process and result standards should be included, in addition to structure standards

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14 *RM No. 511-96-SA/DM of August 21, 1996*

15 *RM No. 673-96-SA/DM of November 19, 1996*

16 *RM No.261-98-SA/DM of July16, 1998*

17 *RM No.768-2001.SA/DM of December 20, 2001.*

18 *Project developed at EsSalud hospitals and MINSA of the Regions of Libertadores Wari, Ancash and José Carlos Mariátegui.*

19 *Developed in the Regions of Libertadores Wari, Ancash and José Carlos Mariátegui.*

- Accreditation should trigger continuous quality improvement processes in the entire facility and not only in one service.
- It is necessary to count with quality standards for facilities at all care levels so accreditation can involve the entire health sector.
- Accreditation should comprise public and private health care services.
- Inter-relate the authorization, categorization and accreditation as complementary elements within the quality assurance framework.
- Amend legislation to include accreditation as a requirement so the facility can provide the Comprehensive Health Insurance service.
- Strengthen competences for accreditation at all levels.

The following were approved: In 2006, the "Manual for Continuous Quality Improvement"[20] and in 2007 the Technical Document on "Quality Standards and Indicators in Maternal and Perinatal Care Quality" at health facilities that comply with Obstetric and Neonatal Functions"[21] and the "Technical Health Standard for Accreditation of health facilities and support services"[22].

Quality Situation at the MINSA Central Level

A series of interventions were carried out in the country as part of the Health Sector Reform, addressed at improving quality in the delivery of services at MINSA facilities. Each on contributed with valuable models, methodologies and instruments. Unfortunately, only some of them carried this forward despite huge technical and financial efforts invested.

With financial support from USAID, Pathfinder International participated in the preparation of many of these tools through Project 2000 and Catalyst. Its technical assistance continued during the execution of the Cooperation Agreement addressed at quality improvement in services at first and second care health facilities. Various activities took place with officials and authorities of the MINSA central level and DIRESAs, with the purpose of recovering the use of the Health Quality Management System, approved by Minister's Order in 2001[23].

The Agreement contributed to socialize the standard through Macro Regional Technical Meetings and Regional Workshops[24] with DIRESA staff and health networks who received

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20 *RM No. 640-2006/MINSA of July 14, 2006.*

21 *RM No. 142-2007/MINSA of February 13, 2007*

22 *RM No.456-2007/MINSA of June 4th, 2007*

23 *Quality Management System approved in December 2001 through RM 768-2001 SA/DM. During the development of the Cooperation Agreement, this regulation was improved and updated by the Health Quality Directorate through RM 519-2006 MINSA.*

24 *The purpose of the three-day regional workshops was to train 30 facilitating experts who in turn would transmit their colleagues at micro-networks and facilities, complex concepts and skills little know at this point at operative levels. The*

training to facilitate dissemination and implementation of the standard. These activities could not be fully carried out because facilitators had other responsibilities. At the end of the process and despite all the efforts, the Regional Quality Management System could not be implemented, among other reasons, due to the absence of methodological quality management and improvement proposals encompassing all Health Sector institutions, especially those in reference to technical-administrative and service providing aspects.

Therefore, the Project focused its technical assistance on the implementation of components in the Quality Management System at the Regional Health Directorates, particularly, Assurance and Improvement. The emphasis was put on the MINSA Sub Sector due to coordination difficulties in sector activities given the characteristics and policies in each Sub Sector.

strategy prepared also included monitoring of trained staff; as well as supervision of duplications, measurement of standards and preparation and execution of improvement projects.

2. THE QUALITY MANAGEMENT SYSTEM

2.1 CONCEPTUAL FRAMEWORK

In June 2001, the Ministry of Health created an organizational unit in charge of setting up the Health Quality Management System in the country, which was defined by Minister's Order No.768-2001-SA/DM in 2001 and updated in 2006 through Minister's Order No. 519-2006/MINSA as part of the decentralization process. The latter contains the "principles, standards, methodologies and processes for the implementation of the Quality Management System addressed at quality improvement of health care services"[25]. The Quality Management System proposed by MINSA was a structure based on four components: Quality Planning, Quality Organization, Quality Assurance and Improvement and Quality Information. Even though due to their nature all of them are inseparable, for illustration purposes, the following is the individual progress made in four of the Agreement intervention regions: Junín, Huanuco, Pasco and Cusco.

2.2. QUALITY MANAGEMENT SYSTEM COMPONENTS

2.2.1 Quality Organization

In order to comply with one of the strategies of the Coordinated Regional Health Plans PRCS, that was to establish a Regional Quality Management System, the four regions were organized in the different administrative levels. The *"Regional Quality Management Technical Committee"* was established in Junín, Pasco and Cusco, the *"Quality Management Thematic Committee"* was established in Huanuco as coordination, consulting and proposal spaces[26] that depend on the Regional Health Board. At the end of the project, these were special effective in Junín y Huanuco.

Quality Management Teams[27],[28] were established at DIRESAs, networks and micro-networks. These carry out functions according to their level and scopes. For example, at micro-networks, the team's specific function is to implement continuous quality improvement projects at facilities.

Quality-related functions are continuous activities at the four levels: national, regional, local (networks and micro-networks), de-concentrated entities and health facilities. For this

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25 *Technical Document "Health Quality Management System" of May 30, 2006*

26 *These coordination spaces were made up by: the Regional Government, , DIRESA, EsSalud, Armed and Police Forces Sanitation, Professional Associations, Universities, Civil Society, among others*

27 *At DIRESA, Teams were made up by the Sub-Directorate, People's Health Directorate, Planning Directorate, Comprehensive Care and Quality Directorate, Quality Official, Human Resource Official, and Sanitary Strategies Officials*

28 *In the networks, these teams were made up by the Network Director, the Comprehensive Health Insurance Official, Sanitary Strategies Officials, Health Promotion Official, Human Resource Official and the Epidemiology Official*

purpose, in Huanuco, Junín, Pasco and Cusco, the Project took part in the preparation of Coordinated Regional Health Plans and to the establishment of Technical Committees or Thematic Committees in charge of system implementation. Meanwhile, in Ucayali y San Martín, their Health Program was prepared in a different way. These Committees were formed as structures of the Regional Health Boards.

As was previously indicated, political, organizational, technical and human resource setbacks[29] in the regions made the integration of Health Sector institutions difficult. Therefore, efforts were focused on the creation of an Institutional Quality Management System at DIRESAs to ensure the achievement of quality levels at MINSA facilities.

2.2.1.1 Quality in the Regional Government. The Regional Quality Management Technical Committee (CTR-GC)

The Regional Quality Management Technical Committee – CTRGC- was established as part of the structure of the Regional Health Boards, and was made up by representatives of various institutions[30]. In Junín the CTRGC[31] main function was to prepare coordinated technical proposals to facilitate the implementation of the Regional Quality Management System, whose strategic objective was approved by the Junín Coordinated Regional Health Plan (PRCS).

In Huanuco, the Committee was named Regional Quality Thematic Committee, established in 2003. Its members mostly belonged to different health sector institutions. In view of the refusal of the Regional President to sign the common agenda with USAID, activities were suspended (six months after having begun the PRCS implementation), right at the time of the transfer of capabilities to the team and the consolidation of the committee. Despite of this, at the initiative of key actors, activities were carried out addressed at quality improvement and the achievement of the strategic objective. For example, the thematic committee's experience was shared with the Cusco team in 2005 during the implementation of its PRCS.

The Pasco region established its CTRGC after approving the PRCS. The Committee used to meet on a monthly basis headed by the DIRESA Quality Director until the approval of its work plan in 2007 when it stopped its activities.

In Cusco, the CTRGC was quite ephemeral due to political problems between the Regional Government and DIRESA, which prevented its consolidation. The change in regional authorities in 2007 has improved the relationship between both institutions, which resulted in a better functioning of the Committee.

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[29] *Among which we can mention: lack of leadership and regulatory technical acknowledgement by DIRESA; dependency on local EsSalud branches and the Armed and Police Forces at its central office; lack of organization in the private sub-sector*

[30] *Regional Government, Regional Health Directorate (DIRESA), Regional EsSalud Management, Universities, National Police and Army Sanitation, Professional Associations, and other representatives of Civil Society*

[31] *Committee members were acknowledged through RD No.899-2006-DRSJ/OEGDRH.*

The Ucayali DIRESA is very weak. Its Regional Health Board (CRS) hardly ever meets, except during the preparation of the Regional Health Plan when a popular consultation was carried out. The Quality Management System was never placed on the CRS agenda and the weakness and low commitment of DIRESA High Management did not allow developing this initiative.

At the beginning, the San Martín region established its Regional Health Board (CRS) but due to continuous political problems between the Regional Government and the Regional Directors, the Quality Management System was not established. In addition, the old conflict between EsSalud and MINSA over the ownership of the regional hospital was an impediment for arriving at agreements. It is seemingly contradictory that a region with such an important achievement in quality at its facilities, as shown by the obtainment of two National Quality Awards from the National Industries Association, has not been able to organize a Regional Quality Management System.

2.2.1.2 Quality at Regional Health Directorates (DIRESA). Quality Management Teams

At the beginning of the Cooperation Agreement in July 2004, there was limited organization for quality management at DIRESAs. In addition, the term "quality" was associated to resources and specialists. Officials who knew more about this matter supported the intervention but the others gave little value to sanitary management, which resulted in weak political support. Added to this was the high rotation of key staff members. Only as of 2006, key positions became more stable because people were appointed by the Regional Governments. Finally, at DIRESAs there is a Quality Directorate, Unit or Office but in many cases only one person (not a team) is in charge of all the tasks, which is a limitation.

When the Project began, none of the seven regions had made progress in the establishment of its Quality Management System. Among other things, this was due to little dissemination of the standard, the lack of tools and instruments to make it operative and the absence of qualified human resources to implement it[32]. Efforts made to count with Quality Management Teams from DIRESAs were unsuccessful even though Ministerial Order 041-2005 MINSA established the guidelines for their organization and operation. At DIRESAs, these teams were authorized (see Table 7) to comply with the central level requirement, but they operated irregularly without having full knowledge that their mission was to strengthen quality at health facilities. In practice, quality is more an individual and not a group responsibility. They are people with great management capability that despite the economic, administrative and resource difficulties have managed to make DIRESAS obtain acknowledgments such as the National Quality Award, as in the case of the San Martín Region.

[32] *In the seven regions, it was verified that even though they were the beneficiaries of several projects with strong investments in health staff training, there were no qualified staff categories. Many trainees had left or simply wanted to keep a low profile due to criticisms made to their posts as officials or as persons belonging to the 1990-2000 government regime.*

Table 7: Approval of Technical Quality Management Committees

REGIONS	Directors' Orders for the establishment of the Regional Quality Management Committee and Quality Management Team DIRESA
AYACUCHO	*RD N°450-2002-DESP/DG-DIRESA*
CUSCO	*RD N°059-2007-DRSC/DG-DPH(24-07-07)*
HUANUCO	*RD 288-2007-GR-HCO-DRS-DG-DEASP (04-06-07*
JUNIN	*RD Nº 476-2007-DRSJ/OEGDRH*
PASCO	*RD Nº 204-2005-DG-DIRESA/GR PASCO*
SAN MARTIN	*RD Nº 149-2007-DIRES-SM/DEG-RR-HH*
UCAYALI	*RD N°128-2007-DG/DIRESA-UCAYALI*

2.2.1.3 Quality at Health Networks and Micro-networks. Quality Teams

The situation at the Networks and Micro-networks was not any better at DIRESAs. The fact that many networks were not Budget Executing Units was a limitation due to the technical and administrative dependency on DIRESA. At present, many networks only exist as a formal organizational structure; they do not count with staff or their own budget. Furthermore, some of them do not have a different structure from that of hospitals. The network director is also the hospital director and results in inconveniences such as lack of time to organize and manage both bodies.

On the other hand, the network head hospitals had a complicated organizational climates and efforts to solve this clashed against authoritarian management styles, absence of teamwork, conflictive interpersonal relationships, lack of trust and motivation y addition to lack of provision of equipment and staff. In many cases, the appointment of quality officials had more to do with the need to cover MOF and ROF posts rather than to develop quality functions in the network.

Hospital medical staff, but for a few exceptions, had little involvement in favor. On the contrary, they demanded solutions that were out of the hospital or network scope or accepted the leadership of activities that they did not assume in practice. The project's efforts to improve this situation had little repercussion.

As previously mentioned regarding DIRESAs, the involvement of quality officials (mainly obstetricians and nurses) was key. At the beginning of the intervention, many of them had academic limitation in quality management, which they managed to overcome through training and technical assistance provided by the project to DIRESA and networks.

At a micro-network level, a critical factor was the inexperience and high rotation of professional staff (and to a lesser extent, of technical staff). Many were carrying out their SERUMS, therefore, their permanence at the facility had a deadline, which made difficult to set up quality teams in networks and micro-networks. Senior staff members who had more knowledge about the problems in the area, had plans to further their studies, which broke up many teams that were working well, due to the initiative and leadership of these same professionals. This situation became worse in view of the absence of an incentive and motivation policy for professionals to make they stay in remote areas more attractive.

In the same way as in the networks, the level of knowledge and skills of professional staff (including the micro-network heads) on quality management at the facilities was scarce. In addition, they had difficulty in considering all the facilities in their jurisdiction as a service producing unit or basic functional unit to be supervised and taken care of, and assumed that their responsibilities were limited to the facility where they worked. They thought the problems of the other facilities in the micro-network were none of their business. Finally, they were afraid to measure quality standards because they thought this was equivalent to an evaluation and eventually, they could be sanctioned for deficient performance.

Despite what was previously mentioned, quality management teams were organized in networks and micro-networks of the seven regions (Table 8), even though in some micro-networks and facilities these teams exist just by name and quality activities are carried out by the quality official or the official in charge of the sexual health and child component strategy.

Table 8: Quality Management Teams (EGC) established in the total Networks, Micro-networks and Hospitals Intervened

Region	Networks			Micro-networks			Hospitals		
	Total	with EGC	% with EGC	Total	with EGC	% with EGC	Total	with EGC	% with EGC
TOTAL	**22**	**19**	**86**	**111**	**76**	**69**	**19**	**19**	**100**
Ayacucho	3	3	100	8	6	75	2	2	100
Cusco	3	2	67	24	18	75	2	2	100
Huánuco	2	2	100	20	14	69	2	2	100
Junín	4	3	75	18	10	38	7	7	100
Pasco	3	3	100	14	10	71	2	2	100
San Martín	4	4	100	21	15	71	2	2	100
Ucayali	3	2	67	6	3	50	2	2	100

2.2.2 Quality Planning

Quality Planning is the component that defines general quality policies that coordinate design processes and system development. It involves all institution levels, from

executives to operators and includes the definition of objectives and policies, design and preparation of strategies in all the health system bodies. One of the weakest points in the regions was the "formal" involvement of the executive level. Sometimes the support given was only limited to incorporating in the Annual Operative Plans (POA), some quality activities or signing agreements with the central office for measuring quality standards. Upon conclusion of the "planning" stage, these agreements and commitments became the responsibility of the Quality Unit, which worked without staff or resources. Despite this fact, the following progress was made.

2.2.3 Quality Assurance and Improvement

Quality Assurance is the series of actions that are deliberately and systematically carried out to establish standards and monitor and improve performance of staff and facilities in a continuous way so care service can be effective, efficient and safe. Continuous Quality Improvement is the methodology to achieve the established standards and indicators based on the application of assurance instruments. Quality Assurance and Improvement ensures users good services provided by the institution.

Quality assurance and improvement is based on defining quality standards measured through indicators. The first measurement is carried out by the quality teams through a self-evaluation to help identify gaps ("improvement opportunities") between the standard ("ideal") and the indicator observed. Then, teams should carry out interventions through the PMCC to close this gap and monitor its achievement through periodic and continuous measurements.

The project worked with the regions on maternal perinatal and infant quality standards defined by MINSA. The sequence began with training of management teams in standards and their measurement. Then, it continued with self-evaluation or first measurement and the identification of "improvement opportunity" on which continuous improvement projects (financed with own resources or local government support) were based. This was followed by technical assistance in subsequent measurements until the standard was achieved.

The implementation of continuous quality improvement projects has allowed to:

- Re-direct the purchase of products and goods through the SIGA (Information System on Administrative Management), review the request for medicines of the SISMED and direct the scheduling of purchase of supplies[33]
- Know the standards of the Referral and Counter-referral System (which the staff at the majority of facilities did not know about) as a quality standard.
- Improve the attracting system to SIS affiliations.
- Comply with comprehensive care standards for children and pregnant women.

[33] *When verifying the non-compliance of a certain standard, they would notice this depended on a product that was not being included in the purchasing schedule*

- Contribute to the compliance of standards related to lab tests by implementing them as a product foreseen in comprehensive care standards for children and pregnant women
- Coordinate the MN work with its peripheral facilities
- Link activities of PROMSA, HR, sanitary strategies, etc.
- Identify training needs of staff based on self-evaluation of standards
- Measure the effectiveness in the use of SIS resources through an evaluation of the achievement of a standard linked to a certain product
- Identify gender and infant violence problems by measuring standards in pregnant women and children
- Direct human resource policies by motivating staff with incentives to make progress in continuous improvement.

2.2.3.1 Strategy for implementing Continuous Quality Improvement processes in Micro-networks.

In 2003, the Catalyst Project incorporated information and contents on the Quality Management System of its Training Program to improve the response capability for Obstetric and Neonatal Emergencies at the micro-networks. This was not enough to improve quality at health facilities. Neither was training through regional workshops carried out by MINSA, which made it necessary to directly reach micro-network health staff through a joint work – DIRESA, Networks – to boost improvement in care service quality.

The Cooperative Agreement strategy was addressed at generating a quality measurement and improvement culture. It had two stages. In the first, health staff was organized and trained and in the second, direct technical assistance was provided to the micro-networks for monitoring activities. One of the main concerns was having a Quality Team at each micro-network, made up by workers of all facilities and not only of the head micro-network. Through horizontal involvement and democratic leadership, the goal was for everyone, professionals and non-professionals, to be involved in decision-making.

Not all network and micro-network officials agreed on the democratization of decisions, probably for fear of losing authority or of internal problems. However, in many cases the proposal created personal and institutional renewal, organization and development. For example, the Pongo de Caynarachi, Jepelacio and Huimbayoc micro-networks – winners of the Quality Award of the Industries Association – who assumed the challenge of working as a team in a coordinated and systematic way.

On the other hand, without neglecting the attendance to workshop trainings, the new strategy included direct and frequent technical assistance to micro-networks. In addition to complying with commitment and agreed tasks, this allowed interacting on problems, needs and expectations with the workers, thus creating a relationship that facilitated the establishment of a quality culture. The staff acknowledged that it was simpler to apply

maternal and infant standards after understanding the underlying logic on measurement and improvement of quality standards for first care level facilities.

2.2.3.1.a Quality Standard Chronology.

To achieve the indicator of Intermediate Result No. 1: "50% of health facilities developed quality improvement processes", an interrelation strategy was designed among all levels of the Ministry of Health. This included working with MINSA officials (especially with the Executive Health Quality Directorate, DECS, and the National Sexual and Reproductive Health Strategy, ENSSR) and DIRESA to generate political support to the micro-networks. Networks and micro-networks were also included to empower health staff on continuous improvement and service quality culture.

Between 2004 and 2005, technical assistance was provided to micro-network health facilities for the application of quality standards for first care level. When these were temporarily suspended, maternal perinatal quality standards were applied at facilities that complied with Basic Obstetric and Neonatal Functions (FONB). Later, the application of maternal perinatal quality standards were included for facilities that complied with Primary Obstetric and Neonatal Functions (FONP), quality standards for facilities that complied with Primary Infant Functions (FIP), and quality standards for facilities that complied with Essential Obstetric and Neonatal Functions (FONE).

The experience gathered allowed to duplicate the work since July 2006, when the Accreditation Regulation was passed, using the methodology and list of standards for accreditation of health facilities in a dynamic and participate way.

2.2.3.1.b Technical assistance to the regions in the application of quality standards and indicators for the first care level.

In 2004, the project and the Executive Health Quality Directorate, (DECS), of MINSA agreed on providing technical assistance to the regions in the intervention area, summarized as follows:

i. Encourage the application of Quality Standards and Indicators for the First Care Level, published in 2002 by the Quality Assurance and Accreditation Directorate.
ii. Support the dissemination and application of Quality Standards and Indicators for First Care Level of MINSA.
iii. Promote a quality culture in micro-networks based on standard measurement and their improvement through the execution of improvement projects.

b.1) Quality improvement and DIRESA

Setting up a favorable climate for quality improvement requires for health staff to acknowledge the importance of the issue and apply the tools and methodology in their daily practice. A key aspect was the commitment and support given by

the DIRESA Director and his Management Team and by the Quality Official. They were sensitized in the need to count with a quality team and organizational guidelines at DIRESA, networks and micro-networks.

A work plan was coordinated with DIRESA Quality Officials that included the following:

- Election of a Quality Official at each network and micro-network.
- Establishment of Quality Management Teams at DIRESA and networks and Quality Teams (made up by 5 workers trained in Quality Management at the micro-networks
- Involvement of training officials of DIRESA and networks, monitoring and evaluation of quality activities in the region.
- Dissemination and sensitization of all workers at the micro-network on continuous quality improvement.
- Monitoring of standard measurement and improvement at each micro-network and the involvement of staff in these activities.
- Evaluation of results obtained in the measurement and execution of improvement projects through regional technical meetings.

b.2) Implementation of activities with Micro-network health staff

Work organization at micro-networks began with the identification and selection (carried out by quality officials of DIRESA and networks) of five workers to make up the quality teams. These were trained[34] in 18 three-day Regional Workshops[35] and in which six or seven micro-networks participated. After the training, the application of standards and the preparation and execution of quality improvement projects was supervised.

b.3) The National Quality Award of the Industries Association

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[34] *The following was the training content:*
- *Introduction to health quality.*
- *The Quality Management System*
- *Tools for measuring and evaluating health quality*
- *Quality standards and indicators for first care level*
  - *Guideline for self-evaluation of quality*
  - *Internal and external users surveys*
  - *Software to enter information and data analysis*
- *Continuous Quality Improvement*
  - *Identification and prioritization of improvement opportunities.*
  - *Cause analysis of improvement opportunity.*
  - *Preparation of improvement projects.*
  - *Types of improvement projects*
  - *Planning of improvement cycles*
  - *Monitoring of improvement cycles.*

[35] *In the following regions: Ucayali 2, Huanuco 4, Junín 5, Pasco 2 and San Martín 5*

During the first quarter of 2005, The Executive Health Quality Directorate (DECS) requested the support of the Project for disseminating the methodology used by the National Industries Association in seven regions on the preparation and systematization of improvement projects, based on which it issued Minister's Order 640-2006 "Continuous Quality Improvement Manual" (July 14th, 2006). This document contains the steps and tools for continuous quality improvement in addition to the guidelines for the preparation of projects on quality improvement in order to achieve the Management of Excellency in Quality Improvement.

Five training workshops were organized in Huanuco, Junín, Pasco, San Martín and Ucayali, attended by representatives of DIRESA, networks and micro-networks. A technical meeting was carried out in each region with the network and micro-network representatives, whose quality teams had prepared and executed improvement projects in 2004-2005. The terms and conditions for the "National Quality Award and Acknowledgement of Improvement Projects 2005" were made known and the preparation of the Nomination Report of the project to the award in question was supported.

A Committee appointed by the DECS selected 34 projects around the country out of which 20 corresponded to micro-networks of five project intervention regions. The projects selected were nominated before the Institutional Development Committee of the Industries Association. They went through a strict evaluation process that included the project's documentary review, its relevance and the visit to health facilities for verifying *in situ* changes and improvements produced. The projects carried out by the Pongo del Caynarachi and Jepelacio micro-networks of the San Martín region went to the final stage fo the contest and the award was granted to the **Jepelacio Health Center for the successful results of its project "Cultural Adaptation of Maternal Health Services"**. The conviction of the staff on the importance of community and local authorities' involvement in the execution of improvement projects was crucial in this achievement.

Training of staff for "Cultural Adaptation of Maternal Health Service".

Adaptation of delivery room for attention in vertical position

Two years later, another micro-network in the San Martín region was given the "National Quality Award and Acknowledgement of Improvement Projects 2007" with the project **"Together against Malaria in Huimbayoc 2004-2007"** for having reduced the cases of malaria by *Plasmodiun vivax* from 1,217 to 8, and the cases of infection by *Plasmodiun falciparum* from 523 to zero.

Space Spraying: Fumigation

2.2.3.1.c Maternal perinatal quality standards for facilities that carry out basic obstetric and neonatal functions (FONB); primary ones (FONP) and Essential ones (FONE)

Maternal and infant mortality is a sanitary problem which needs prioritized attention in the country. Therefore, it is necessary to know the maternal perinatal care quality in health facilities, measured through standards. In the absence of the latter, the project prepared a standard proposal[36] in 2005 for facilities that carried out basic obstetric and neonatal functions (FONB). The proposal took into account the type of facility and care level, so every standard and indicator referred to the response degree the facility should offer based on the Obstetric and Neonatal Functions (FON) model that considers four types:

- Primary Obstetric Neonatal Functions (FONP)
- Basic Obstetric Neonatal Functions (FONB)
- Essential Obstetric Neonatal Functions (FONE)
- Intensive Obstetric Neonatal Functions (FONI)

After this classification by Functions, MINSA prepared a Health Facility Categorization Standard, taking into account 3 levels and 8 Categories, whose obstetric and neonatal functions are shown on Table 9.

Table 9: MINSA Health Facilities by Care Levels and Categories

Care Level	Category	Obstetric and Neonatal Function
First Level	I - 1	Primary Obstetric Neonatal Functions (FONP)
	I - 2	
	I - 3	
	I - 4	Basic Obstetric Neonatal Functions (FONB)
Second level	II - 1	Essential Obstetric Neonatal Functions (FONE)
	II - 2	
Third level	III - 1	Intensive Obstetric Neonatal Functions (FONI)
	III - 2	

Selected Standards:

[36] *The proposal received contributions developed by the Quality Assurance Project (QAP) and other tools previously prepared by Project 2000 such as the Perinatal Information System (SIP2000) and the instrument for determining the Obstetric and Neonatal Resolving Capacity of health facilities (FON). Likewise, it copied the quality model proposed by Dr. Avedis Donabedian, who in 1966, introduced the concepts of Structure, Process and Result, which constitute the dominant paradigm in the evaluation of health care quality.*

Structure:

- "Resolving Capacity of Health facilities on Resources". Facilities at all function levels (FONP, FONB, FONE and FONI), should comply with no less than 80% of its resolving capacity on resources.

Process:

- Prenatal care
- Follow up of pregnant women
- Childbirth care
- Post-partum care
- Newborn care
- Newborn Resuscitation
- Care of obstetric complications
- Care of neonatal complications
- Family planning

Result:

- User's satisfaction
- Childbirth Plan and institutional childbirth
- Institutional care coverage
- Perinatal Mortality
- Perinatal Morbidity
- Gender-based violence

In addition to standards and indicators for FONB facilities, complementary instruments were prepared to evaluate the quality in facilities: instructions with the forms for data-gathering and estimation of indicators; Excel spreadsheet for reporting and monitoring and survey of pregnant women and new mothers to measure user's satisfaction after prenatal care and childbirth, respectively.

The proposal on standards and instruments was coordinated and discussed with the National Sexual and Reproductive Health Strategy (ENSSR) and the Executive Health Quality Directorate (DECS) that took it up and disseminated it in ten regions of the country in July 2005. They provided guidelines and monitored progress directly. The project assumed its dissemination, training and monitoring in the 7 prioritized regions.

Its validation in the regions during the first stage allowed identifying inconsistencies in standards and instruments, which were discussed during the first "Technical Meeting on the Analysis of indicators in Continuous Quality Improvement in Maternal and Perinatal Health"[37], with representatives from the regions. The relevant amendments were approved and its application was started in September 2005.

[37] *The technical meeting was organized by the ENSS, with financing of the project's Coverage with Quality and technical assistance from Pathfinder International*

The successful experience in the application of FONB maternal perinatal standards resulted in the preparation in 2006 of standards for FONP, FONE and FONI facilities, again through coordinated work between DECS, the ENSSR of MINSA, and the Project's technical team. Once these were validated, MINSA approved them through Minister's Order 142-2007/MINSA through the Technical Document "Quality Standards and Indicators in Maternal and Perinatal Care at Facilities that carry out Obstetric and Neonatal Functions". It then became a basic tool to achieve quality in pregnant women and newborn care.

c.1) Application of maternal perinatal standards in the 7 regions

The application of maternal standards made it possible to coordinate the work from the central level up to the micro-network in a different way from that of the application of quality standards for the first care level. Participating in this process were the heads of the micro-networks and quality and sexual and reproductive health strategy officials. Regional training workshops[38] were carried out, with the presence of seven or eight micro-networks at each one. Monitoring and coaching mainly covered the micro-network heads, which are the ones that carry out basic obstetric and neonatal functions, including the micro-networks considered a priority by DIRESA, even though some of them requested for these standards and indicators to be measured in all their facilities.

[38] *Training included:*

- *Quality subject matters and tools*
  - *Definition of Quality and Health Quality*
  - *Paradigm and change*
  - *Quality Management System (Components, Organization /Assurance and Improvement*
  - *Continuous quality improvement: Self-evaluation, prioritization and opportunity analysis*
- *Maternal perinatal quality standards for FONB facilities*
  - *FONB Standards and indicators*
  - *Self-evaluation of FONB standards*
  - *External user opinion polls*
  - *Report sheet and monitoring of FONB standards*
- *Continuous improvement cycle*
  - *Improvement projects*
  - *Investment projects*
  - *Cooperation projects*

c.2) Maternal perinatal standards for hospitals

At the beginning of the project, only the staff of hospitals in the Ucayali, San Martín, Junín and Ayacucho regions knew about continuous quality improvement as they had participated in Project 2000. At these hospitals, even though not on a regular basis, the quality Implementing Teams in charge of measurement and improvement operated, and used Self-supervision of 25 maternal and neonatal standards used by Project 2000. During 2004 and 2005, technical assistance was provided to these teams to continue with this work and to make facilities comply with quality standards. This was a requirement to qualify as a Training Center, within the Competence Development Center model also promoted by the project.

Even though there were Implementing Teams, hospitals did not count with Quality Management Teams aimed at achieving sanitary results. In most cases, there was only one person in charge of quality activities; but they did not count with the support of the facility's High Management, and in many cases, not even with that of their own colleagues. Medical staff, especially specialists at a hospital level, had little involvement despite efforts developed. Those who did participate were obstetricians and nurses.

Out of the seven DIRESAs of the project, Ucayali, Junín and Cusco, count with hospitals (category II-2) in the capital of the department and in several support hospitals (category II-1) in their provinces. Huanuco has a regional hospital (Hermilio Valdizán) category II-2 and one (Tingo María Hospital) category II-1. Pasco, has a hospital II-1 and two facilities I-4 (Oxapampa and Villa Rica) that work as a facility II-1, they have a surgical center and are located halfway from a facility with resolving capacity to attend obstetric emergencies. San Martín has a hospital II-1, (Moyabamba Hospital) and a facility (Tarapoto

Maternal Perinatal Center), with essential maternal neonatal resolving capacity (FONE). Finally, Ayacucho only counts with a II-2 hospital; its other facilities belong to category I-4.

Table 10: Health Facilities that carry out Essential Obstetric and Neonatal Functions trained in FONE standards

Region	Hospital	Category
Ayacucho	Regional de Ayacucho	II-2
Cusco	Regional del Cusco and Antonio Lorena	II-2
Huánuco	Hermilio Valdizán	II-2
	Tingo María	II-1
	Carlos Showing Ferrari	I-4
Junín	Daniel A. Carrión and El Carmen	II-2
	Domingo Olavegoya (Jauja), La Merced (Chanchamayo, Junín (Junín), Felix Mayorga Soto (Tarma), and Manuel Higa Arakaki (Satipo)	II-1
Pasco	Daniel Carrión	II-1
	Oxapampa	I-4
San Martín	CMP de Tarapoto	I-4
	Moyabamba	II-1
Ucayali	Regional de Ucayali and San José de Yarinacocha	II-2

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After launching quality standards for FONE facilities, the preparation of a work plan was coordinated for its application that included training[39] of health staff in managing standards and indicators, instruments for obtaining them (SIP 2000 and FON), quality instruments and the methodology for preparing improvement projects. In total, 19 facilities participated in this process. Table 10.

c.3) Maternal perinatal standards for health centers

In July 2006, MINSA launched maternal perinatal quality standards for facilities that carry out primary obstetric and neonatal functions (FONP); and some months later, infant standards for facilities that carry out primary infant health functions (FIP). As a result, the staff in charge of applying them was not the

[39] *Training included:*
- *Quality Management System*
- *Maternal standards for essential facilities (FONE)*
  - *Instruments and Guidelines*
  - *User-satisfaction surveys (APN and post-partum)*
  - *SIP 2000 and FON*
- *Tools and methodologies for continuous quality improvement*
  - *Identification and prioritization of improvement opportunities.*
  - *Cause analysis of improvement opportunity.*
  - *Preparation of improvement projects.*
  - *Types of improvement projects*
  - *Planning of improvement cycles*
  - *Monitoring of improvement cycles.*

professional or technical staff of micro-network heads, but rather technical staff from the periphery, which required training them in the application methodology of standards and improvement processes.

Comprehensive Care Directors and officials in charge of the Child Component, Quality and ENSSR of DIRESAs organized training meetings[40] and technical assistance at the micro-network heads to ensure direct involvement of technical staff in the training and not through duplications.

Technical and professional staff of health posts and centers felt motivated by the training and by the presence of officials from the networks and DIRESA with whom they established a productive dialog. These officials were able to verify in situ the limitations, strengths and material conditions of facilities in the periphery, all of which resulted in proposals for solutions.

2.2.3.1.d Infant quality standards

Concern for care of children under five made possible the implementation in 1996 of Comprehensive Care of Prevalent Infant Diseases (AIEPI), at health facilities in the country and which was institutionalized in 2006[41] as an intervention strategy within the Comprehensive Health Care Model (MAIS) to reduce morbidity and mortality in children under five. As it is know, comprehensive care is addressed at the child not only for prevention but also for underlying or underestimated health problems.

d.1) New infant standards.

Infant health care quality standards point towards comprehensive care. In February 2006, coordination was carried out with the Child Component Area of the Comprehensive Care Directorate to prepare and implement infant health quality standards for facilities that carry out basic and primary infant functions (FIB and FIP). A proposal on standards, indicators and measurement instruments was presented based on the application experience of maternal perinatal quality

[40] *Training included:*
- *Introduction on health quality.*
- *Quality Management System*
- *Tools for measuring and evaluating health quality*
- *Maternal standards for primary facilities (FONP)*
  - *Instruments and Guidelines*
  - *User-satisfaction surveys (APN and post-partum)*
  - *Continuous quality improvement*
  - *Identification and prioritization of improvement opportunities.*
  - *Cause analysis of improvement opportunity.*
  - *Preparation of improvement projects.*
  - *Types of improvement projects*
  - *Planning of improvement cycles*
  - *Monitoring of improvement cycles.*

[41] *RM 506-2005/MINSA institutionalized infant care strategy AIEPI*

standards. Due to the importance the first care level has for MINSA, standards were prepared for facilities that carry out primary health functions (FIP), keeping in mind that facilities, categories I-1, I-2 and I-3, would be in charge of their application. Based on the experience of this application, standards and indicators could be prepared for facilities I-4 that carry out Basic Infant Functions (FIB); then for those who carry out Essential Infant Functions (FIE); and finally for those which carry out Intensive Infant Functions (FII). Altogether, 10 standards and indicators were defined.

Proposed standards:

Structure:

- "Resolving Capacity of health facilities on Resources". An adequate service delivery for children under 5 requires that facilities at all functional levels carry out no less than 80% of functions that correspond to them.

Process:

- Child health surveillance systems in the family and community.
- Effective referral and counter-referral of children under five.
- Comprehensive care of children under five ensured by the AIEPI methodology.
- Children under a comprehensive care plan.
- Parents and/or guardians should be informed of the child's health at the end of the medical visit in order to know what care to provide them at home.

Result:

- Children of the health facility jurisdiction with birth certificates.
- Children with adequate growth rates.
- Children with adequate development rates.
- Children with complete vaccinations.

The proposal was thoroughly discussed with central level officials and their contributions were included. At the end of May 2006, standards began to be applied in Ayacucho and Cusco and then in other regions. Management Science for Health, MSH that works in infant health in communities of the Alternative Development Program (PDA) was in charge of training and transferring health staff to these jurisdictions, the management of instruments (standards, instructions, methodology, etc.) used by the Cooperation Agreement in its improvement strategy.

d.2 Simultaneous application of primary maternal and infant standards in the micro-networks.

In September 2006, when they launched the primary infant standards, it was decided to continue with the intervention strategy that followed the primary maternal perinatal standards; the decision was to integrate the training and

monitoring processes of both lists as these would be applied by the same health staff.

In virtue of agreements between Comprehensive Care Directors and officials in charge of the Child Component, Quality Officials and the ESSR of each DIRESA, a training [42] schedule was organized, which included Technical Meetings for all micro-network health staff addressed at the application of primary maternal and infant standards, notwithstanding the professional profile. Based on deficient standards found, improvement projects were prepared and executed. Coordination was carried out with DECS of MINSA taking into account the Manual for Continuous Quality Improvement in order to apply a single methodology in preparing these projects.

2.2.3.1.e Regulations and accreditation standards.

The first known accreditation for health establishments can be traced back to 1993, when the Ministry of Health appointed an Inter-institutional Sector Committee for Hospital Accreditation. This Committee was in charge of developing accreditation instruments, such as a Hospital Accreditation Manual and Guideline, approved in 1996. Between 1997 and 1999, the regulatory framework was established as well as the elements and processes required for executing the accreditation program, which included orders approving the process for public and private hospitals, orders authorizing certifying entities, a coordination, policies and procedures office, certification entities and an order promoting self-evaluation of health facilities as a requirement for their accreditation.

After six years of preparation and two of implementation, there was little success: the Ministry of Health did not regulate the accreditation process adequately and the private Certifying and Accrediting Entities governed the process and instilled it with their self-profiting logic. Costs were too high for public or mixed management hospitals and only six large hospitals, five private ones and one of the Armed Forced were able to be accredited, with the aggravating circumstance that the first and second care levels were practically excluded. Towards 2000, this accreditation was almost

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[42] *Training included:*

- *Introduction on health quality.*
- *Quality Management System*
- *Tools for measuring and evaluating health quality*
- *Maternal and infant standards for primary facilities (FONP and FIP)*
  - *Instruments and Guidelines*
  - *User-satisfaction surveys (APN and post-partum)*
- *Continuous Quality Improvement*
  - *Identification and prioritization of improvement opportunities.*
  - *Cause analysis of improvement opportunity.*
  - *Preparation of improvement projects.*
  - *Types of improvement projects*
  - *Planning of improvement cycles*
  - *Monitoring of improvement cycles.*

extinguished due to lack of credibility and the development of alternative proposals from investment projects.

There was consensus in the health sector for improving the accreditation model, making it unitary, democratic and equal and including human resources (health executives and workers) which constitute critical elements for accreditation and quality improvement. Since the beginning of the nineties, after getting over the "lost decade" in health, investment projects and diversified international cooperation began to invest in health workers' training programs.

Between 1992 and 2000, the approach on the workers' performance improvement was consolidated in the policies and practice of the Ministry of Health. The experience achieved in clinical skill training, in the improvement of service delivery in the first care level and self-supervision of health care services were the pioneers in a new accreditation concept, which gives autonomy to the effort of the service delivery teams themselves, through self-evaluation and leaves MINSA with the role to regulate and promote self-regulation.

In December 2001, the Ministry of Health institutionalized its quality policies with the approval of the National Health Quality Management System, and identified it as a basic principle in health care. It set forth that quality can be defined as the series of technical-scientific, material and human characteristics that health care should have in the constant search for user's satisfaction. In 2002, the quality standards and indicators are prepared for the first care level, in coordination with the decentralized Health Ministry directorate team, public and private entities involved in this issue and technical cooperation entities.

It is in this context that Technical Accreditation Norm No. 050-MINSA/DGSP-V.02 was approved. It was first approved on July 26, 2006, reviewed and once again approved with very few amendments on June 4, 2007. The effective Norm gathers aspects that already existed in the first version such as self-evaluation during the first stage of the quality improvement process, accreditation committees with more than one member, the decentralized criteria of the operation and incentives for accredited facilities, among others.

Notwithstanding the progress mentioned above, the Norm and its corresponding List of Accreditation Standards was the result of a long, hard and at times, unnecessary review, involving theoretical and ideological discussions led by MINSA, whose regulating role is oftentimes paradoxical, as officials make decisions based on their own criteria and not on the needs of the country.

e.1) Application of accreditation standards for health facilities.

Since the end of 2005, the Executive Health Quality Directorate (DECS) strengthened the Quality Assurance and Improvement Component in the Quality Management System, among other things with the Accreditation of health

facilities. The project took part in the preparation and validation of Technical Health Norm No. 050-2006/MINSA/DGSP- V.1 for the Accreditation of Health Facilities and Medical Support Services, as well as in the List of Standards for accreditation of such facilities, approved by Minister's Order 703-2006/MINSA, on July 26, 2006. The second version of the Accreditation Norm was approved in June 2007 with Minister's Order 456-2007/MINSA.

The project contributed to its application in San Martín, Cusco and Huanuco DIRESAs. Through Technical Meetings, officials, internal examiners and health staff of hospitals and micro-networks were trained on the following issues:

- Care quality at health facilities in the region
- Quality Management System
- Health accreditation: Scope of the Norm and instruments
- Self-evaluation during first stage of Accreditation process
- Concepts and methodologies of accreditation evaluation techniques.
- Analysis of Self-evaluation techniques
- List of standards for internal evaluation of health facilities
- Accreditation Software
- Field experience: application of list of standards
- Preparation of plan for Self-evaluation of their health facilities
- Conclusions and commitments

e.2) Sensitization on the accreditation norm at DIRESAs.

Addressed to DIRESA officials, it included the dissemination of responsibilities and tasks arising from the Norm; and the joint preparation of a work plan for its implementation in hospitals and micro-networks. Accreditation Committees were established in hospitals and micro-networks; technical and administrative health staff was selected and Internal Examiners were trained in self-evaluation of standards according to the category of health facilities.

e.3) Initial application of the Accreditation Norm in the San Martín Region.

In San Martín, 20 micro-networks were trained on the norm. The self-evaluation processes were carried out in health facilities in four micro-networks, which applied the list of accreditation standards according to their category. As can be seen on Table 11, during this first measurement, the large majority did not even comply with 50% of standards, which shows the precarious conditions in which these facilities provide services. Only the Jepelacio Health Center, the head of the micro-network of the same name, surpassed 85% of standards required for its category (I-3). The same did not happen with the other three facilities in its jurisdiction.

Results show that the main deficiencies are found in the macro-processes related to service delivery, especially in outpatient care, hospitalization and emergency.

Next in order of importance come macro-processes on referral and counter-referral, management of medicines, information, supplies and materials, equipment and infrastructure. These results clearly show the precariousness with which first care level facilities develop their activities; and at the same time, they are an appeal for carrying out strong investments in human resource training and in the purchase and maintenance of equipment and supplies. The San Martín DIRESA continues with the process and the person in charge of quality carries out analysis meetings with the micro-networks, encouraging the preparation of improvement projects to overcome deficient standards.

Table 11: Results of self-evaluation of Accreditation standards in San Martín

Network	Micro-network	Facility	Score	Rating
San Martín	Urbana 2	HC Morales	**33**	Does not Qualify
		HP Catacachi	**37**	Does not Qualify
		HP San Antonio Río Mayo	**17**	Does not Qualify
		HP Churuzapa	**19**	Does not Qualify
		Las Flores de Río Mayo	**11**	Does not Qualify
		HP Rumizapa	**24**	Does not Qualify
		HP Maceda	**18**	Does not Qualify
		HP Panchilla	**12**	Does not Qualify
		HP Santa Ana Río Mayo	**10**	Does not Qualify
	Cuñumbuque	HC Cuñumbuque	**39**	Does not Qualify
		HP San Rafael de Río Mayo	**6**	Does not Qualify
		HC Zapatero	**39**	Does not Qualify
		HP Nuevo Celendin	**46**	Does not Qualify
		HP Progreso	**11**	Does not Qualify
		HP Uchumullaca	**22**	Does not Qualify
		HP Carañayacu	**12**	Does not Qualify
		HP Santa Cruz de Shitarayacu	**20**	Does not Qualify
		HP Bagazan	**5**	Does not Qualify
		HP Nuevo Mundo	**32**	Does not Qualify
		HP San Juan de Talliquihui	**28**	Does not Qualify
		HP Alto Andino	**25**	Does not Qualify
Rioja	San Fernando	HP Atumplaya	**42**	Does not Qualify
		HP Perla Mayo	**39**	Does not Qualify
		HC San Fernando	**29**	Does not Qualify
Moyobamba	Jepelacio	HC Jepelacio	**89**	Qualifies
		HP Carrizal	**36**	Does not Qualify
		HP Shucshuyacu	**48**	Does not Qualify
		HP Nuevo San Miguel	**53**	Does not Qualify

e.4) The Accreditation process of health facilities in the Cusco region.

In Cusco, Accreditation in the Regional and Antonio Lorena hospitals and in the micro-networks of the La Convención and Cusco Norte networks was assumed by the Quality and Sanitary Management Directorate of DIRESA. The staff[43] responded in a heterogeneous way. Even though they acknowledged the importance of accreditation, they were unsure of their capacity to achieve it.

[43] *Directors and Deputy Directors; management teams, quality teams and department and service management*

Added to this was the dissatisfaction with the current hospital categorization, deficiencies in infrastructure and equipment, the ineffectiveness of some arrangements, loss of identity with the institution, frustration and dissatisfaction of workers, and a deteriorated organizational climate, among others.

Progress was slow. It took many weeks to choose the Accreditation Committees and the Internal Examiners and much more time to organize and conduct self-evaluation. Despite of this, little by little workers and executives are assuming the challenge of improving care quality in the two hospitals with greater resolving capacity in the region.

Work with the micro-networks was less complicated. A schedule was established with the La Convención and Cusco Norte networks for informing staff and training internal examiners at each micro-network. The first self-evaluation results were foreseen for November 2007. The schedule included monitoring and supervision of the Self-evaluation processes, the implementation of improvement cycles by the networks as well as the final supervision by DIRESA.

2.2.3.1.f The Technical Norm on Referral and Counter-referral

In 2004, MINSA published the "Technical Norm on Referral and Counter-referral of the Ministry of Health Facilities"[44], to ensure continuity in care within the Comprehensive Health Care Model by organizing facilities into networks, in the context of Decentralization and citizens' right to health. The Norm includes processes and procedures of the National Referral and Counter-referral System.

During 2005 and 2006, the norm was disseminated in various macro-regional workshops to which staff from DIRESAs and networks attended. Each region in turn organized the necessary structures and procedures for referral and counter-referral, coordinated with the Maternal Infant Insurance (SMI) and to the Comprehensive Health Insurance (SIS).

f.1) Referral and Counter-referral, SRC, a macro quality process for accreditation of health facilities.

The fifteenth Macro-process of the Accreditation Norm for Health Facilities and Medical Support Services is the Referral and Counter-referral[45] whose objective is to ensure continuity in health care in a service network, including community

[44] *RM 751-2004/MINSA that approves the NTS 018/MINSA/DGSP-V01 of July 26th, 2004 whose implementation shall be carried out by the Executive Service Managements of the central level and DIRESAs.*

[45] *The Comprehensive Health Care Model of the Ministry of Health is based on universal principles of equal opportunities, care comprehensiveness, quality, efficiency, respect of people's rights, decentralization and citizen involvement. Consequently, all services – promotion, prevention, recovery or rehabilitation – a person receives at the facility or other spaces should be inter-related in continuity so the user can be recruited, identified ,evaluated and followed up within an orderly system, integrating promotional, preventive and recovery care coordinated by resolution levels.*

involvement. This macro-process has four standards and thirteen evaluation criteria. Their compliance ensures users that the health services provide good care.

f.2) Implementation of the Referral and Counter-referral Norm.

The Executive Service Directorates of DIRESAs, with the support of MINSA, organized the administrative and service part of health staff by complexity levels of facilities in the regions for the Referral and Counter-referral System. This task was complicated due to the little resources assigned and high staff rotation. The Project provided technical assistance for the analysis of the system in each region and for the exchange of experiences. It was found that at the level of hospitals, networks and DIRESA the system implementation was good, but that in the micro-networks it was necessary to strengthen the community organization regarding referrals. This is precisely one of the indicators of the management agreements subscribed by DIRESAs.

During the implementation of the Norm, the need arose to count with a computer tool to register RC quantitative and qualitative indicators. Pasco, Cusco, Junín and Huánuco each prepared local software, using various strategies to share lessons learned: regional macro workshops for exchanging progress in computer designs for the SRC, radio conferences to share experiences in hospitals and operative units in the application of a care quality measurement instrument of referrals and internships (Oxapampa network) for learning "in situ" about the system documentation. The Project and DIRESAs selected pilot networks (see Table 12) in the 7 regions to ensure the full implementation of the system, updating their flow maps and list of services provided for health facilities that make up the network.

Table 12: Prioritized networks for the implementation of the Referral and Counter-referral System

Region	Network	No. of Micro-networks
Ayacucho	Huanta	2
Cusco	Cusco NorthNetwork	12
Huanuco	Leoncio Prado	10
Junín	Chanchamayo	4
Pasco	Oxapampa	7
San Martín	San Martín	9
Ucayali	Coronel Portillo	5

Of all the projects prepared for continuous quality improvement, 22% had the purpose of putting into effect and implementing the referral and counter-referral system at health facilities intervened in the project.

2.2.4 Quality Information: Instruments

The Cooperation Agreement has contributed to quality information with computer instruments that pursue the progress of Project 2000 and the Catalyst project in this field:

2.2.4.1 For accrediting health facilities

2.2.4.1.a Accreditation System for Health Facilities and Support Medical Services. Accreditation Application 1.0

The ACCREDITATION Application 1.0 is an instrument for the timely digital compilation and storage of data registered in the "Evaluation forms for accrediting facilities", useful for decision-making of health networks, DIRESAS and MINSA. The Accreditation Application includes a visual, intuitive and user-friendly interface and an internal management of business rules (validations) with help messages and options to facilitate the use of the keyboard. It is easy to use and adapts to the different users, cutting down learning time on its use and training costs. The characteristics and requirements of the system are found in Annex 7.

2.2.4.2 For maternal perinatal standards

2.2.4.2.a Improved Maternal Perinatal Information System (SIP2000)

Care of pregnant women and newborns use the Maternal Perinatal Information System (SIP2000) to register data on health conditions of pregnant women or new mothers, the development of the fetus and newborn, as well as other diagnostic, therapeutical and maternal perinatal management information, from beginning to end. Patients' development is monitored and assessed individually for decision-making based on evidence as part of continuous improvement.

Through the SIP 2000, permanent indicators are obtained about a certain condition or situation during the different stages of pregnancy: prenatal, childbirth, care of incomplete abortion, care of pregnancy complications, mother's discharge, care of newborn and discharge status of newborn. Automation of clinical information facilitates timely processing of data and is useful for the facility, health staff and patients.

The SIP 2000 was approved by Minister's Order No. 008-2000-SA/DM of January 17, 2000 (see Annex 8) that orders its obligatory use at all facilities of the Regional and Sub-Regional Health Directorates, and the Maternal Perinatal Institute and

entrusts the General People's Health Directorate with its implementation. SIP 2000 instruments are:

- Maternal Perinatal Clinical Record
- Prenatal Control Card, and
- Analytical Application of Maternal Perinatal Production and Service Quality Indicators

These instruments replace the Base Perinatal Clinical Record and the Analytical Application of the Latin American Center for Perinatology and Human Development (CLAP)[46] based on which these were developed. Over the last three years, this system was optimized with COMPLEMENTARY MODULES that allow the automatic cross reference of variables.

a.1) System Components

1. Maternal Perinatal Clinical Record (HCMP)

The Maternal Perinatal Clinical Record registers data provided by the patient and what the examiner observes at each visit, from the first prenatal visit.

Structure of the HCMP (See Annex 9)

The Record is made up of four pages with the following:

Page 1	Page 2	Page 3	Page 4
Particulars and background	Main observations of prenatal care.	Childbirth care / Post-abortion care	Discharges and Re-admissions
Baseline data of current pregnancy	Specific indications of prenatal care	Care of newborn	Discharge indications
	Maternal Pathologies, with date and diagnose of diseases or events experienced by pregnant woman following the CIE10 coding.	Puerperium	Epicrisis
	Principal and more frequent pathologies related to pregnancy, delivery and puerperium.	Principal and more frequent pathologies related to newborns.	Principal indicators of operative delivery or induction and medication

2. Maternal Perinatal Card (CMP), see annex 10.

[46] *The Maternal Perinatal Clinical Record was developed based on the CLAP Basic Perinatal Clinical Record. Participants were: health staff that provides maternal and perinatal care at all levels and categories in facilities; national experts as well as members of the Obstetrics and Gynecology Association and the Pediatrics Association through multi-skilled National Workshops. It was validated in 18 Hospitals, 32 Health Centers and 72 Health Posts and at present its use has extended to more than 80% of facilities of the Ministry of Health.*

To systematically register data of each pre natal care visit. The idea is for each pregnant woman to carry updated information with her on her pregnancy development to be used in case she goes to another health facility. The card contains the curves on "Uterine Height per Gestational Age" (percentiles 10 to 90) and the curves on "Weight Gain by Gestational Age" (percentiles 25 to 90) developed by the CLAP.

3. Analytical Application of Maternal Perinatal Production and Service Quality Indicators

The Analytical Application software is used for digitally compiling and storing data registered in the Maternal Perinatal Clinical Record (HCMP) based on which timely and reliable information can be generated to build indicators in maternal perinatal care to help make decisions based on evidence in the different care levels of the health system.

This Application was developed prioritizing a user-friendly interface. Data is entered from the first prenatal care visit and systematically at each visit, so there is permanent follow up of the pregnant woman. Each stage of the pregnancy, delivery, puerperium, fetus development and newborn care process is evaluated. It allows to program house calls for pregnant women who do not attend their doctor's appointments, or in view of some risk factor, they need closer supervision.

4. Parts of the Application

Part I: Particulars and Background: To enter data on particulars, obstetric background, family and personal background and previous pregnancy data, if it were the case. Data considered as ALERT appear in yellow.

Part II: Baseline Data of Current Pregnancy: Data on normal, current weight, height, date of last menstruation, previous and current anti-tetanus vaccine doses, blood type of pregnant woman, emergency hospitalization or care, luetic serology and hemoglobin tests according to MINSA regulations, psychoprofilaxis and general clinical test, as well as some special analyses.

Part III: Pre-natal Controls/Checkups: To enter data of each checkup and to have access to them. It plots the uterine height in relation to the gestational age and weight gains based on normal weight following the Tables prepared by the CLAP.

Part IV: Maternal Pathologies: Helps enter diagnoses of the different maternal pathologies according to the CIE 10 and the date such diagnose is carried out

Part V: Delivery and Post-abortion:

Part VI: Neo-natal Pathologies: Helps enter diagnoses of the different newborn pathologies according to the CIE 10, including diagnosing date

Part VII: Newborn, Discharges and Re-admissions:

5. Application Structure (See Annex 11)

When the Application is opened, some icons appear on the screen for each type of reports that can be obtained, such as:

- Database: Contains information on the total number of pregnant women attended at the facility during their different pregnancies, the number of existing Clinical Records in relation to prenatal and childbirth care, including appointment dates.
- Editing: Helps add new care of a same pregnancy and multiple pregnancies (twins, triplets, etc). You can look up Clinical Records of patients who have already given birth or that are still undergoing their checkups.
- Quality: Shows reports related to information quality, for example filling out or inconsistency Control.
- Indicators: Shows reports on the frequency of pathologies, its distribution and a group of pre-established care quality indicators
- Analysis: Contains health statistics, cross-reference of variables and risk assessment
- Tools: Helps configure the facility, network and staff that works in the maternal infant area. It shows the Tables used in preparing the System
- Reports: Provides data on pregnant women with critical pathologies, that come in or not for their checkups, causes of mortality, and information on pregnant women whose measurement parameters do not agree with the gestational age
- Help: Part of the system that responds to doubts on the management of the System

a.2) Complementary Module BABIES[47]

The name of the modules is the plural form of the word baby in English, BABIES, and includes two variables: a) weight at birth, and b) age at death of the fetus or newborn considered as indicatives of maternal health condition, social condition of women and neonatal survival forecast. Both indicators are combined in the BABIES matrix, which turns it into a simple yet powerful tool to help determine the problem, assess performance, choose the intervention and monitor and evaluate the process.

[47] *Built for SIP 2000 based on a group of indicators developed at the Atlanta CDC with support from CARE and successfully used in Tanzania.*

B: BIRTHWEIGHT
A: AGE OF DEATH
B: BOXES
I: INTERVENTION
E: EVALUATION
S: SYSTEM

BABIES orders the weight group at birth and age of death in the boxes resulting from these two variables. Cases are grouped by intervention categories, therefore they are a useful tool for informed decision-making that can be used at all levels: community, health centers, hospitals and DIRESAS.

From the SIP 2000 database, BABIES uses the variables of weight at birth and age of death to obtain death frequencies and specific mortality rates per one thousand born in an established group. This changes the normal one-dimensional look on mortality (per weight or per gestational age) to a two-dimensional one where the weight and age are cross-referenced. Comparison in time of indicators resulting from these combined variables will allow knowing the main causes of death and determine interventions to prevent maternal infant death.

BABIES Module Report (See Annex 12)

a.3) Probable Delivery Module

Provides a list of childbirths that should occur within a certain period of time in the jurisdiction of the facility to help identify pregnant women who are close to giving birth in order to carry out a follow up so the delivery can be institutional. The module warns about anything in the pregnant woman's background that should be taken in mind during care (for example, cesarean operations, how many, multiple pregnancies, etc.) to act correctly and carry out a reference to prevent harm in the patient. The report of this module indicates the probable delivery date based on Walt's rule or Nagele's rule, clinical record number, name of pregnant woman, address and important background information.

Probable Delivery Module Report (See Annex 13)

a.4) Complementary Referral and Counter-referral Module:

It helps to identify the causes why a pregnant woman is referred to a certain facility following the diagnose decision established in the CIE X.

a.5) Deceased Newborns Module

Provides specific information on newborns born alive that die. The report indicates the newborn's clinical report number, its name, mother's clinical

record number, mother's name, date of birth, pregnancy termination date, newborn's weight upon birth, gestational age at birth and main reason for death.

Deceased Newborns Report (See Annex 14)

a.6) Report Module for Production of Maternal Perinatal Services

Provides information for MINSA's Reproductive Health Strategy on health service production. It includes all care levels and contributes to significantly cut down data-gathering time to optimize time engaged in health service delivery. Information gathered refers to the type of pregnancy (low risk, high risk), house calls provided, frequency of prenatal care, adolescent care, clinical tests, place for birth deliveries, and type of personnel in charge of this and newborn conditions. It also provides information on critical pathologies related to pregnancies and that could have repercussion in the newborn.

Service Production Module Report (See Annex 15)

2.2.4.2.b Obstetric and Neonatal Functions

In order to register the compliance of obstetric and neonatal functions at facilities, the FON Application is used. This is software with which data registered in the "FON Forms" is digitally gathered and stored. Its purpose is to gather timely and quality information to generate management indicators for decision-making in the networks, DISAS, and MINSA's Central level regarding allotment of resources to facilities. It was developed using a visual, intuitive and user-friendly interface, with an internal management of business rules (validations) that facilitates its use for all users. Its management training is simple and low cost.

The characteristics of the FON Application, system requirements and form of use are shown in Annex 16.

2.2.4.3 For Infant Standards

Infant Standards for facilities that comply with Primary Infant Functions were developed and disseminated at Level I-1, I-2 and I-3 Facilities (Basically, Health Posts and Health Centers without admission) where they were validated.

The main data source used is the Child's Clinical Report approved in the Care Regulations for Children. The Project worked in coordination with the MSH and MINSA for developing the Computer Application. Activities included:

- Adaptation of the development methodology of the maternal perinatal computer application (SIP2000) to the infant area.
- Evaluation of variables of clinical record to process data.
- Transfer of the application design to the MSH for its development

The Child's Clinical Report was modified by MINSA, which made it necessary to carry out changes in the application under the charge of the MSH.

Upon termination of the Cooperation Agreement, Basic Infant Standards and Indicators (FIB) were prepared for type I-4 Health Centers, which were in the validation phase in October 2007. The Child's Clinical Record shall be used as a data source.

2.2.4.4 For Referral and Counter-referral

Upon termination of the Project, there is software for data gathering on referrals and counter-referrals of patients, whose final version was revised in September 2006.

The development of the software began between April and July 2006, with a failed intent for Pasco and Junín DIRESAS to work in coordination in order for the five other regions of the project to implement this software and subsequently, MINSA in the rest of the country. As this idea was not successful, they chose to work with the Pasco DIRESA software, this being simpler and more viable to duplicate in other regions.

In-person observations made in Oxapampa, Villa Rica (and those carried out in Satipo, Chanchamayo and Tarma; coordination with DIRESAS Huancavelica and Cusco) and coordination with MINSA, reveal that the main limitations for counting with referral and counter-referral indicators have to do with meager financial and staff resources, which prevents the timely registration of data, its analysis and decision-making based on them.

The application developed by the Pasco region has a local approach. However, it can be implemented in other regions as an initial stage in order not to delay more the registration of referrals and counter-referrals and to efficiently obtain indicators. For the future, this application should be adapted to MINSA's software standards.

At the closing of the project, Pasco and Junín are implementing the software each developed, while Huancavelica created a monitoring instrument for referrals and counter-referrals in EXCEL.

2.2.4.5 For periodic Certification of Medical Professionals

For registering files of applicants for re-certification as general practitioners or specialists, an information system has been designed called Certification and Re-certification System of the Medical Association of Peru. It is a data processing tool in which the evaluation of each applicant is compiled and processed by the Review Committee of the Medical Association of Peru. For more details on this instrument see Annex 17.

It consists of the following icons:

Main Menu

Used to register files, status (Received, Being Reviewed, Passed, Failed), the Review Committees and Users who operate the SISTCERE System.

Files (Data Entry)

Used to register data of files received, once entered, users who operate the SISTCERE, can register the evaluation status (Being Reviewed, Passed, Failed) according to the file case.

STRATEGIC PRODUCT 1: QUALITY MANAGEMENT SYSTEM

ACHIEVEMENTS	
QUALITY PLANNING	
➢ Work Plans of Quality Directorates and/or Quality Units of the Junín, Pasco, Huánuco, Cusco, San Martín and Ucayali DIRESAs approved by the respective General Directorates. ➢ Measurement and continuous improvement of maternal – perinatal quality standards included in the Annual Operative Plans (POA) of the Junín, Pasco, Huánuco, Cusco, San Martín and Ucayali DIRESAs. ➢ Self-evaluation of Accreditation standards in the pilot MN included in the 2007 Management Agreements between the DECS of MINSA and the Junín, Pasco, Huánuco, Ayacucho, Cusco, San Martín and Ucayali DIRESAs. ➢ 100% of micro-networks (12) of the Tarma, Chanchamayo and Satipo networks, and the El Carmen Hospital of the Junín region took part in the Validation of Accreditation Standards pilot for categories I-1; I-2; I-3; I-4; II-1 and II-2 included in Technical Norm 050-MINSA/DGSP-V.01 2006.	
QUALITY ORGANIZATION	
Region	➢ 04 Regional Technical Committees of the Quality Management System (CTR-SGC) established and approved: Junín, Pasco, Huánuco and Cusco. ➢ 90% of the members of the Regional Technical Committees of Junín, Pasco, Huánuco and Cusco trained in Quality Management and Continuous Improvement
DIRESA	➢ Establishment and approval of Quality Management Teams in the Junín, Pasco, Huánuco, Cusco, San Martín and Ucayali DIRESAs. ➢ Establishment of Accreditation Committees and Internal Self-evaluation Teams for accreditation standards at the Antonio Lorena Hospital and the Regional Hospital in Cusco. ➢ 100% of the San Martín DIRESA officials and 40% of officials from the Junín, Pasco, Huánuco, Cusco and Ucayali DIRESAs trained in Quality Management and Continuous Improvement.
Networks	➢ 86% (19) networks taking part in the 7 regions with Quality Teams (made up by officials in charge of quality, sexual and reproductive health strategy and child component) ➢ 100% (19) hospitals of the 7 regions with Quality Teams (made up by staff from the maternal and neonatology services) ➢ 70% of staff from the maternal and neonatology services of hospitals in the 7 regions (that comply with FONE) trained in measurement and improvement of maternal standards
Micro-networks	➢ 69% (76) micro-networks taking part in the 7 regions count with a Quality Team made up by officials in charge of quality, sexual and reproductive health strategy and child component. ➢ 69% (76) of the Quality Teams of participating micro-networks in the 7 regions trained in quality improvement and measurement of first level and basic, primary maternal perinatal and infant standards ➢ 50% (20) micro-networks of the San Martín region have Accreditation Committees and Internal Evaluation Teams trained in the first Accreditation phase (Self-evaluation). ➢ 45% (17) micro-networks in the Cusco region have Accreditation Committees and Internal Evaluation Teams trained in the first Accreditation phase (Self-

ACHIEVEMENTS	
	evaluation).
QUALITY ASSURANCE AND IMPROVEMENT	
DIRESA	➢ Quality Teams of the San Martín, Huánuco and Ayacucho DIRESAs execute improvement projects at their facilities. Some of their facilities have deserved first place at the National Meetings on Successful Experiences in Quality organized by the DECS of MINSA between the years 2004 and 2006.
Networks	➢ 100% (19) of the Junín, Pasco, Huánuco, Ayacucho, Cusco, San Martín and Ucayali hospitals evaluated maternal quality standards for facilities that carry out essential obstetrical and neonatal functions (FONE). ➢ 100% (19) hospitals in Junín, Pasco, Huánuco, Ayacucho, Cusco, San Martín and Ucayali prepared maternal quality standard improvement projects for facilities that carry out essential obstetrical and neonatal functions (FONE).
Micro-networks	➢ 70% (79) of the micro-networks in Junín, Pasco, Huánuco and San Martín evaluated first care level standards at their facilities. ➢ 90% ((174) of the micro-networks in Junín, Pasco, Huánuco, Ayacucho, Cusco, San Martín and Ucayali evaluated maternal and perinatal quality standards in facilities that carry out basic obstetrical and neonatal functions (FONB). ➢ 80% (155) of the micro-networks in Junín, Pasco, Huánuco, Ayacucho, Cusco, San Martín and Ucayali evaluated maternal and perinatal quality standards in facilities that carry out primary obstetrical and neonatal functions (FONP). ➢ 63% (70) of participating micro-networks in the regions of Junín, Pasco, Huánuco, Ayacucho, Cusco, San Martín and Ucayali evaluated infant quality standards for facilities that carry out primary infant functions (FIP) ➢ 20% (4) of the micro-networks in the San Martín region count with results from the first self-evaluation of accreditation standards. ➢ 2 micro-networks in San Martín (Jepelacio in 2005 and Huimbayoc in 2007) won the Acknowledgement for Management of Improvement Projects awarded by the National Industries Association.
QUALITY INFORMATION SYSTEM	
National	➢ 31 of the 34 health regions in the country (except Puno, Ica, Callao, including the 7 of the project) used the FON to analyze their resolving capacity based on resources. ➢ 30 of the 34 health regions in the country (except Puno, Ica, Callao, including the 7 of the project) use the SIP2000 to register information from maternal and perinatal clinical records in their main hospitals. ➢ 20 of the 34 health regions in the country (including the 7 of the project) have trained staff at their DIRESAs in the use of the ACCREDITATION Application for processing self-evaluations of Accreditation standards. ➢ 850 health facilities report and/or register maternal and perinatal clinical records in the SIP2000. ➢ The Medical Association of Peru keeps a registry of recertified doctors at a national level in the SISTECERE Application.

ACHIEVEMENTS	
DIRESA	➢ The Pasco and Junín DIRESAs have developed an application to register referrals and counter-referrals in their regions. These were proposed to MINSA for use at a national level in order to obtain indicators of the Referral and Counter-referral System.

II. STRATEGIC PRODUCT 2: POLICY ON HEALTH HUMAN RESOURCES

1. CONCEPTUAL FRAMEWORK OF THE RHUS POLICY

Since 2001, the National Health Policy in Peru explicitly included in the sector's agenda the development of human resources as a condition for enhancing equal opportunities and quality in health care. This happened ten years after a previous reform that failed to include the State's responsibility on various public health functions[48]. Here relies the importance of the 2002-2012 Health Policy Guidelines that comprise the Human Resource Sector Policy and the National Policy Guidelines for Development of Health Human Resources[49] [50] based on competences.

Technical assistance of the Cooperation Agreement in this area was directed to the regions of Huánuco, Junín, Pasco and Cusco whose Development Plans included health human resource management and served as a framework for preparing their Regional Coordinated Health Plans PRCS[51]. Each of them included specific activities for the implementation of National Policy Guidelines for Development of Health Human Resources based on competences according to regional health needs.

48 *Bases for guidance of decentralized management of Health Human Resources, IDREH, 2004.*

49 *National Policy Guidelines for development of Health Human Resources, IDREH 2005*

50 *Minister's Order. RM No. 1007-2005/MINSA of September 2005.*

51 *One of the strategic objectives of the Huanuco PRCS is to improve health human resources at all care levels. The Junín PRCS in its regional policy No. 12 and the Pasco PRCS in its regional policy No. 11 make reference to the development of health human resources based on competences. In its Policy No. 15, the Cusco PRCS indicates the development of human resource competences regarding respect and dignity in comprehensive health care.*

2. PREPARATION OF REGIONAL POLICIES

The Ministry of Health implemented the national policy guidelines through the Human Resource Development Institute, IDREH, based on the creation and consolidation of coordination spaces between social actors in different levels. Guidelines were adapted to the regions through coordinated actions with the Social Development Management of Regional Governments.

2.1 ORGANIZATION OF REGIONAL TEAMS

During a first stage, the strategic importance of the RHUS was disseminated and its connection with sanitary results among staff from EsSalud, Armed Forces and Police Forces Sanitation, private clinics; public and private universities and higher education institutes, regional offices of professional associations and others, summoned by the Regional Health Boards. Afterwards, Regional Human Resource Technical Committees CTR-RHUS were established in Junín and Pasco[52], as well as the Thematic Human Resource Committee, MT-RHUS, in Huanuco[53] [54], approved through Regional Orders, which were in charge of preparing an analysis on the RHUS situation and to adapt and legitimize RHUS national policies in its region.

At the Huánuco, Junín and Pasco DIRESAs [55], (and in some of their health networks[56]) Human Resource Teams were made up to lead the implementation of RHUS policies: the design of work competences, work competence regulations for the first care level, incentives and motivation, selection and hiring of staff, among others. In Cusco, the leadership befell on the Management Team.

The analysis of the RHUS showed similar results in all regions that can be summarized as follows:

- Lack, almost in general, of the competence profile in the creation of RHUS.
- Inexistence of a RHUS Managerial Information System with the involvement of regional actors

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52 *Conformation of the RHUS Regional Technical Committee: Junín, Regional Ordinance No. 047-GRJ/CR; Pasco, Regional Ordinance No. 091-2006-GRP/CR and Regional Executive Order No. 073-2007-GR-PASCO/PRES*

53 *RHUS Development Thematic Committee in Huanuco. Technical coordination instance, advisory services and analysis of RHUS Regional Policies in which educational institutions, public and non-public health service providers, professional associations, regional government and local government participate.*

54 *Conformation of the RHUS Thematic Committee in Huanuco: and Regional Executive Order No. 312-2003/PR (April 30th, 2003) and Re-composition of the RHUS Thematic Committee, Regional Managerial Order No. 334-2006-GRH/GRDS (21 August 21st, 2006)*

55 *Conformation of the Human Resource Committee in the Junín DIRESA: Director's Order No. 235-2006-DRS/OEGDRH; Pasco: Director's Order No.065-2006-DG/CR*

56 *Human Resource Committee of the Oxapampa Network (Pasco) approved by Director's Order No.067-07-DE/RSS-OXAPAMPA and the Chanchamayo Network (Junin approved by Director's Order No.090-06-GR-JUNIN-UTES Chanhcy and re-structuring of the committee by Director's Order No.119-06/GR-JUNIN/UTES CH*

- Lack of coordination of RHUS competences, roles and functions from the regional level to the operative levels (Network, MN).
- Lack of training evaluation instruments to measure its impact at a regional and local level
- Lack of approval mechanisms and acknowledgement of health community agents, notwithstanding their social importance in health actions.
- Lack of specific regulations of RHUS management in the evaluation, selection and hiring process of staff based on competences.
- Limited acknowledgement, motivation and well-being actions for health staff.
- Lack of strategic alliances between the employer and the health worker in the regional and local scope.

Based on these results, an agreement or social pact was prepared among the institutions in the Region (see Annex 18, Agreements Document) for executing the RHUS Policy Implementation Plan (see Annex 19, Work Plan).

3. REGIONAL POLICIES

3.1 POLICY 1: CREATION OF RHUS

The educational supply in Peru continues on the rise but lacks coordination with health care requirements and needs of the population. Policy 1 seeks to reconcile efforts, demands and products from educational institutions that train health professionals, health care service delivery facilities, professional associations, trade associations, civil society and other institutions in the regional scope to guide training of human resources based on occupational profiles required by the Health Care Model currently effective in the country. In this sense, the Cooperation Agreement has contributed with activities detailed below:

❖ **SINEACE Law and Regulation**

Since 2003, several actions were carried out to regulate training and professional exercise through laws:

- March: Technical Meeting[57], of school and faculty associations and professional associations organized by CAFME to discuss a preliminary document on the University Educational System on accreditation and other strategies.
- May: Technical Meeting [58] with politicians and academic authorities to inform them about the experience of the Medical Schools Accreditation Committee (CAFME) and the proposal of the Peruvian Association of Nursing Faculties and Schools (ASPEFEEN), gathering suggestions for the accreditation of universities.
- July: Enactment of the General Law on Education (Law 28044) that included the creation of the National Evaluation, Accreditation and Certification System for Educational Quality (SINEACE) and that made professional certification obligatory in the health field.
- October: Establishment of a Quality Initiative Group in Higher Education, GICES[59], at the request of the Cooperation Agreement to submit proposals and supervise the preparation

GICES
Grupo de Iniciativas para la Calidad de la Educación Superior

[57] *Technical Meeting: "Bill on the National University Educational System and the Future of the Accreditation of Medical Faculties or Schools". Participants were: 35 professionals from CAFME, ASPEFAM, ASPEFEEN, ASPOFOBST, Nurses, Obstetricians, Doctors Associations and cooperating and bilateral agencies.*

[58] *Meeting: "Quality Assurance in University Education" in which academics and experts informed Congress people on the experience of the Medical Faculties Accreditation Committee (CAFME) and on the proposal of Nursing Schools and Faculties, ASPEFEEN.*

[59] *In the last quarter 2003, Pathfinder International summoned professionals to work on the General Law on Education regarding SINEACE, with the establishment of the tasks and initiatives group, GICES.*

of SINEACE's Law and Regulations, together with other institutions[60]. In 2004, the Executive submitted such Bill to Congress, which included elements from the GICES proposal. It was enacted[61], in May 2006, and a year later, the Regulation on July 10, 2007.

3.1.1 Accreditation of Schools and Faculties

3.1.1.1 Accreditation of Medical Schools and Faculties

3.1.1.1.a National Medical Exam (ENAM)

The National Medical Exam is a key instrument for accreditation of Medical schools and faculties. It was developed by the Peruvian Medical School Association, ASPEFAM, to the end of evaluating undergraduate medical education quality in Peru. The Ministry of Health considered it beneficial for the Health Sector and approved its annual application at all medical schools in the country through a Minister's Order[62]. It also ordered MINSA authorities to give facilities to medical interns in scheduling their shifts and service activities in order to take this exam. On its part, the National Medical Internship Committee, CONAREME, established taking this exam (ENAM) as a requirement to apply to the medical internship program for graduates in 2006.

In 2003, after a meeting on National Evaluation Exams Experiences for Medical Students, the Medical Education Committee submitted to the Association Board the proposal for the implementation of the ENAM, which was approved taking into account that the 1st National Medical Exam of 2003[63], should be considered as an operative research applied to students in their 6th and 7th year of study during its pilot phase. Places for taking the exam were at 4 school facilities that offered to participate voluntarily: North (1), Lima (2), and South (1).

The second ENAM took place on November 13th, 2005. Those participating were 1,565 students from internships of 19 faculties or medical schools and 120 professionals and students from other grades.

On November 26th, 2006, the third National Medical Exam was successfully developed in 22 medical schools, members of ASPEFAM, in which 2,306 applicants, including interns (98%), doctors and students, participated.

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60 *Universidad Nacional Mayor de San Marcos (San Marcos National University), National Rectors Assembly, Universidad Nacional de Cajamarca (National University of Cajamarca) and others.*

61 *Annex 20: Law No. 28740. Law on the National Evaluation, Accreditation and Certification System for Educational Quality (SINEACE). May 19th, 2006. It regulates the evaluation, accreditation and certification processes of educational quality, defines the participation of the State and regulates the scope, organization and operation of SINEACE, referred to in articles 14 and 16 of the General Law on Education No. 28044.*

62 *Annex 21: Minister's Order No. 620-2006/MINSA, July 6th, 2006 (published in the El Peruano Newsletter on July 10th, 2007). National Medical Exam.*

63 *Up to then, the only experience on a National Exam in the country was the one from ASPEFAM for the two last years of education.*

3.1.1.1.b Strengthening and consolidation of CAFME: accreditation standards, standard verifiers and external verification.

In 1999, the first University Accreditation System was created in the country through the Committee for Accreditation of Medical Faculties or Schools, CAFME. During that year, in view of the excessive growth of these faculties, a work group was formed sponsored by MINSA with the involvement of the Medical School, the National University of San Marcos, the Cayetano Heredia Peruvian University, the National Medical Academy and the Peruvian Association of Medical Faculties. This group designed a bill, which was enacted as Law No. 27154[64], which created CAFME as an autonomous entity.[65]

CAFME[66] has prepared minimum standards for accrediting Medical Schools or Faculties, approved by Supreme Order No. 013-2001-SA of January 5th, 2001. It selected and trained a first group of verifiers of these minimum standards and included all Medical Faculties and Schools in the accreditation process. Between April and October 2002, the first seven faculties were accredited while the CAFME's work continued in updating and improving current regulations on accreditation, revision, restructuring and validation of minimum accreditation standards and in increasing the number of trained verifiers. At the end of the Project, minimum accreditation

64 *Annex 22: Law No. 27154 - CAFME*

65 *CAFME is headed by a MINSA delegate and made up by representatives of the Ministry of Education, the National Rectors Assembly, CONAFU and the Doctors Association. .Their advisors come from the National Medical Academy and the Peruvian Medical Faculties Association, ASPEFAM.*

66 *Procedures Manual approved by Minister's Order No. 196-2002-SA-DM, of January 23rd, 2002.*

standards were reviewed and updated in 2003[67], to include contents of the AIEPI strategy, and again in 2006[68].

The Ruling of the SINEACE Law [69] published in 2007, orders ceasing of CAFME functions, which up to then was in charge of accrediting medical schools and faculties, transferring such functions to higher university education institutions (CONEAU).

During its life, CAFME managed to:

- *Accredit 23 out of the 29 medical faculties and schools in the entire country.*
- *Stop the creation of new medical faculties*

3.1.1.1.c Experimental Laboratory for Evaluating Health Science Competences

In 2004, ASPEFAM decided it was necessary to have an evaluation system for medical students that not only included theoretical knowledge but also practical experience on clinical competence. The model chosen was an Experimental Clinical Competence Evaluation Laboratory (LEEC) created as the main nodule of a network made up by evaluation centers for specific issues (regional epidemiological situation) in different parts of the country. The LEEC focus is on the medical student's training evaluation at a first moment and on other health professions in the future. It counts with a technical team made up by teaching doctors and representatives of the obstetrics and nursing school associations.

The idea of the LEEC sprung from a visit made by ASPEFAM members in 2003 to the National Board of Medical Examiners, NBME, in the U.S. In 2005, its cooperative design[70] and implementation began with a first technical nucleus in ASPEFAM that consolidated in 2005-2006 with the carrying out of two important workshops[71].

Upon conclusion of the Cooperation Agreement, the Laboratory has managed to:

- ✓ Motivate and make associations and faculties interested in the use of the LEEC for competence evaluation.
- ✓ Train 18 teachers in the evaluation methodology of clinical skills developed by FAIMER, and
- ✓ Prepare 11 cases of simulated patients for the validation process

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67 *Annex 23: Supreme Order No. 004-2003-SA CAFME Standards – July 24, 2003 (AIEPI Strategy: indicator 49.1 of variable 49).*

68 *Supreme Order No. 007-2006-SA approved on July 24, 2006.*

69 *Annex 24: Regulation of the SINEACE Law published on page 348782 of El Peruano Newsletter on July 10, 2007).*

70 *Technical assistance comes from NBME and the Foundation for Advancement of International Medical Education and Research (FAIMER), with the participation of members of technical committees from ASPEFAM and representatives from ASPEFEEN, ASPEFOBST and the Cooperation Agreement.*

71 *2005 Workshop "Clinical Skills Evaluation Exam". 2006 Workshop "Experimental Laboratory for Evaluation by Competences." Participants were: 18 Peruvian teaching doctors that constitute the specialist technical team on this issue and NBME and FAIMER professionals.*

Based on the progress made in the National Medical Exam and the Laboratory, the Project contributed to the first stage[72] with the implementation of a Health Teachers Training Center, CEDS, to strengthen teachers' skills in medical faculties and schools to train and evaluate by competences. The current scenario is favorable as a result of the regulation of the SINEACE Law.

3.1.1.1.d Medical Faculties Management School

A study made by ASPEFAM revealed limitations in the academic management of medical faculties. Therefore, it was decided to establish a Medical Faculties Management School addressed at creating high and intermediate management teams with the purpose of increasing efficiency and quality in the operation of their programs, improving management capacities of the university system as a whole and consolidating a self-evaluation university model to guarantee quality in medical education and health care for the Peruvian population[73].

The School's activities began in 2003 with Faculty Deans and Medical School Directors. From then on, the target group comprised officials from various levels who were trained on critical management knots: Clinical field management and Curriculum by Competences, research methodology in medical education and academic supervision, among others.

Upon conclusion of the Cooperation Agreement, the following achievements can be highlighted:

- ✓ Development and validation of a curriculum for team training
- ✓ Preparation of video or printed teaching aids
- ✓ Development of the virtual course "ProMédicos Perú "[74]

3.1.1.2 Accreditation of Nursing Faculties and Schools

3.1.1.2.a Basic curricula for education in obstetrics and nursing: A valid Methodology for improving educational quality

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72 *The first stage included the preparation of: a) an analytical report on instruments developed by the ENAM and the LEEC and methodologies for evaluation of competences at medical faculties and schools; b) conceptual, methodological and instrumental bases for the CEDS project, and c) report on the prospective analysis for the inclusion of evaluation by competences at ASPEFAM member faculties.*

73 *Competences of School graduate*
- *Use of a strategic approach in understanding problems and opportunities of its Faculty and in the preparation of proposals for institutional development.*
- *Use of own administration concepts and theories for proposing innovative quality improvement strategies at the School*
- *Proactive management of its organization*
- *Use of theoretical and regulatory instruments for administrative management for upgrading management at the Faculty.*
- *Ethical attitude and leadership in university and sanitary management in their sphere.*

74 *Has financial sponsorship from the Merck Foundation*

The discrepancy between higher health education and the needs of the population and the sanitary system motivated the obstetrics, nursing and medical schools and faculties to undergo at different times and with different styles, reforms in their curricula to provide their respective schools and faculties with updated and standardized study programs in tune with health sector guidelines and reality.

This effort for improving quality in professional education was started at the obstetrics schools and faculties (under the direction of the Peruvian Association of Obstetrics Schools and Faculties - ASPEFOBST) and spread to the nursing and medical faculties under the name of nuclear curriculum. Previously, nursing and obstetrics education was based on a bio-medical health perspective when working requirements included higher grades in the preventive-promotional area. In this sense, the curricular reform (based on competence approach) in obstetrics and nursing is a self-adaptation educational exercise to labor market requirements – especially those of the Ministry of Health, which is the principal employer – in the absence of a regulating authority, through the definition of performance standards for each professional by level of complexity.

The preparation of the basic obstetrics and nursing curriculum by ASPEFOBST and ASPEFEEN and educational institutions comprised the analysis of the main actors' setting, the updating of approaches and the demographic, social and cultural health trends, labor market, professional competence and educational supply, among others. Workshops and technical meetings were carried out and the process also included the creation of committees, work teams and interest groups. In addition, it comprised the conceptual, contextual and organizational strengthening of schools and faculties.

Basic nursing curriculum. In nursing, ASPEFEEN's decision resulted from self-evaluation and external evaluation in 2004. It received technical assistance from ASPEFOBST (and from the National Learning Service from Colombia, SENA), for developing skills in the preparation methodology of the basic competence approach curriculum for continuous improvement of educational quality. ASPEFEEN and ASPEFOBST's joint interest shows a unique technical assistance form for strengthening each other and sharing experiences and lessons learned in addition to implementing strategies to mobilize resources more efficiently.

Self-management is an element worth mentioning in this process, especially for updating issues such as child and adolescent care, the AIEPI strategy (included through a strategic alliance with PAHO together with other health promotion strategies to decrease infant and maternal morbi-mortality), progress in public health, adult and elderly health, management and administration, women health and gender and research. The project contributed to strengthening the inclusion of AIEPI components.

The final version of the basic curriculum was approved at a general dean's assembly in 2006. It includes competences in maternal perinatal health, AIEPI and communication and health promotion. Two National Exams have been carried out. The standardized curriculum contains competences every nursing student should acquire during his or her education at any faculty or school in the country. Its purpose is to close the gap between what the demand requires and academic preparation. It is headed at each university by the Curricular Committees that self-evaluate the status at each one regarding the basic curriculum and work towards achieving an education that is compatible with the demand.

3.1.1.2.b National Nursing Exam (ENAE)

In the absence of standardized procedural and methodological criteria for evaluating nursing graduates, in 2004, the Peruvian Association of Nursing Schools and Faculties, ASPEFEEN, approved the "National Nursing Exam", ENAE, in 2005.

Similarly to the ENAM, the ENAE has also been designed to contribute to quality improvement in undergraduate programs. It provides educational quality assurance in Nursing and it is an instrument for evaluating the competence of graduates using appropriate technologies to assess comprehensive learning, including the knowledge, technology and values in caring for people, the family and the community. Competences include skills for solving complexity problems in various scenarios; combining knowledge and practice, ethics and critical standing in face of reality and proposing improvement in comprehensive Nursing care.

3.1.1.2.c Profile by competences of nursing graduates, self-evaluation Committees, Training of external Examiners

Between 2002 and 2003, ASPEFEEN, with technical and financial support from USAID, prepared the educational profile of graduates from the Undergraduate Programs of the Nursing Faculties/Schools [75] that describes competences students should have upon finishing their educational process to ensure good working performance, which is efficient, rational, critical, ethical and scientifically and technological trained. The definition of competences was based on functional areas and the vital cycle stages included cross-curricular topics such as mental health, health communication and education.

[75] *Annex 25: Workshops for the Educational Profile of Nursing Graduate in the Under-graduate Programs:*
- ✓ *Comprehensive Contextual Analysis for the Preparation of the Educational Profile of the Peruvian nurse at an undergraduate level.*
- ✓ *Methodology for the Preparation of the Nursing Educational Profile at an undergraduate level based on Competences.*
- ✓ *Preparation of the Nursing Educational Profile at an undergraduate level based on Competences.*
- ✓ *Workshop on the Integration of the Nursing Educational Proposal at an undergraduate level based on Competences.*

At the same time, quality standards were prepared for the accreditation of Nursing Schools and Faculties[76], focused on basic criteria for institutional operation. Then, quality criteria in teaching were initially included based on the Colombian model, which consists of a two-level system:

- Basic Quality Standards of essential program operation aspects assessed through documents and that originate continuous improvement plans
- Quality Standards for the Nursing Undergraduate Program[77] based on the Graduate Profile. These assess results of Improvement Plans resulting from the evaluation of Basic Standards.

ASPEFEEN's Basic Quality Standards comprise 9 areas. They include 32 variables and 68 indicators and their respective verification sources in a continuous improvement sequence[78] ranging from self-evaluation to accreditation.

A group of teachers from different institutions of the country were trained as external examiners or evaluating peers. Training of the first 26 examiners (from 12 universities), was in 2006[79] and of other 43 (from 18 universities) in May 2007. To September 2007, 44 out of 47 nursing schools and faculties nationwide had concluded their self-evaluation and 30 had had external evaluation visits. The preparation of second level standards is still ongoing.

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[76] *Five macro-regional workshops were developed to socialize the proposal on Basic Quality Standards with the participation of representatives from nursing faculties and schools nationwide.*

[77] *Annex 26: Basic Quality Standards for Nursing Undergraduate Programs*

[78] *Sequence for accreditation: a) Self-evaluation of Basic Quality Standards, b) Continuous Improvement Proposals, c) External Peer Visiting, d) Continuous Improvement Proposals, e) Self-evaluation of second level Quality Standards, f) Continuous Improvement Proposals, g) External Peer Visiting and h) Accreditation.*

[79] *Was in charge of an Advisor of the National Accreditation Committee from Colombia, CNA*

3.1.1.3 Accreditation of Obstetrics Schools and Faculties

3.1.1.3.a Basic Curriculum

The Peruvian Association of Obstetrics Schools and Faculties, ASPEFOBST, began quality assurance activities in 2003 with a national study[80] on maternal perinatal health. Based on this data and the analysis of different study curricula, it prepared a basic curriculum that contained essential aspects to be complemented with the needs of each institution and each region. Representatives from all obstetric schools in the country were involved.

The above mentioned study and three macro-regional workshops helped identify local gaps between the reproductive health situation, competences required by the obstetrician and the needs of reproductive health care which gave way to care strategies according to the demand.[81]

At the beginning of 2005, the preparation of the basic obstetrics curriculum was finished and validated in pilot obstetric faculties and schools.

3.1.1.3.b Accreditation of obstetrics faculties and schools

At the end of 2006, when the standardized basic curriculum and profile of the obstetrics career graduate were finished, ASPEFOBST prepared quality standards for the accreditation of obstetrics faculties and schools and a guideline for self-evaluation of standards[82] for accreditation. These were validated in 6 faculties in different regions and at a workshop to which 24 out of the 25 obstetrics faculties/schools from all over the country attended. Its final version was finished in July 2007. Twenty-six examiners were trained at 10 pilot faculties and schools; these in turn formed peer or external evaluating teams. In September 2007, self-evaluation started at the 10 pilot faculties/schools and at other non-pilot ones at their own initiative with technical assistance from ASPEFOBST.

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80 *The study included the application of two surveys, one addressed at users and the other to professionals in obstetrics in departments that count with faculties or schools that train obstetricians*

81 *Annex 27: ASPEFOBST SR Analysis and Strategy. Report on 3 macro-regional Workshops*

82 *Annex 28: Self-evaluation and accreditation guideline for obstetrics schools and faculties*

3.1.1.3.c Results of self-evaluation carried out at pilot faculties/schools:

- ✓ Only two (out of 10) schools/faculties complied with 16 of the 19 standards required for accreditation. Of the remaining 8, one shall be re-evaluated in 4 months and 7 should start an improvement process before being re-evaluated, as their score is below 40% (8 out of 19) of standards qualified as acceptable.
- ✓ In the series of institutions evaluated, 33% of standards qualify as acceptable, 46 % in process and 21% as deficient.
- ✓ Standards with higher compliance level were found in the educational project and human resource management; lower level ones were admission, research and financial management managed by the university, without involvement from schools/faculties.
- ✓ The 10 schools/faculties have prepared their self-evaluation plans including the cost of technical assistance from ASPEFOBST.

3.1.2 Periodic Certification

On August 3rd, 2004, the National Board of the Medical Association of Peru, CMP approved the regulation of the Certification and Re-certification System with the purpose of ensuring society that the services provided by doctors have a sufficiency level according to the regulations. Article one of the new regulation indicates: «*The Medical Association of Peru, based on the attributions granted by law, bylaws and other effective norms, administer a certification and re-certification system that allows –within reasonable limits- a good competence level in the medical professional »*

At present, re-certification of the Medical Association goes from an academic credit-based model to one that includes work competences, in a model that combines continuous professional development in the classroom, in-service learning and indirect performance evaluation.

Medical re-certification responds to the pursuit of care quality, measured through international standards. A university degree awarded at the beginning of the professional exercise is not valid forever. It requires periodic renewal that implies acquiring new knowledge, evaluated through standards prepared by scientific societies that define and group competences. These are minimum competences, different from those of developed

countries and differentiated by regions. The certification of the general practitioner is different from that of a specialist and those among specialists.

Process is slow at the Peruvian Medical Association, among other things due to the lack of continuity of teams in charge of re-certification, even though this is obligatory, as has been acknowledged by private and social security institutions that require such re-certification for selection and hiring of doctors.

A good number of doctors do not have access to re-certification, especially those who work in the peripheral and urban areas, where there is limited possibility of courses and information not to mention the high cost, in addition to the difficulty in obtaining paid leaves of absence for training. This can be due to the "resistance" observed in many medical sectors and not to an opposition to the process.

On its part, the Obstetricians Association of Peru, COP, (unlike the CMP model, in which certification is automatic) assumed the re-certification process in two stages: certification and re-certification, both with a competence approach through an exam testing knowledge and proof of basic performances.

The COP created the SINADEPRO (System for Professional Development in Obstetrics) for certification and re-certification, in charge of the design and organization of the system, the design of instruments for evaluating professional competences, training of examiners, as well as the start up of certification and re-certification [83].

An aspect worth mentioning is the speed with which certification and re-certification are developed. In only two years (2005-2007), they have prepared: the competence profile, the Continuous Education Program (with health promotion modules, care, management, research, teaching), in addition to the decentralized structure in regions and national sensitization and mobilization.

The SINADEPRO heads certification by generating guidelines and instruments for professional performance evaluation adapted to each care level and to each region. Its success factors are: leadership and dynamism of the National Board of the Obstetricians Association of Peru and Regional Boards, the involvement of young professionals, the creation of an autonomous and technical system in charge of certification, strengthening of regional structures and an advanced professional certification model.

Certification at the Nurses Association of Peru, CEP, (regulated by Law No. 27669) is the closest experience to what is established in the SINEACE Law, with a competence-based approach and standardized evaluation.

The three periodic certification experiences seek to achieve the best professional performance. The Medical Association has gone from a mixed model of documentary evidence to another that incorporates performance evaluation. The Nurses Association,

[83] *With technical assistance from the Agreement and SENA Colombia.*

whose model is similar to a performance evaluation based on competence standards, should overcome functional dependency on bodies responsible for certification. The Obstetricians Association has an advanced competence certification system model, but internal management problems have hindered its progress.

Lessons learned from periodic certification:

1. Self-regulation as key factor of the periodic certification process.
2. Inter-institutional coordination to make processes and innovations feasible.
3. Systematic and cooperative work to further the improvement of professional exercise.
4. Voluntary certification linked to incentives or obligatory certification but linked to the creation of a quality evaluation culture.
5. Control of processes and social supervision of those involved.
6. Accreditation of effectors of educational alternatives and training programs for updating competences.
7. Inter-institutional and international relationships for process standardization.

3.1.3 Research in Health

Policy 1 includes, in addition to the regulation of health education, research in health. In this sense, the experience of a region is briefly described.

Pasco Region

In the framework of RHUS' Policy 1, the First Workshop on Prioritization of **Health Research Lines and RHUS** was addressed at establishing Health Research Lines to improve quality and the level of regional research and contributing to the development of quality improvement in health services. Those involved were regional representatives and members of the RHUS Regional Technical Team[84].

Criteria were prioritized for research (scope of the problem, institutional importance, feasibility and sustainability, impact, pertinence, vulnerability, cost and relevance[85]) and research lines:

- Effectiveness of analysis methods, treatment and prevention of prevalent infectious diseases
- Evaluation of interventions in diseases of high prevalence, incidence or lethality
- Academic research in prevalent diseases according to life stages
- Research on non-transmissible diseases by life stages
- Local continuous information systems to integrate notification and research systems

Upon conclusion of the workshop, a regional agenda on health research was defined[86], but still pending is the definition of strategies and activities and their approval by the regional government. Likewise, recommendation was made to count with an organized Research and Ethics unit in the DIRESA to head health research, its financing and systematization, and the implementation of the RHUS educational policy.

The Regulation for the operation of the Regional Health Research and Human Resource Committee of the region was prepared. Its purpose is to promote academic levels through scientific and social Research Projects; regulate procedures and guidelines for the acknowledgement of research work; incentive workers' research work acknowledging their initiatives, intellectual productions and monographic works.

This regulation project is found on DIRESA's Webpage on contributions and comments and is being reviewed by the Health Service Networks of the Pasco DIRESA (see the executive proposal in Annex 29).

84 *Made up by representatives of the Regional Government, DIRESA, Health Sciences Faculties (Obstetrics, Nursing and Dentistry) and the Research Institute of the Daniel A. Carrión University, Von Humboldt Higher Technological Institute, EsSALUD, Dentistry, Obstetrics and Nursing Professional Associations and worker representatives.*

85 *Prioritization criteria also take into account social, cultural and educational factors with a comprehensive and multi-skilled approach, research of natural focal points, and study on effectiveness, germ-fighting resistance and evaluation of interventions.*

86 *Document: Workshop for preparation of Health Research Lines in the Pasco Region, 2007.*

3.2 POLICY 2: RHUS STRATEGIC PLANNING

The knowledge of aspects linked to the availability and distribution of RHUS originated as a need for policy 2 on human resource strategic planning with equal rights taking into account demographic, socio-cultural and epidemiological profiles, as well as health needs of the population, especially the most deprived.

To the end of knowing the supply, demand and need of doctors in the country in the near future, the Medical Association of Peru carried out a study called "Current and Prospective Analysis of Supply, Demand and Need of Doctors in Peru 2005 – 2011"

3.2.1 Lack of Proper Regulation in Medical Training

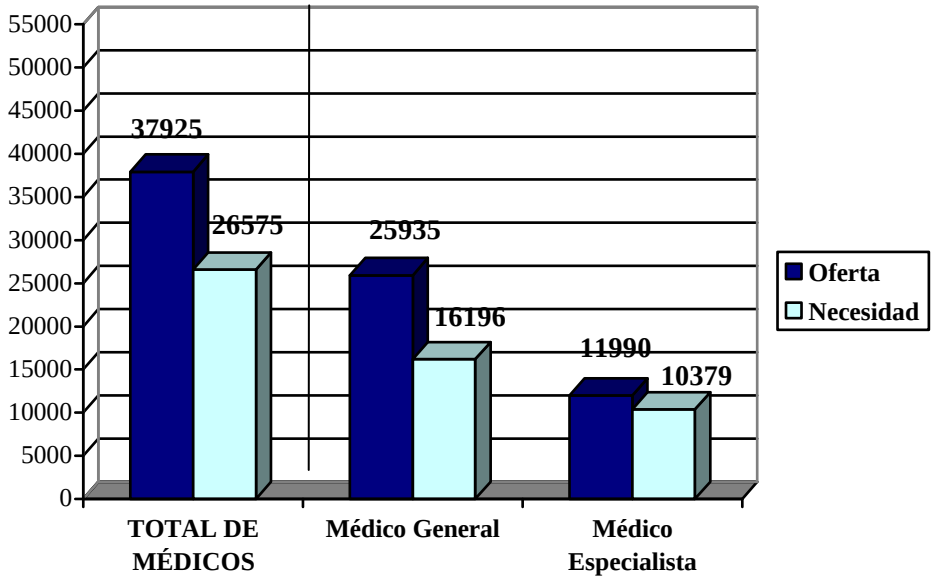
There is a significant increase of medicine graduates (current and projected) mainly in private universities. According to the projection based on the trend of the last few years (2.8% in public universities and 12.7% in private universities) nationwide, we will go from 2,156 graduates in 2005 to 3,218 in 2011. This increase shall happen even though Medical Faculties of public universities (and some private ones) adapted the number of vacancies to the standards established by the Medical Faculties Accreditation Committee and kept them during the accreditation validity period; while most Medical Faculties in private universities increased the number of vacancies after their accreditation.

Vacancies are still increasing due to the opening of some branches of Medical Faculties and the unauthorized operation of others. The little effectiveness of the regulation does not only obey to university autonomy but also to the Law on Investment Promotion in Education (LD No. 882 of November 1996) that in Article 2 establishes: "every natural or legal person has the right to free private initiative for educational activities. It hereby authorized to found, promote, conduct and manage profit and non-profit Private Educational Institutions." Based on this Law, several universities ignore educational regulations and profit from education. The educational quality is doubtful, even though practically all existing medical faculties have been accredited for complying with minimum standards.

3.2.2 Over-supply of Doctors

The current supply of general practitioners (graduated and with a degree) is 25,935, higher than the demand estimated at 16,196 (based on the use of services). There would be an over-supply of 9,739 general practitioners and also of specialists estimated at 1,611 by comparing a supply of 11,990 with a demand of 10,379. This is due to the expansion of health services, especially public, that despite this expansion, it only covers 52% of those who need health care. Diagram 4.

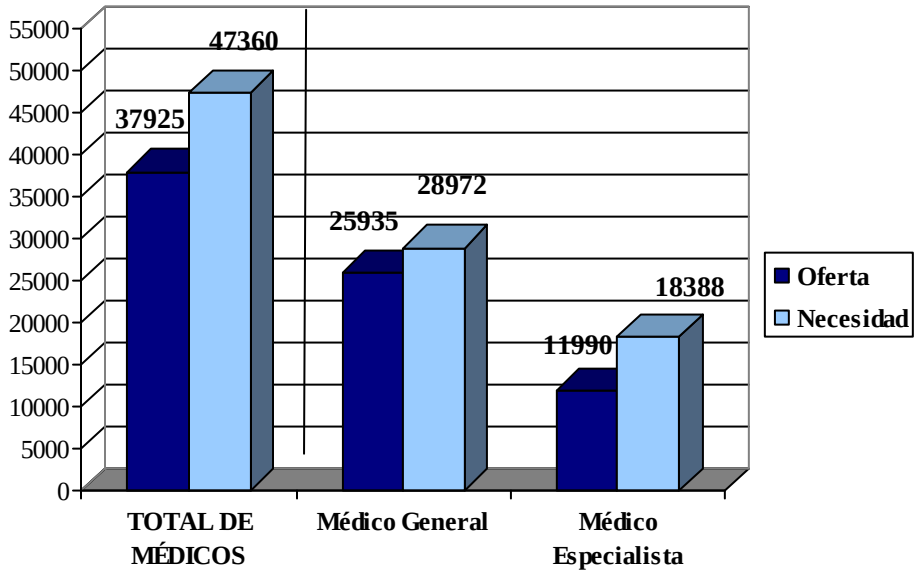
Diagram 4: Supply and Demand of Doctors



TOTAL DE MÉDICOS – TOTAL NUMBER OF DOCTORS
Médico General – General Practitioner
Médico Especialista – Specialist Doctor
Oferta – Supply
Necesidad - Need

If services were expanded to cover 48% of the remaining population that requires them and do not have them, the need for general practitioners would be 28,977. If the supply is for 25,935, there would be a deficit of 3,044. In the case of specialists, such deficit is of 6,398, estimated by comparing the supply of 11,990 with the need for 18,388. Diagram 5.

Diagram 5: Supply and Need for Doctors



(igual que arriba)

Special fields with more deficits are the four basic ones: gynecology and obstetrics, pediatrics, internal medicine and surgery; in addition to orthopedics and traumatology, ophthalmology, cardiology, gastroenterology and psychiatry.

3.2.3 Centralized and Unequal Distribution

The supply of doctors in Lima exceeds both the demand and the estimated and projected need, which shows the centralism of these professionals. Departments with the highest supply deficits of general practitioners in relation to the demand are: Cajamarca, Puno, San Martín, Huanuco and Huancavelica; on the other hand, the highest over-supply is found in Lima, Arequipa and Ica. Regarding specialists, the departments with the highest deficits are: Puno, Cajamarca, Cusco and Ayacucho; while those with an over-supply are Lima, Callao, Arequipa and Lambayeque.

3.2.4 Supply, Demand and Need Trends of Doctors in Various Scenarios

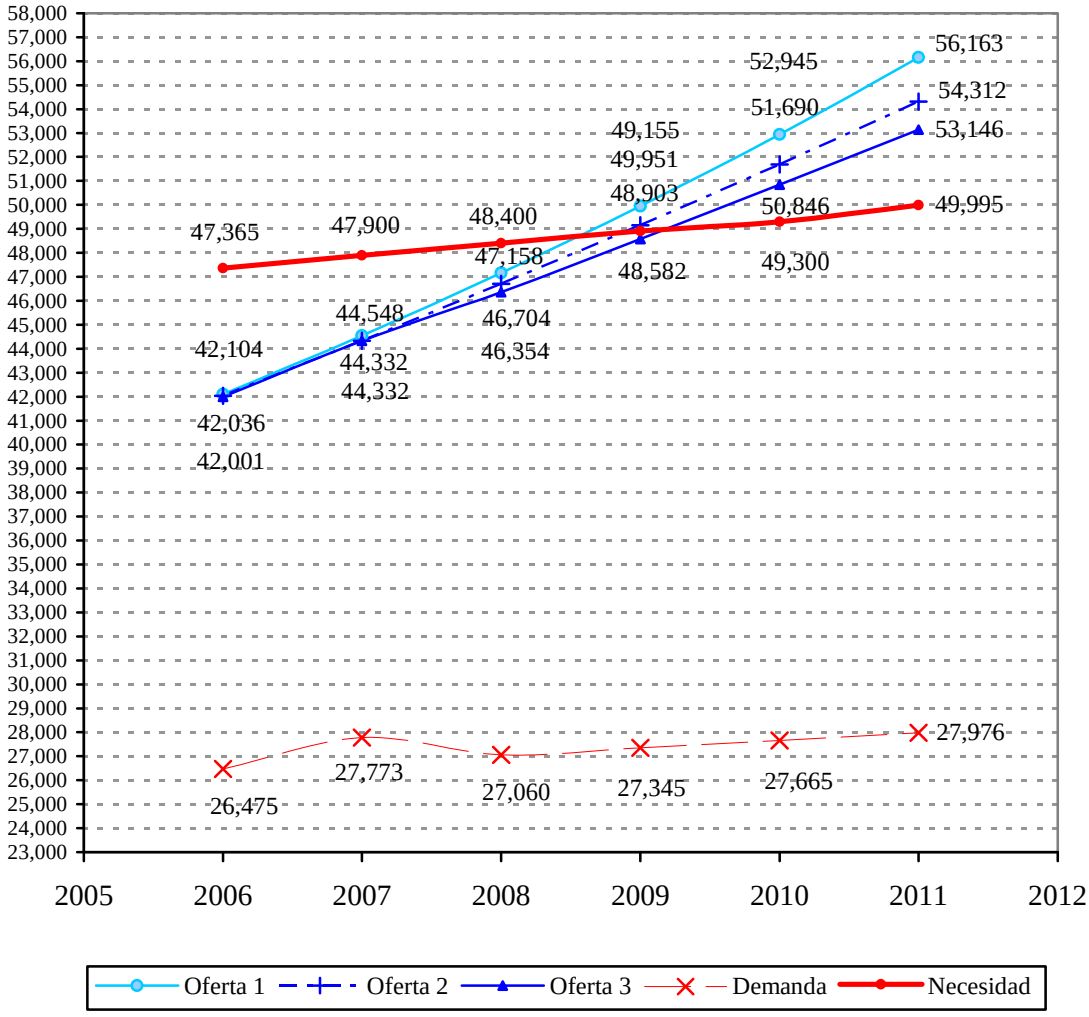
The gap between supply and demand of doctors in the next few years will continue to grow according to the different scenarios:

Scenario 1: The current supply growth trend is kept. The gap between supply and demand in 2011 shall be 28,187.

Scenario 2: Supply is cut down to half: The gap in 2011 shall be 26,336.

Scenario 3: The supply is cut down to one fourth. The gap in 2011 shall be 25,170 (Diagram 6).

Diagram 6: Supply, Demand and Need for Doctors in Three Scenarios



Oferta – Supply Demanda – Demand Necesidad – Need

In all cases, over-supply is high and this is due to the large number of graduates from Medical Faculties of private universities, some recently created. In relation to the number of necessary doctors to attend the entire population, projections indicate this would be covered between 2009 and 2010 (Diagram 6).

3.2.5 Future of professional medical education and exercise is not too encouraging according to Experts' prospective Analyses

According to experts, the future supply of medical studies shall be characterized by the following:

- An over-educational supply in private universities, while public supply remains the same,
- The Peruvian Association of Medical Faculties (ASPEFAM) shall exercise a weak regulation of medical studies. Greater influence shall be exerted by the National

Evaluation, Accreditation and Certification System for Higher Education - SINEACE.

On the other hand, the amount and distribution of doctors in the country shall be characterized by the excessive number of general practitioners and a centralized and unequal distribution (the same distribution for specialists).

Finally, the future labor situation of surgeons shall be characterized by:

- medical under-employment, unemployment and multi-employment in average proportion
- absence of health human resource planning
- average income of doctors in the public sector, way below what they deserve and in the private sector, below average.

3.3 POLICY 4: DEVELOPMENT OF RHUS COMPETENCES

Permanent training and education constitute strategic tools which are supported by good training management and the use of ideal instruments for developing health staff skills to make them effective and efficient. The following is the experience of Competence Development Centers.

3.3.1 Competence Development Centers. Regional bodies for improving competences of health professionals.

During 2002 and 2003, the Project "Improving the Health of Peruvians" carried out training programs in Obstetrics and Neonatal Emergency care, EMOB, for all professionals (doctors, obstetricians and nurses) of micro-networks in the health regions of Huanuco, Ucayali and San Martín. A Training Module was prepared that included management of hemorrhagic and non-hemorrhagic obstetric emergencies; immediate care and neonatal resuscitation, in addition to sexual and reproductive rights, gender-based violence and health care quality.

Post-training supervisions in Huanuco and Ucayali revealed that even though the trainees had trained their micro-network colleagues and had made progress in the guidelines for first care level, there were still issues that needed to be solved, among which were:

- High rotation of trained staff
- Little use of the active management of childbirth as a strategy for preventing post-partum hemorrhages, key training issue
- No use of FON and SIP 2000 as information instruments
- Absence of a Local Health Committee and regulations for patient referral.

The need to coach micro-networks in EMOB initial care up to their referral to hospitals was identified.

At the beginning of 2004, MINSA, in answer to the proposal of the Health Sector Reform Support Program, PARSALUD, designated the following hospitals as internship teaching places in EMOB: Maternidad de Lima (Lima Maternity Hospital), San Bartolomé, Ayacucho Regional Hospital and Maternal Perinatal Center in Tarapoto. However, it lacked instruments to evaluate the teaching quality at such places and insisted on training micro-network staff at Hospitals in Lima (due to the larger resolving capacity of these in face of hospitals in the regions), which was quite costly.

Based on the Regulation that establishes the functions of the Human Resource Management Offices[87], and based on the findings of supervisions, the Project proposed the creation of Competence Development Centers, CDC, to train professionals of micro-networks using a competence approach.

3.3.1.1 Strategy Phases at Competence Development Centers, CDC

1. **Cooperative Agreement Proposal on Competence Development Centers. March 2004**

   One of the purposes of the Competence Development Centers, CDC, was to develop skills of regional officials, especially of the Human Resource Executive Office to manage training processes by training tutors in hospitals of each region. The idea was to train micro-network staff in comprehensive care of the main mother child health problems to reduce maternal perinatal morbi-mortality.

   The CDC includes two instances:

   - **Regional CDC**: ruling instance for training management (planning, execution and evaluation of competence improvement processes of health professionals) within the Human Resource Management and Development Office of DIRESA. Headed by a Committee[88].

   - **Hospital CDC**: regional and/or support hospitals, training places selected for complying with minimum quality standards and other requirements[89] .

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87 *Supreme Decree No. 023-2005-SA*

88 *The Committee in charge of the Regional CDC is made up by the Head of the Executive HR Management Office headed by DIRESA. A representative of the People's Health Directorate, the DIRESA Training Coordinator, the DIRESA Quality Coordinator, the DIRESA Community Participation Coordinator, Director(s) of hospital(s) in the Region, a representative from the Network Managers, and a representative from the Training Offices of Facilities -CDC.*

89 *a. Comply with standards and indicators of a "CDC Facility".*
b. Encourage development of Continuous Quality Improvement processes in facilities in the region.
c. Manage and dispose of resources for developing planned activities.
d. Update syllabus and protocols.
e. Include permanent health education methodology.
f. Select tutors
g. Develop updating programs for tutors including internships in the IMP.
h. Train staff of networks and micro-networks according to a regional Training Program.
i. Organize together with the regional CDC, activities for follow up, monitoring and evaluation of trained staff at each facility.

The CDCs strategy was presented at a multi-sector and mult-regional meeting in May 2004 within the framework of the ***Healthy and Safe Maternity Week*** with the subscription of ***Commitment Documents*** to be executed by participating institutions[90].

In July 2004, the CDC strategy was reviewed at two ***Technical Meetings***[91]. The preliminary version of the "***Guideline for the evaluation of standards and indicators at CDC Facilities"*** was prepared for service training of EMOB as well as a plan for the implementation of CDC facilities, to ensure training quality.

In August 2004, a new version of the Evaluation Guideline was ordered and CDC Committees of Health Directorates in Huanuco, San Martín, Ucayali, Junín, Pasco, Ayacucho and Cusco were created.

2. Creation of Regional CDCs

In 2005, Regional Technical Committees of CDCs at DIRESAs were created in 6 regions according to the following Director's Orders (RD):

- Junín: RD No. 028-2005 DRSJ/OP of January 17, 2005
- Huanuco: RD No. 027-2005-GR-HCO/DRS-DG-DEA-OP of January 24, 2005
- Ucayali: RD No. 024-05-GRU-DRSU-OA of January 26, 2005
- Pasco: RD No.033-2005 DG-DIRESA GR PASCO of March 16, 2005
- Cusco: RD No.0336-2005 DRSC-DEGORH of April 21, 2005
- San Martín: RD-DG-DIRESA-SM/01/10/2005

[90] *General People's Health Directorate of the Ministry of Health, Regional Governments: Huanuco, San Martín, Ucayali, Junín, Pasco, Ayacucho and Cusco, Health Directorates of the Regions: Huanuco, San Martín, Ucayali, Junín, Pasco, Ayacucho and Cusco, Specialized Maternal Perinatal Institute and Pathfinder International*

[91] *12 institutions took part: Regional Government of Ayacucho, Ayacucho Health Directorate, Regional Hospital of Ayacucho, Femme Perú – Car, Regional Government of San Martín, San Martín Health Directorate, Tarapoto Maternal Perinatal Center, Ministry of Health: Comprehensive Reproductive Health Care Directorate, Ministry of Health: Family Care Directorate, Human Resource Development Institute, Specialized Maternal Perinatal Institute, Catalyst Consortium - Pathfinder International*

These Committees were made up by staff from DIRESAS and hospitals[92] and were in charge of rating hospitals as CDC-Hospitals. During the first semester of the same year, 7 Regional Competence Development Centers were opened in the 7 regions [93] through the designation of physical areas in DIRESA facilities, to which the project donated audiovisual equipment, mannequins, instruments and furniture. Rating and evaluation of Regional CDCs was made jointly with the IDREH.

CDCs strengthened DIRESA's managing function in training their professionals by improving their relationship with the facilities. Later on, when the facilities were categorized as hospital- CDC or CDC-MN, they showed they counted with ideal professionals to improve competences in their colleagues in their own regions.

3. Technical assistance for evaluating CDC - Hospitals

A technical team[94] evaluated 12 hospitals (see Diagram 7) with the purpose of verifying if they could become CDC - Hospitals. The evaluation was made by applying the five-component Evaluation Guide: Resource management and availability, standardized Management, Competences acquired by interns, permanent education in health, and use of data.

4. First evaluation of CDC - Hospitals

Of the 12 hospitals evaluated, none achieved the minimum score needed to qualify (80%). Diagram 7. Only the Ayacucho Regional Hospital and the Tarapoto Maternal Perinatal Center, that had already been teaching centers, managed to comply with 70% of standards.

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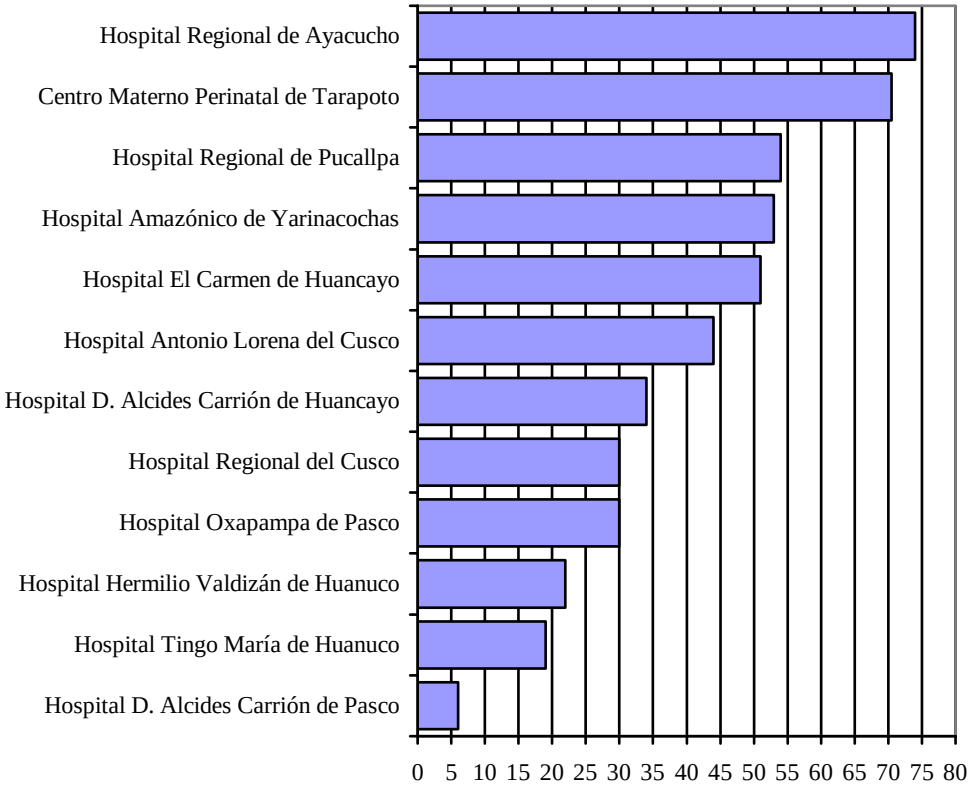
92 *Regional Technical Committees of the CDCs are made up by the Director of the DISA Human Resource Management and Development Office, the DISA Quality Director, Director of the DISA Health Promotion, DIRESA's Training and Women Area Officials, Director of the CDC Facility, Heads of the Gynecology-Obstetrics and Pediatrics or Neonatology Departments of CDC Facility, Training and Quality Official of the CD Facility"*

93 *Opened in San Martín, Junín and Ucayali in February 2005, in Huanuco in April, and in Cusco, Ayacucho and Pasco, in May.*

94 *The Technical Evaluation Team of the DCD-Hospital was made up by MINSA (Comprehensive Reproductive Health Care Directorate, Family Care Directorate, and Human Resource Development Institute), the Specialized Maternal Perinatal Institute, Pathfinder International and the Competence Development Center Committee of the Health Directorate in each region.*

Diagram 7: Score obtained by the 12 facilities CDC in the first evaluation



At the beginning of 2005, a Technical Committee counseled by the Project helped improved standards at the evaluated hospitals that did not qualify as CDC - Hospitals. Guidelines were prepared for EMOB care, maternal perinatal indicators were updated, tutors were trained and training programs were prepared.

5. Second evaluation of CDC - Hospitals

In 2005, 10 hospitals out of the 12 evaluated were qualified by DIRESA, with technical assistance from the Project, as CDC – Hospitals through the self-evaluation of standards. The process was conducted by staff from the same facilities, grouped into CDC-Hospital Technical Committees. Results showed that these facilities had optimum academic and administrative evidences for training. Facilities that were rated were:

- Tarapoto Maternal Perinatal Center
- Pucallpa Regional Hospital
- Yarinacochas Amazon Hospital
- Huancayo El Carmen Hospital
- Cusco Antonio Lorena Hospital
- Huanuco Hermilio Valdizán Hospital
- Tingo María Support Hospital

- Oxapampa Support Hospital
- Ayacucho Regional Hospital
- Huancayo Carrión Hospital

3.3.1.2 Training of Tutors for CDCs and health service Suppliers in EMOB

In the second semester 2005, the IDREH and other organizations[95] systematized the CDC - Hospital experience by preparing the document ***"Methodology and Instruments for Rating Regional Teaching Centers for Training under the modality of Obstetrics and Neonatal Emergency Internships"***, validated in Huancavelica and Andahuaylas. This methodology was used to prepare other instruments for Rating Regional Teaching Centers for Training for internships in Clinical Laboratory and Blood Bank. The name was changed from CDC Hospital to Teaching Centers for Training.

In 2006, the IDREH, with technical support from the Project, prepared the ***"Methodological Guideline for Evaluating competences in care of pregnant women and newborns"*** used to evaluate interns.

During the project, 96 tutors from 6 regions (Ayacucho did not take part in this training program) were trained at the Maternal Perinatal Institute of Lima. Likewise, training on EMOB care was carried out in regional hospitals for a total of 1,163 health service suppliers through workshops organized directly by the Project or through duplications carried out by professional previously trained by the Project. Their distribution by region and special field of expertise is shown on Table 13.

Table 13: Professionals trained in EMOB care. 2003–2006

Trained Professionals		TOTAL	Ayacu-cho	Cusco	Hua-nuco	Junín	Pasco	San Martín	Ucayali
Tutors trained at the National Maternal Perinatal Institute of Lima:									
TOTAL		96	0	19	18	8	8	22	21
Doctors		35	0	6	6	2	3	7	11
Obstetricians		35	0	8	8	3	3	8	5
Nurses		26	0	5	4	3	2	7	5
Suppliers trained at workshops carried out by Pathfinder and through duplications:									
TOTAL	Total	1,163	30	118	647	20	82	74	192
	At workshops	433	30	60	177	20	16	39	91
	through duplications	730	0	58	470	0	66	35	101
Doctors	Total	185	0	18	82	3	12	20	50

[95] *MINSA's National Sexual and Reproductive Health Strategy, National Maternal Perinatal Institute, San Bartolomé Maternal Infant Teaching Hospital, PARSalud, and Pathfinder International*

	At workshops	98	0	10	29	3	5	17	34
	through duplications	87	0	8	53	0	7	3	16
Obstetricians	Total	316	0	25	187	6	16	20	62
	At workshops	149	0	10	79	6	5	15	34
	through duplications	167	0	15	108	0	11	5	28
Nurses	Total	262	0	20	155	11	19	10	47
	At workshops	126	0	10	69	11	6	7	23
	through duplications	136	0	10	86	0	13	3	24
Technicians	Total	391	30	55	215	0	35	24	32
	At workshops	60	30	30	0	0	0	0	0
	through duplications	331	0	25	215	0	35	24	32
Others	Total	9	0	0	8	0	0	0	1
	through duplications	9	0	0	8	0	0	0	1

Micro-network staff was also trained at CDC - Hospitals through 39 internships in 6 regions. As can be seen in Table 14, there were 177 trained persons, mostly nurses. The most active CDC - Hospital was the Carrión Hospital in Junín with a total of 14 internships and 70 trained persons.

Table 14. Number of micro-network internships and interns

Region	Internships	Interns			
		Total	Doctors	Nurses	Obstetricians
TOTAL	**39**	**177**	**48**	**74**	**55**
San Martín	8	33	11	12	10
Ucayali	6	27	9	9	9
Huanuco	6	25	5	10	10
Junín	14	70	16	32	22
Pasco	1	2	1	1	0
Cusco	4	20	6	10	4

In 2006, the IDREH carried out a rating of the same 12 hospitals that had previously been evaluated by the Project (Diagram 7). As a result, there are currently four CDC - Hospitals qualified by the Institute as Teaching Centers for Internships in Obstetric and Neonatal Emergencies. The rest are in an on-going improvement process of their standards and administrative procedures for a new evaluation. Table 15.

Table 15: Situation of Hospitals evaluated by the IDREH to qualify as CDC upon conclusion of the Cooperative Agreement

Region	Hospital	Rating by the IDREH
Ucayali	Pucallpa Regional Hospital	On-going
	Yarinacocha Amazon Hospital	On-going
Junín	**Carrión Hospital**	**Qualified**
	El Carmen Hospital	On-going
San Martín	**Tarapoto Maternal Perinatal Center**	**Qualified**
Huanuco	**Hermilio Valdizán Hospital**	**Qualified**
	Tingo María Hospital	On-going
Cusco	Regional Hospital	On-going
	Antonio Lorena Hospital	**Qualified**
Pasco	Carrión Hospital	On-going
	Oxapampa Hospital	On-going
Ayacucho	**Regional Hospital**	**Qualified**

3.3.1.3 Competence Development Center in Micro-networks – CDC-MN- as a local strategy

The successful strategy of Competence Development Centers -CDC – Hospitals, at a regional level, was also implemented as a pilot experience in micro-networks through Competence Development Centers in Micro-networks (CDC-MN) to improve access to training of staff that works at health posts in Huanuco, Cusco, Junín and Pasco.

3.3.1.3.a Access to training at micro-networks

The problem of access to health training at a local level can be summarized in three aspects: local training needs, demand and supply.

Training needs: maternal-neonatal-infant morbi-mortality and chronic infant malnutrition are regional and local sanitary priorities in micro-networks that have determined the pilot CDC-MN training program topics[96].

Huanuco: At the Margos Micro-network, childbirth care was key to re-direct the primary obstetric-neonatal services at levels I-1 and I-2 (FONP) facilities and basic facilities (FONB) and training needs. Between2002 and 2006, there was an increase in institutional childbirth deliveries at all health post in the micro-network at an average of 186% (from 97 to 278 childbirth deliveries). The increase was greater at the Margos Health Center, but figures only cover 54% of the total expected childbirths. The ratio, (46%), of home childbirth deliveries is still high[97]. Infant chronic malnutrition is also high (56%) compared to that of the region (42.8%) and the country's (25.4%)[98].

There is a paradox; on one hand, a large proportion of childbirth deliveries occur at homes, which brings difficulties in the childbirth delivery community reference. On the other, there is an increase of childbirth deliveries at health posts that do not ensure basic obstetric and neonatal functions, therefore, pregnant women and newborns could be at risk if complications should arise.

Facilities type I-1 and I-2 are more in contact with communities and attend approximately 75% of the demand, especially in scattered and rural towns. This service demand in turn generates a need for effective training hours for health staff and community agents of these facilities, which expand and promote coverage of these health facilities.

At the Margos (rural) and Amarilis (peri-urban) micro-networks in Huanuco, the training demand of community agents is ten times greater than that of health staff. The

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96 *Huanuco PRCS, Pasco PRCS, Junín PRSC, Cusco PRCS*

97 *Source: Indicators RMMN-SIS DIRESA Huanuco*

98 *ENDES 2000*

situation is more critical in rural areas due to scattered location, less population density and larger number of towns. As can be seen in Table 16, in the two micro-networks, if you include all staff of health facilities I-1 and I-2, the number of municipal agents to be trained is 1,245 versus 65 health service suppliers.

Table 16: Estimated training demand at the Margos and Amarilis Micro-networks

TRAINEES	MARGOS MN	AMARILIS MN
Total	980	440
Health Staff : Technicians	12	21
Health Staff: Professional	18	14
Municipal Authorities (deciders)	25	20
Community agents: 55 per town	895	350

According to the INEI (2005) the Margos Micro-network has179 towns and the Amarilis Micro-network, 70

The training supply is critical in the rural and semi-urban area. Health staff at health posts type I-1 and I-2 do not have access to training programs that ensure minimum maternal infant care quality, clinical-preventive and health promotion standards. The average training hours for technical staff in the last year was 10 hours, a meager number if compared to the standard recommended by the Medical Association of Peru, which is 48 hours.[99]

To make up for this deficiency and taking into account the importance of facilities I-1 and I-2[100], the strategy Competence Development Centers – Micro-network was implemented. A CDC-MN is a health facility in a micro-network that complies with specific standards and indicators to train and generate competences (particularly in maternal-infant health) in professionals, technicians, municipal managers and community leaders to ensure quality health care.

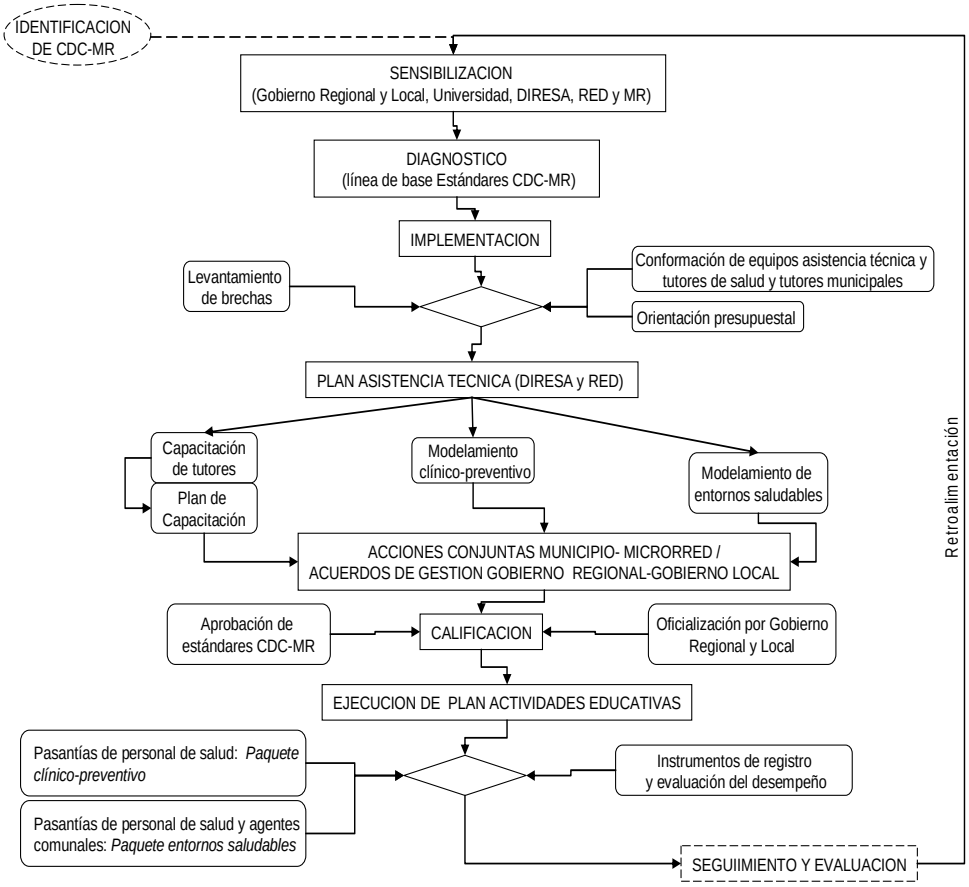
[99] www.cmp.org.pe *Professional re-certification process.*

[100] *According to MINSA (EE.SS database., 2005), health posts type I-1 and I-2, represent 87% of all facilities at the Margos Micro-network and 95% of the Amarilis MN; while facilities I-1, under the charge of technicians are 50% and 38%, respectively.*

3.3.1.3.b The Management Process of CDC-MN

The outline indicates the route for the successful implementation of a CDC-MN, which includes activities shown in diagram 8.

Diagram 8: Route for the implementation of Competence Development Centers in Micro-networks, CDC-MN



b.1) Preparation of the proposal for the Competence Development Center CDC-MN

The same methodology for the preparation of standards and indicators for rating of CDC-Hospitals developed by the IDREH was used, but clinical training at the CDC-MN emphasizes comprehensive maternal infant care training with a preventive approach adapted at a local level[101].

[101] - *Evidence 01. Methodology and Instruments for Rating of Training Teaching Places at Health MN*

- *Evidence 02. "Standards and Indicators for Rating CDC- MICRO-NETWORK, as Competence Development Centers in Maternal Perinatal and Infant Care Quality."*

The following was prepared: a) a record sheet "Standard and Indicators for Rating CDC-MICRO-NETWORK, as Competence Development Centers for Maternal Perinatal and Infant Care Quality" made up by 4 elements[102], 8 standards and 40 indicators, b) a package of instruments to know the learning-teaching capacity (designed instruments) and care quality in the micro-network (gathered instruments), c) checklists to evaluate tutorial skills of tutors (model classes and in-service training), and their performance in comprehensive care of pregnant women, newborns, children and health promotion.

Quality management instruments were used to evaluate care quality at the micro-network: analysis sheet of FONB resolving capacity, quality standards for FONB, FONP, FIP facilities; performance evaluation checklists per work competence in pregnant women and newborns, technical maternal infant care guidelines and promotion guidelines for healthy surroundings.

CDC-MN standards were validated by experts from the DG-PROMSA, IDREH, DIRESAS, Hospitals and Micro-networks from Ayacucho, Junín, Cusco, San Martín and Huanuco, who validated a series of performance evidence proposed in the model. In addition, the CDC-MN was included as a third component of the CDC- Management (DIRESA and Network) and CDC-Hospital platform so policies on competence development would reach the local level. Validation was comprehensive, which enabled the adjustment of standards, indicators, verification items and other tools.[103]

Table 17: Criteria for identifying a CDC-MN

✓ Health Center (category (I-3/ I-4) micro-network reference nucleus
✓ Compliance of basic obstetric and neonatal functions
✓ Located 2 hours away from a FONE facility
✓ Availability of trained professional staff 24 hours a day
✓ Micro-network with 7 or more health posts
✓ Population of the jurisdiction: approximately 10,000 inhabitants
✓ Potential demand above 300 annual childbirth deliveries
✓ Greater or equal to 75 daily average care services
✓ District Municipality with jurisdiction on the majority of Health Post in the micro-network
✓ Communities with average health interventions

Based on criteria shown on Table 17 to determine micro-networks as CDC-MN, 6 micro-networks were selected for pilot interventions: Margos MN and

[102] *Components of the record sheet are: resource management and availability, permanent health education (EPS), standardized clinical – preventive management and actions with the community*

[103] *Evidence 03. Document on Experts Meeting CDC-MR- IDREH Meeting 04-18-07*

Amarilis MN (Huanuco), Pichanaki MN (Junín), Villa Rica MN (Pasco), Urubamba MN and Santo Tomás MN (Cusco).

b.2) Implementation of the proposal "Competence Development Center CDC-MN"

There were three stages in the implementation: institutional arrangements, identification and closing of gap based on standards and rating of the CDC-Micro-network:

Institutional Arrangements. In order to implement the proposal, it was necessary to reach political and institutional agreements at a regional (Regional Government, DIRESA and Network) and local (district Municipality, Network, Micro-network and University) level to ensure resource availability[104]. The Technical Quality and Human Resource Team of the Network was key as a local operator as well as the team of tutors from the health center (health tutors) and from the district municipality (municipal tutors).

Analysis of Facilities for CDC-MN. Each pilot CDC-MN was evaluated by applying[105] the record sheet "Standards and Indicators for Rating CDC-MICRO-NETWORK, as a CDC in Maternal Perinatal and Infant Care Quality". Participative techniques (DIRESAS, District Municipality and technical team) were used for evaluating and verifying information sources[106].

The evaluation helped identify gaps in standards, which were later closed through different activities:

- Training in teaching-learning-evaluating techniques for health and municipal tutors, including skills for model classes, functional map design and validation of work competence regulation for managing training at facilities I-1 and I-2[107]
- Clinical-preventive training of health tutors through the standardized management of cases as well as the use of clinical practice guidelines for EMOB and infant emergency care[108].
- Strengthening of model healthy surroundings (successful housing-classroom-community neighbor association) focused in homes with

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104 *Evidence 04. Document on Institutional Arrangements-Level DIRESA-RED – List of Participants*

105 *The analysis was similar in Margos, Villa Rica and Pichanaki. In Amarilis, capacities were transferred to DIRESA and to the Huanuco Network for managing the process. In the Cusco region, only the analysis phase was reached.*

106 *Evidence 60, 07, and 08: Analysis of Development Capacity of Educational Activities of Micro-networks Margos, Villa Rica and Pichanaki, respectively.*

107 *Evidence 10. Training Material for Tutors-Model Class Videos-Certificate. Tutor evaluation sheets. Functional Map. Checklists*

108 *Evidence 11. Tutor training lists CDC-MN*

pregnant women and children under 3, educational institutions and neighbor associations[109].

- Preparation of a "Training program in basic care and emergency in pregnant women, newborns and children (technical level)" for organizing educational activities in the CDC-MN.
- Organization and rating of the CDC-MN through Agreements[110] between the Municipality and the Micro-network.[111]

The intervention did not succeed in making a work performance baseline of staff at Facilities I-1 and I-2, but it ensured the availability of instruments for future evaluations[112].

Rating of CDC –MN: Rating of CDC-MN was operative and technical-regulatory. An evaluating team made up by DIRESA–Network facilitators and university teaching advisors[113], rated the CDC-MN and issued a regulatory technical report. The CDC-Margos (with sanitary influence in the districts of Yacus, Chaulan), was approved by the Social Development Management of the Huanuco Region.

[109] *Evidence 12. Performance evidence record sheets of healthy surroundings model. Technical guidelines of schools, families-housing and healthy communities implemented in the service were used as well as technical record sheets for follow up of interventions*

[110] *Evidence 09. Agreements Document between the CDC-MN and the Municipality. In the Huanuco Region, the implementation of the CDC-MN Amarilis was considered in the Management Agreement between the Regional Government and the Municipalities of Amarilis and Cayran. The Subscription of these Agreements has been extended to the district of Margos*

[111] *Evidence 14. CDC-MN Rating Report. Technical reports from the Network and DIRESA*

[112] *Evidence 13. Training program for basic care and emergencies in pregnant women, newborns and children (technical level) CDC-MN Margos*

[113] *Evidence.15. Functions of University Teaching Advisors. Agreement between the Hermilio Valdizán University and the Social Development Management for Teaching Assistance at Competence Development Centers CDC-MN.*

b.3) Execution of educational activities in the "Competence Development Center CDC-MN"

Educational activities prioritized quarterly training[114] programs for micro-network health technicians, offering two packages:

- Clinical-preventive training (six days long)
- Training on healthy surroundings (six days long)

Of all pilot CDC-MN, only Margos executed active teaching-learning activities, the execution of "Training Programs" is pending in the others.

Results obtained. 04 Competence Development Centers, CDC-MN, implemented and acknowledged (02 operative) by the Social Development Management, with 96 training hours in the clinical-preventive package (on pregnant women, newborns, children) and in family-housing-community promotion. The development of both is variable; for example, the clinical-preventive package was predominant in Margos, while in Villa Rica and Pichanaki it was the Healthy Surroundings Promotion. Table 18.

Table 18: Competence Development Centers CDC-MN

COMPETENCE DEVELOPMENT CENTERS –MN	Number
CDC-MN Evaluated	04
• Operative CDC-MN *(Margos Health Center and Carlos Showing Health Center, Amarilis, Huanuco)*	02
• CDC- in analysis phase (Villarrica Health Center in Pasco and Pichanaki Health Center in Junín)	02

- Trained health professionals and municipal officers (see Table 19) and organized in teams for developing activities in teaching-learning, implementation, follow up and evaluation of training programs in the CDC-MN).

Table 19: Training carried out in the CDC-MN

COMPETENCE DEVELOPMENT CENTERS –MN	Number
Certified health tutors	30
Approved health tutors	28
Approved municipal tutors	24
Technicians programmed for training to Dec. 2007	96

[114] *Evidence 16. Educational Activities Program CDC-MR September 2007-08-23*

- Joint municipal-micro-network actions for promoting healthy practices in mothers and children and developing educational activities with community agents in the Margos, Villa Rica and Pichanaki CDC-MN. At the Amarilis CDC-MN, these actions are part of the Management Agreement between the Regional and Local Governments.

- Investment of SIS resources from the Margos Micro-network to finance training: mobilization and food for staff and community agents, educational materials and supplies for training, among others.

3.4 POLICY 6: NEW LABOR REGULATORY FRAMEWORK

The new comprehensive labor regulatory framework should consider hiring based on occupational profiles by competences. Policy 6 points towards this basic RHUS regulation aspect. The following has been carried out:

3.4.1 Identification of Work Competences for Care Level I: Categories I-1 and I-2. Competence Profiles

Technical teams were established in each region headed by RHUS Management Teams of DIRESA, made up by representatives of service delivery entities, educational entities (universities and higher education institutes), professional associations and other institutions.

Upon conclusion of the Project, there will be a minimum competence profile proposal for Care Level I, Category I-2 and working profiles by competences for health workers at facilities Category I-2: Doctor, Nurse, Obstetrician and Nursing Technician. (See Annex 30: work competence profiles in Huanuco).

3.4.2 Regulation of Competences, for Care Level I, Categories I-1 and I-2

Technical teams in Huánuco, Junín and Pasco designed the Work Competence Regulations, NCL, which were discussed and approved at macro-regional workshops to obtain a final NCL version of prioritized competence units for pregnant women and children areas and training management. (See Annex 31, NCLs).

3.4.3 Evaluation of Performance by Competences for Care Level I, Categories I-1 and I-2

Following the same methodology of internal workshops and technical meetings, evaluation instruments were prepared (15 checklists and 10 questionnaires) of competences for final NCL in the areas: pregnant women, children and management. The instruments are being applied and validated by technical teams in the following selected micro-networks:

Amarilis, in Huánuco; Villa Rica Network, in Pasco, and Pichanaki in Junín. (See Annex 31, evaluation instruments).

3.4.4 In the Regions.

- **Pasco.** DIRESA's **Work Competence Regulatory Committee**[115] was established to conduct the implementation of Work Competence Regulations in the region. The DIRESA Human Resource Committee prepared the **Induction Guideline** (approved by the Committee and currently posted on DIRESA's Webpage) for the health worker (appointed, under contract, SERUMS, Resident). Its purpose is to establish an effective and efficient institutional dynamics with the commitment of all workers. It also prepared a proposal for a **Selection and hiring guideline** (currently posted on DIRESA's Webpage) of the health worker that standardizes mechanisms and criteria and speeds up procedures to recruit, select and hire health workers based on competences[116]. This proposal does not include progress made in the Occupational Profiles and Work Competence Regulations currently being prepared[117].

- **Huanuco.** An incentives proposal has been designed through the Human Resource Thematic Committee.

3.5 POLICY 7: IMPROVEMENT OF WORKING CONDITIONS, MOTIVATION AND COMMITMENT

The purpose of Policy Guideline No. 7 for Development of Health Human Resources is to: *"improve working conditions, motivation and commitment of the worker to contribute to a renewed organizational culture and make feasible the delivery of quality services"*. The Project prioritized the regions of Pasco, Junín and Huanuco to implement this guideline because it counts with a Coordinated Regional Health Plan and with Regional Health Human Resource Policies approved by the Regional government.

Policy 7 includes 2 strategies: a) promote the development of incentive and motivation mechanisms based on performance for staff in the different sub-sectors, and b) incorporation of staff's well-being service as part of the comprehensive human resource development management. The following gives detail of the intervention in the three regions.

3.5.1 Pasco Region

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115 *The NCL Committee was approved by the Regional Government on September 12th, 2007 through Regional Executive Order No. 0640-2007-GR Pasco/Pres. It is made up by representatives of the Regional Government's Social Development Management, DIRESA, DIRESA's HR Management and Development Executive Office, health education institutions, Professional Associations, health workers' representatives and Nursing Technicians, among others.*

116 *This Guideline is applied to appointed workers and workers under contract under Legislative Decrees DL 276, DL 728, respectively, and also to staff under service providing contracts of the Pasco DIRESA, in compliance with the effective regulation.*

117 *Report of the Macro-regional workshop "Towards the Evaluation and Certification of Health Work Competences", carried out on September 5th, 6th and 7th, 2007.*

The Villa Rica micro-network was chosen as the initial intervention place. Even though they had a management team, their members had multiple functions, which weakened their organization. Their priorities were sanitary ones and had limited RHUS development.

The Local Development Office in the district, which was in charge of implementing the effective regulation, was unaware of the existence of the Coordinated Regional Health Plan 2005-2015 and of regional policies in Human Resources. The local Government and the MN worked together in promoting healthy surroundings, but not in the area of incentives and motivation of health workers. On the other hand, DIRESA's, network's and MN's management teams lacked coordinated actions for motivating and providing incentive to the health worker. Finally, the community did not know about regional and local regulations on motivation and incentives of health human resources. Added to this was the existence of weak local coordination spaces.

It is in this framework that Regional Policy 7 on health workers' motivation and incentives (non-monetary) was implemented in the Villa Rica district (Pasco Region) in September 2006. To September 2007, progress made has been remarkable.

Implementation Activities

1. Information and training

At DIRESA, *the Human Resource Committee was created*[118] that, together with a representative from the local government and the organized community, was in charge of the implementation of RHUS Policies. The Villa Rica MN was selected and prioritized by Director's Order[119] and support was sought from the Oxapampa Network Management Team, to which Villa Rica belongs. A "*NETWORK Human Resource Committee"*, created by Headship Order [120] , was sensitized in RHUS management, mainly in the incentives policy.

In the local government, sensitization was aimed at the mayor and councilpersons who were unaware that public health management includes RHUS management and that this should be implemented by the local government.

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118 *The RHUS Committee of the Pasco DIRESA was approved by Director's Order No. 065-2006-DG/CR*

119 *Director's Order No. 040-2007-DG. "Designation of the initial intervention place for the implementation of Health Human Resource Policies".*

120 *Departmental Order No. 010-DE/HRVE-2006 "Conformation of the Management Team of the Villa Rica MN Departmental Order No. 007-DE/HRVE-2007 "Re-structuring of the Management Team of the Villa Rica MN".*

Table 20: Number of Trained People in the Pasco Region

INSTANCE	TRAINED	NUMBER OF TRAINED PERSONS	
		Pasco	Junín
TOTAL		**82**	**63**
REGIONAL GOVERNMENT	Regional Development Manager Regional Health Board Regional Human Resource Committee	01 08	
DIRESA	Management Team Human Resource Committee	08	07
	Human Resource Office	03	03
OXAPAMPA NETWORK	Human Resource Committee	22	08
VILLA RICA MN	Management Team	08	16*
LOCAL GOVERNMENT	Councilpersons Board	06	06
	In charge of the Local Development Office	01	01
COMMUNITY		25	23

** trained, 6 members of the San Luis de Shuaro MN management team and 10 from the Pichanaki MN*

In order to know the situation of health human resources in the district, a participative analysis was carried out, which is detailed in the following section. The organized community was key in citizen surveillance actions of local RHUS policies. During this phase, 82 key actors were trained in the Pasco Region and 63 in Junín. (See Table 20).

2. Local Participative Analysis of RHUS Management

The analysis was jointly prepared by health staff, local government, community and the organized civil society[121] to find out about the situation of RHUS management, its main problems, strengths and weaknesses, existing resources and opportunities for problem solving. Results are the ones shown on Table 21.

Table 21. Results of participative analysis

Problems identified: • Lack of a local labor incentives program at an inter-sector level • Lack of acknowledgement for work carried out • Lack of motivation for achievement of goals • Low pay. No incentives for workers with good working performance. • Staff clock-off work at the exact going out time • Staff not identified with their work • Lack of motivation meetings and fraternization at work • Little interest on the part of health facility in workers' problems, on family and social well-being issues. • Lack of incentives for working health staff • No incentives for most hard-working people
Two prioritized problems: 1. Inexistence of an institutional proposal/local annual plan/program of incentives for the appointed worker or worker under contract. 2. Little interest on the part of the health facility in workers' problems on family and social well-

[121] *Participants in the analysis were: representatives from the Villa Rica MN, Oxapampa Network, DIRESA, health posts and centers of the MN jurisdiction, local government, community and neighbor associations, community agents, Von Humboldt Higher Technological Institute, National Police, Committees of people displaced by Political Violence, among others*

being issues.
Problem Causes: • Inadequate communication • Work overload due to small number of staff • No true value is given to workers as human beings (they are just another resource) • Deficient inter-personal relationships • Health staff with multiple functions
Prioritized Activities: 1. Institutionalization of a non-monetary incentives proposal[122] with the involvement of the organized community and local government in designing such, where the local government and the MN assume shared management responsibility. 2. Preparation of an institutional Social Well-being proposal with the involvement of DIRESA, Network and MN, whose responsibility would befall on the MN and the Oxapampa Network.
Responsibilities of prioritized activities: 1. Health incentives Policy: Local Government's responsibility 2. Health worker Social Well-being Policy: Oxapampa Network and Villa Rica MN's responsibility

The analysis allowed reaching agreements and commitments and defining the role of each actor in the institutionalization of a non-monetary incentives policy in the local sphere. Each actor assumed their functions: the local government (officials and board of councilpersons) in charge of managing public health and organizing the community in the district sphere[123] and neighbor and community associations in charge of citizen surveillance and involvement as a key element for strengthening public and community management.

3. Participative and coordinated design of regulatory proposals. Approval.

Those who participated in the design of incentives policies were: *The Villa Rica MN management team, the Villa Rica Technical-District Committee -COTEDI*[124] *and Neighbor and Community Associations*, instances officially acknowledged[125]. Together, they prepared the Acknowledgement Guideline for the Ministry of Health's Health Workers[126], the Guideline on the best worker approved by the Pasco Regional Government[127] and the Coordinated Health Program that respond to Policy 11, Regional Health Policies[128] and Policy 7. It contains the incentives issue at an

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122 *Document on agreements for the implementation of the Work Plan for the Incentives Policy, 2006.*

123 *Law No. 27972, "Framework Law on Municipalities"*

124 *Mayor's Order No. 076-2007-MDVR/A "Conformation of the Villa Rica District Technical Committee*

125 *Report No. 084-007-OSCS-MDVR submitted by the Head of Community and Social Services informing on the appointment of Ms. Amelia Peralta Torres as representative of the neighbor associations of the Villa Rica district on August 21st at the neighbor association board meeting.*

126 *R.M. 954-2005/MINSA, approving Administrative Guideline No. 072-MINSA/OGGRH-V.01- "Procedure for selecting the Best Worker at the Ministry of Health's departments".*

127 *Regional Executive Ordinance No. 0295-2007-GR Pasco "Procedures for the designation of the Best Health Worker in the Pasco Region"*

128 *Regional Ordinance No. 091-2006-GRP/C "Health Human Resource Policies in the Pasco Region".*

Benefits and incentives for Best Worker:

individual and group level. For the former, the selection of the best worker has been proposed, and for the latter, well-being actions for workers and their families.

Three meetings were carried out to comply with the individual incentives guideline and **to choose the best worker**: the first was with MINSA staff (Villa Rica MN management team, representatives from the RHUS Committee from the Oxapampa Network and DIRESA) to adapt the best worker guideline of the Regional Government to the local sphere. The second meeting was with the Local Government, to review the guideline and establish an Evaluating Committee including delegates from neighbor and community Associations. The third meeting was with COTEDI and education, health and national police representatives and delegates from Neighbor and Community Associations to review benefits and incentives[129].

- **Institutionalization of the proposal.**

The institutionalization of guidelines on Best Health Worker and Social Well-being was carried out at different levels. In the case of the Best Health Worker Guideline, a technical dossier was prepared. The ODL supervised the preparation of a technical opinion document and the file was followed up until the guideline was approved[130].

The Social Well-being Guideline was first reviewed at the Villa Rica MN and then at the Oxapampa Network by the RHUS Committee. It was approved by the NETWORK Director[131].

4. Initial implementation of the regulation

After both the BEST WORKER AND SOCIAL WELL-BEING incentive guidelines were approved, a roadmap (see Annex 32) was prepared with the local government, COTEDI and MN, which includes the following steps:

√ Establishment of an evaluating committee by Mayor's Order[132].
√ Summoning all health facilities to participate in the process.

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129 - *Written acknowledgement or congratulations through a Mayor's Order and a copy of such for the records*
- *Diploma, medal and merit badges, scholarships and/or training programs.*
- *Tourism Programs*
- *Public acknowledgement (through loudspeakers), expressing the respective personal achievements,*
- *Granting of paid leave of absences,*
- *Acknowledgement through publications and photographs in institutional magazines and news boards,*
- *Conformation of work teams with institutional responsibility.*

130 *Mayor's Order No. 230-2006 -MDVR/A- "Procedures for the designation of the Best Health Worker of the district of Villa Rica".*

131 *Director's Order No. 020-07-DE-RSS-OXAMP "Guideline on Social Well-being of the Oxapampa Network Health Workers"*

132 *Mayor's Order No. 174-2007-MDVR/A "Conformation of the Evaluating and Rating Committee for the Designation of the Best Health Worker in the district of Villa Rica.*

- √ Setting up of the evaluating and rating Committee.
- √ Rating and evaluation of candidates
- √ Organization for acknowledgement and award-giving to the Best Worker
- √ Evaluation of the process and report on results

The Social Well-being guideline, (see roadmap in Annex 32) was reviewed by the Villa Rica MN management team, the RHUS Committee representative of the Oxapampa Network and the DIRESA representative. The guideline establishes short and medium term benefits.

Short-term benefits:

- √ Appointment of a person in charge of Social Well-being.
- √ Approval and execution of the Recreation, Culture and Sports Program
- √ Sending of Birthday greetings
- √ Health campaign for workers
- √ Reading room
- √ Creation and approval of an Institutional Choir.
- √ Multi-sport Championship, etc.

Long-term benefits:

- √ Breast-pumping room.
- √ Workers integration room during breaks.

- **Budget for individual and group incentives**

  COTEDI members succeeded in making the local government include the Best Health Worker guideline in the 2008 participative budget, consisting in a tourism and training scholarship.

  For the Social Well-being guideline, the Oxapampa Network has allotted 2% from the directly collected resource funding source. This percentage has been included in the bill for the Operative and Budget Plan, POI, 2008.

- **Process results at the Villa Rica Micro-network**

  - Upon conclusion of the Project, there is great interest on the part of the Villa Rica MN and local government to continue with the health incentives policy, currently in its pilot stage.
  - DIRESA, Network and MN Human Resource Offices are committed to the development of an incentives policy for best worker.
  - Local spaces have been officially constituted to analyze and discuss RHUS policies, especially incentive ones.
  - There is health staff capable of developing continuous improvement of RHUS management with the purpose of improving care quality.

- Citizen coordination and participation spaces have been created with mechanisms for community representation through community agents and COTEDI members.

3.5.2 Junín Region

The experience on the incentives policy carried out at the Villa Rica MN was duplicated at the San Luis de Shuaro MN and the Pichanaki MN in the Junín region. The difference in these MNs was that there was greater coordination between MINSA health facilities and the Local Government. This was due to Health Promotion activities previously carried out by the Project, which facilitated its implementation. Lessons learned at Villa Rica were used, enabling to shorten some stages, such as sensitization.

3.5.3 Huanuco Region

In the framework of the Regional Human Resource Policies implementation in the Huanuco Region[133] and after having made the analysis of the RHUS situation[134], the problems shown on Table 22 were discovered.

Table 22. Problems for implementing regional RHUS Policies in Huanuco

[133] *Agreements of the Regional Board of the Regional Government approved on October 19, 2007*

[134] *Baseline Report on the situation of RHUS Policies in the regional and local sphere of the Huanuco region 2006*

- Lack of incentives for staff under contract
- Lack of incentives for Health Community Agents
- Little accessibility to training programs.
- Unequal distribution of incentives between administrative and service staff.
- Inadequate management of stationed staff permanence.
- Non-compliance of workers' medical checkup.
- Non-rewarded practice of values.
- Change initiatives ignored by supervisors.
- Inadequate staff management.
- Lack of incentives policies (written acknowledgements, medals)
- Constant staff rotation.
- Non-rewarded or unpaid overtime hours.
- Staff promotions not complied with.

In order to solve these problems, an Incentives Guideline was proposed, in which the Speaker team and key regional and local actors took part in its preparation. Among these, were members of the Thematic Committee for the Development of Health Human Resources, the Regional Health Board and Local Government[135]. This team was trained (Table 23) on incentive issues, and specifically, on non-monetary incentives[136].

Table 23: Trainees in the design of incentives guideline Huanuco

Level	Number of Trainees
Total	**134**
Regional	**50**
• Regional Government	7
• Thematic Committee on RHUS Development	23
• DIRESA	13
• Hermilio Valdizán National University	4
• Hermilio Valdizán Regional Hospital	2
• Higher Technological Institute Aparicio Pomares	1
Local	**84**
• Huanuco provincial Municipality	1
• Amarilis district Municipality	2
• Huanuco health network	11
• Carlos Showing Health Center	33
• Perú – Korea HC	2
• La Esperanza HP	3
• Llicua HP	3
• Paucar HP	1
• Malconga HP	2
• Health Promoters	26

135 *Technical Speaker Team for Health Human Resources, Huanuco, 2007*

136 *Bases for guidance of Human Resource Decentralization management, IDREH, 2004*

The design of the Incentives Guideline[137] was based on the effective national and regional regulations, defining the objective, application scope, legal bases, procedures, criteria for appointment and responsibility levels. Incentives are similar to those of the Best Worker Guideline from the Villa Rica district[138] and the Well-being Guideline[139] from the Pasco DIRESA. Criteria were established for granting incentives, such as for example, to be a role model for all workers in the sense of social values that are beneficial for the entity, among others.

3.5.3.1 Results in the regions

The following has been achieved between 2006 and October 2007:

- In May 2007, the Best Worker Guideline was approved in the Pasco Region; and at the DIRESA level, the Social Well-being Guideline.
- In the Villa Rica district, the best worker of the year was chosen, to be publicly acknowledged by the Mayor in November, during the city's anniversary.
- The Chanchamayo Network in Junín has publicly acknowledged 8 health workers. The Pichanaki and San Luis de Shuaro local governments have approved the best worker guideline and an Evaluating and Rating Committee is being implemented.
- The Villa Rica District Technical Committee has included in its Functions Regulation, aspects related to health human resources.
- In Pasco, Junín and Huanuco, the HR Offices of DIRESA, Networks and MN has ideal professionals for developing continuous management improvement of HR in order to count with motivated, acknowledged and skilled workers to improve care quality.
- Local authorities from the regions intervened have included in their working agendas the need to improve conditions and technical competences of health human resources, to solve the main health problems in the population.

3.5.4 Suggestions and Recommendations

1. The NETWORK AND MN's Operative Plan and the local government participative budget should include activities for the implementation of the RHUS policy.

2. Promote community involvement for an effective supervision of RHUS policies and their consolidation.

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137 *The incentives guideline is pending approval by the Huanuco DIRESA because it is awaiting the Work Competence Regulations (being prepared) to which they will be adapted. (See Annex 33 of the Incentives Guideline Proposal)*

138 *Mayor's Order No. 230-2006-MDVR/A-Villa Rica "Procedure for the designation of the best health worker"*

139 *Director's Order No.003-07-DG-DIRESA Pasco/GR*

3. Link the RHUS policy to the Healthy Towns strategy to facilitate for health staff that successfully participates in PROMSA to be proposed as a best health worker candidate.

4. Permanent technical coaching of DIRESA to the Network and MN to carry out RHUS policies.

5. Implementation of the RHUS policy as a technical and political strategy, because the regulation, organization and summoning of the community are inherent roles of the local government.

6. Technical assistance should be comprehensive in Promotion, Quality and RHUS processes and not isolated in RHUS Policies, to have a more efficient participation of those involved.

7. The RHUS Manager should assume responsibilities in achieving equal opportunities, quality and efficiency in comprehensive health care and quality in working conditions for health staff.

3.6 POLICY 8: WORKING RELATIONSHIPS BASED ON RESPECT

The working environment should allow the development of human resources through appropriate personal relationships. This implies the development of competences for timely detection of conflicts and skills, among others. The Project carried out a couple of studies on the organizational climate with the purpose of implementing policy 8.

3.6.1 Organizational Climate in Huanuco

Conflicts among the staff are common at the Huánuco DIRESA and its health facilities. There are several causes but the ones that stand out are communication deficiencies, cutthroat competition and rivalry that weaken the organization and damage creativity and productivity.

Therefore, DIRESA and the RHUS Management Team conducted an organizational climate study at the Carlos Showing Ferrari health center. It included a skill-strengthening workshop for 17 persons (3 from DIRESA, 2 from the Huanuco Network and 12 from the Amarilis Micro-network). Among four possible organizational climate measuring instruments[140], the WES was chosen (See Annex 34) because it adapts better to the study area and provides evaluation scales: Inter-personal relationships, self-realization and

[140] *- Organizational climate questionnaire, adapted from the East Lima DISA.*
- Organizational climate Test from TECLA Colombia.
- WES organizational climate survey.
- Organizational climate questionnaire, adapted from Mc Gregor and Schein.

stability/change. Surveys were carried out by University students in three shifts. Seventy-nine workers were interviewed out of a total of 126; the rest refused to provide information.

The results of the organizational climate study can be summarized as follows:

1. Occupational Profile: By occupational group, workers are classified into: medical professionals 32%, medical technicians 31% and medical assistants 15%. Its working regime is: 66% appointed y 22% under contract. 25% with 16 to 20 years of service.

2. Inter-personal Relationships: 75% of workers state there is little voluntary work at the facility, 72% say work in very interesting, 68% state people often create problems by talking about others behind their backs. On the other hand, 53% states that bosses do not encourage critical spirit in workers, but rather criticize them for unimportant things (56%).

3. Self-realization: 70% say too much time is wasted due to lack of effectiveness and 73% of workers say they are always bumping into routine work or against a barrier when they want to do something (positive).

4. Stability/change: 73% of workers indicate things are too disorganized; but if the health center were to be innovated; they would be the first to try out new things (76%).

5. Personal Development: 82% considers it is important to undergo training to move up to higher positions and 87% feels motivated to do so.

Based on these results, the Head of the Amarilis MN together with the management team decided to work on the organizational climate by prioritizing the stability/change dimension as a continuous improvement process and incorporating it into the CDC – MN, for changing the organizational culture.

6. Lessons learned: the sensitization stage is key for other stages. The importance of the study should have been stressed in order to have 100% of the workers participate.

3.6.2 Organizational Climate in San Martín

At the beginning of 2007, technical assistance was provided to DIRESA to strengthen its quality management system, with the purpose of solving some problems related to ill-treatment by workers of the periphery to the population that attend the facilities.

A 180-day Plan was proposed that included a campaign for **No Queues and Fair Treatment,** with the purpose of joining regional, administrative and medical workers under the same objectives and strategies established by DIRESA's managing team. It began by measuring the organizational climate (with the participation of 68% of workers) at DIRESA's central office, and with a survey on the perception of the working climate at that office. Results were later analyzed and workers were sensitized on this issue through six workshops. Therefore, an analysis of needs and perception of workers was obtained together with a solution proposal under the charge of DIRESA. Later, training in quality

management and inter-personal relationships was carried out to support work at networks and micro-networks, with efficiency and quality.

Workers' response to this initiative was favorable. They showed their willingness to support DIRESA's General Directorate and its management team. In turn, DIRESA committed itself to solve problems set forth by the workers during the organizational climate measuring according to its real possibilities.

On their part, workers and the DIRESA management team proposed an Action Plan for the campaign "No Queues and Fair Treatment" carried out at the Morales HC and at the Banda Hospital in Shilcayo. At the end of the experience, complaints from the population dropped down by 50% and 60% of service users were satisfied. A team of psychologists from the health networks participated in this experience. This facilitated the continuation of the experience at other networks and facilities in the region. The result was the strengthening of activities, measurements and quality improvement proposals for the region at DIRESA's Quality Unit.

3.6.3 Other aspects worked on regarding RHUS in the Pasco region

1. DIRESA's management team, with technical assistance from the project, prepared a proposal for a Suggestion Box guideline, to regulate criteria and procedures for its use in agreement with the Quality Management and RHUS Management implementation process. The guideline was reviewed by the Oxapampa Network RHUS team and the Villa Rica MN. It was approved by Director's Order No. 002-07-DG-DIRESA Pasco/GR in January 2007. This Guideline was adapted at the Oxapampa Health Service Network and approved by Director's Order No. 068-07-DE-RSS-OXAMP of April 2007 for its application at the Villa Rica MN.

2. The Pasco DIRESA management Team and the RHUS Committee proposed the institutionalization of the Health Human Resource Manager's Day (as an

[141] on this issue.

3. DIRESA's RHUS Committee has proposed an organization design and another on functions of the RHUS Office[142], which are being analyzed by the General Directorate and the Planning and Budget Office.

4. The Pasco Regional Directorate, through Director's Order No. 144-2007-DG-DIRESA/GR Pasco[143], of June 2007, acknowledged the work carried out by members of the RHUS Committee, the Regional Health Board and PATHFINDER INTERNATIONAL for the technical assistance provided.

5. Banners were prepared as a communication strategy for the implementation of RHUS Policies (approved by USAID[144]) to disseminate RHUS actions in the regions (see Annex 35):

    - Banner 01: Health Human Resource Message/motto "Motivated, acknowledged and competent health workers for the development and well-being of the community

    - Banner 02: Steps for the implementation of RHUS Policies

[141] *Minister's Order No. 960-2005/MINSA del 13/12/2005 "Establish December 11th as the Ministry of Health Staff System Day"*

[142] *Report No. 015-2007-DEGRHH-DIRESA Pasco-Proposal for the Organizational Design of the Pasco DIRESA Human Resource Office of March 22nd, 2007.*

[143] *Director's Order No.144-2007-DG-DIRESA/GR Pasco "Acknowledgement and congratulations to the members of the RHUS Regional Committee of the Health Regional Board of the Pasco Regional Government and to PATHFINDER INTERNATIONAL.*

[144] *- PI-AC-007/2007 in which USAID approves the making of giant posters for dissemination of the central message "Motivated, acknowledged and competent health workers for the development and well-being of the community".*

- PI-AC-13/2007 in which USAID approves the making of giant posters for dissemination of the central message from RHUS in the framework of the implementation of the RHUS Policy in the Pasco Region as well as the authorization for the USAID logo.

STRATEGIC PRODUCT 2: HEALTH HUMAN RESOURCES

COMPONENTS	ACHIEVEMENTS
PREPARATION OF POLICIES	
Adaptation of National Policy Guidelines for RHUS Development to regional reality.	• Establishment and approval of RHUS Technical Committees in Junín, Pasco and Cusco. • Re-structuring and approval of the Development Thematic Committee RHUS Huanuco[145] • Approval through Regional Ordinance of RHUS Regional Policies in four regions: Huánuco, Junín, Pasco and Huanuco.
IMPLEMENTATION OF POLICIES	
ORGANIZATION	• Participative analysis of RHUS situation in 3 districts: Villa Rica (Pasco), San Luis de Shuaro (Junín), Amarilis (Huanuco) and (Cusco) • Establishment and approval of RHUS-DIRESA Management Teams in Huanuco, Junín and Pasco. • Establishment and approval of Management Teams at RHUS-Oxapampa (Pasco) and Chanchamayo (Junín) in the Pasco and Junín regions, respectively • Director's Order No. 040-2007-DG-DIRESA/Pasco to "Select the Villa Rica MN as an initial intervention place for implementing RHUS Regional Policies".
POLICY 1. Education According to the Needs of the Country	
• General Law on Education (Law 28044) enacted in 2006 and regulated in 2007. • Establishment of the Initiatives Group for Quality in Higher Education (GICES) • Law No. 28740 for the Creation of the National Quality in Education Evaluation, Accreditation and Certification System (SINEACE), May 2006 and Regulation of the SINEACE Law (07/10/2007).	
Accreditation of Medical Schools and Faculties	• National Medical Exam (ENAM) acknowledged by Minister's Order No. 620–2006/MINSA, that makes its application compulsory at all medical faculties in the country. • First ENAM (2003) applied to students in their 6th and 7th year of studies. Second ENAM (2005), with the participation of 1,565 internship students and 120 professionals and students from other years. Third ENAM (2006) applied in 22 medical faculties members of the ASPEFAM. • The National Medical Resident Committee (CONAREME) establishes the ENAM as a requirement for medical residents (for graduates as of 2006 on). • Creation of CAFME as an autonomous entity by Law No. 271548. • CAFME standards include AIEPI strategy contents, by Supreme Order No. 004-2003-SA24. July 2003 • Accreditation of 23 out of 29 medical faculties and schools in the country. • CAFME stopped the creation of new medical faculties. • Implementation of the Experimental Laboratory for the Evaluation of Competences in Health Sciences, with a first technical nucleus in ASPEFAM, 2005 –2006. • Creation of the Medical Faculty Management Association to form high and

[145] *The RHUS Thematic Committee in Huanuco was created in 2003 for the implementation of the Coordinated Health Plan 2003–2006. In June 2006, it was re-structured to develop regional RHUS policies.*

COMPONENTS	ACHIEVEMENTS
	intermediate management teams, 2003. • Document on Research Lines in Health and Human Resources of the Pasco Region
Accreditation of Nursing Schools and Faculties	• Basic Nursing Curriculum finished and approved at general deans assembly. It included maternal perinatal health competences, AIEPI and health communication and promotion • National Nursing Exam (ENAE), approved in 2005. Two National pilot Exams carried out. • Competence Profile of nursing graduate • Quality standards for accreditation of nursing schools and faculties. Self-evaluation guideline.
Accreditation of Obstetrics Schools and Faculties	• Basic Obstetrics Curriculum based on competences, approved in pilot obstetrics faculties and schools. • Competence Profile of obstetrics graduate • Basic quality Standards for operation of nursing school or faculty • Quality Standards for the Undergraduate Nursing Program
Periodic Certification	• SISTCERE: New medical re-certification model linked to practice. • National Periodic Nursing Certification System and its ruling. • Permanent Nursing Education Program Model (PEPE). • SINADEPRO • Continuous Obstetrics Education Program (PECO).
Health and RHUS Research	• Document on Research Lines in Health and Human Resources of the Pasco Region
POLICY 2: RHUS Strategic Planning	
• Study: "Current and prospective analysis of supply, demand and the need for doctors in Peru 2005 – 2011.	
POLICY 4: Development of Competences	
• Guidelines for evaluation of standards and indicators at CDC facilities containing five components: Management and availability of resources, standardized management, intern competence, permanent health education and data use. • 433 (doctors, obstetricians, nurses and technicians) trained in EMOB care. • 96 tutors (doctors, nurses and obstetricians) Huánuco, San Martín, Ucayali, Junín, Pasco and Cusco trained at the Maternal Perinatal Institute of Lima • CDC Facilities: Pucallpa Regional Hospital, Yarinacochas Amazon Hospital, El Carmen Hospital of Huancayo, Antonio Lorena Hospital in Cusco, Hermilio Valdizán Hospital in Huánuco, Tingo María Support Hospital, Oxapampa Support Hospital. • Conformation of 10 Technical Committees CDC -facility at qualified hospitals in the seven regions of the project. • Standards and indicators for rating CDC–MN, as Competence Development Centers for maternal perinatal and infant care. • 04 CDC – MR qualified, 02 operative (Margos and Amarilis in Huánuco) and 04 and currently being analyzed. (Villa Rica in Pasco and Pichanaki in Junín). • CDC-MR: 30 certified health tutors and 28 approved, 24 approved municipal tutors and 96 technicians scheduled for training to December 2007.	

COMPONENTS	ACHIEVEMENTS
POLICY 6: New Working Regulatory Framework	
• Work competence (29 productive functions) profile (minimum) for Care Level I, category I-2. • Work profile by competences for workers (doctor, nurse, obstetrician and technician) for category I-2 facility • Work Competence Regulations of prioritized competence units in the areas: children, pregnant women and management (training management). • Evaluation instruments for work competences: 15 checklists and 10 questionnaires. • Occupational Profile and Work Competence Regulations in the areas: person (children, adolescents, pregnant women and elderly), family, community and management approved in Huánuco (Director's Order No. 272-07-GR-HCO/DRS-DG-OEGDRH-DESP of May 2007. • Conformation of the Work Competence Regulatory Committee of the Pasco Region, approved by Regional Executive Order No. 640-2007-GR Pasco/Pres on 9/12/07. • Staff selection guideline designed in Huanuco and Pasco, pending its adaptation to a competence approach. • Management Agreements (July 2007) between the Regional Government and local governments of Amarilis and San Francisco de Cayrán (Huánuco), to improve health human resource work competences in the maternal infant area. • Expansion of Management Agreements between the Regional Government and eight local governments of the CRECER Plan (in September 2007) • Design of Health Worker Induction Guideline of the Pasco DIRESA	
***POLICY* 7: Working Conditions, motivation and Worker's Commitment**	
• Training for 279 persons in Pasco, Junín and Huánuco in RHUS Management – incentives sub-process, for designing the guideline. • Regional Executive Order No. 0295-2007-GR Pasco "Procedures for appointing the Best Health Worker in the Pasco Region". • Mayor's Order No. 230-2006-MDVR/A "Procedures for appointing the Best Health Worker in the Villa Rica district". • Mayor's Order No. 0143-2007 A/MDSLSH "Procedures for appointing the Best Health Worker in the San Luis de Shuaro district". • Mayor's Order No. 099-2007 A/MD Pichanaki "Procedures for appointing the Best Health Worker in the Pichanaki district". • Director's Order No. 792-2006-DRSJ/OEGDRH that approves Administrative Guideline No. 04-2006-"Procedures for appointing the Best Health Worker" of Junin DIRESA • Director's Order No. 011-0GR/JUNIN/ Chanchamayo Network "Procedures for appointing the Best Health Worker". • Director's Order No. 003-07-DG-DIRESA Pasco/GR "Social Well-being Guideline for health worker of the Pasco DIRESA" • Director's Order No. 020-07-DE-RSS-OXAMP "Social Well-being Guideline for health worker of the Oxapampa Network". • Director's Order No. 027-DRSJ/OEGDRH which approves Administrative Guideline No. 01-2007-" Social Well-being Guideline for health worker of the Junín DIRESA • Director's Order No. 097-07-GR/JUNIN/ Chanchamayo Network, of August 23, 2007 "Social Well-being Guideline for health worker of the Chanchamayo Network". • Director's Order No. 074-07-GR/JUNIN/RS Chanchamayo "approves work plan for the 1st Multi-sport Games, Dance Contest as part of Social Well-being activities.	

COMPONENTS	ACHIEVEMENTS
• Mayor's Order No. 174-2007-MDVR/A "Conformation of the Evaluating and Rating Committee for Appointing the Best Health Worker in the Villa Rica district". • Mayor's Order No. 181-A/MDSLSH "Conformation of the Evaluating and Rating Committee for Appointing the Best Health Worker in the San Luis de Shuaro district". • Director's Order No. 091-07-GR/JUNIN/ Chanchamayo Network "Best Worker Acknowledgement during 2006 made to Ms. Graciela Maria Minaya Quezada, nursing technician I- from the Chanchamayo health service Network". • Director's Order No. 002-07-DG-DIRESA Pasco/GR "Suggestion Box", January 18th, 2007- Pasco DIRESA • Director's Order No. 068-07-DE-RSS-OXAMP, "Suggestion Box", April 9th, 2007- Oxapampa Network • Conformation of the Speaker Team in Huanuco for designing incentive, selection and performance evaluation guidelines based on competences. • DIRESA Incentives Guideline –Huanuco and Pasco, currently being adapted to the competence approach.	
POLICY 8: Working Relationships Based on Respect and Dignity	
• Training of 17 persons for the organizational climate study at the Carlos Showing Ferrari HC of the Amarilis – Huanuco MN. • Measurement of the organizational climate at the Carlos Showing Ferrari HC. 79 out of 126 workers took part. • Prioritization of the stability/change aspect for the continuous improvement cycle coordinated to the CDC – MN for changing the organizational culture. • Measurement of the organizational climate at the San Martín DIRESA with the participation of 68% of workers. • Execution of the Action Plan "No Queues and Fair Treatment" executed at the Morales HC and at the Banda Hospital in Shilcayo (San Martín). • Drop in 50% of the number of complaints by service users. 60% of satisfied users (San Martín).	

III. STRATEGIC PRODUCT 3: HEALTHY TOWNS

1. BACKGROUND INFORMATION

A number of institutions and documents[147] argue that the population's health is promoted by providing it with control over their social determinants identified as causes of the disease. Health promotion is based on this as a key strategy of public health

In Peru, health promotion has moved toward a modern orientation through social communication which commits individuals to a change of habits. The challenge is to link the actions of regional authorities, local communities and individuals to build healthy scenarios as an expression of citizens' participation and the exercise of rights and responsibilities in health.

The initial experience of healthy municipalities was in Cajamarca (2002-2003) through a consortium[148] that developed a project called Building Healthy Neighborhoods in neighboring towns of Cumbe Mayo, Pueblo Libre and San Vicente. This experience was visited at the beginning of the Project by various local government authorities with the idea of duplicating it in the 7 regions under the Agreement.

The strategy of health towns included different approaches:

- Healthy Development and Well-being is being not only disease-free but includes also social, economic, cultural, environmental, political and educational appropriate conditions for a comprehensive development: personal, family, community, district and regional wise.
- An approach toward health and development determinants.
- An empowerment, organizational and participative management approach. Health promotion is everybody's responsibility not the health sector's alone.
- A health decentralization approach: through a Healthy Town, local governments are given the responsibility of promoting development in their areas.
- An integral and interdependent coordination of various scenarios: Town, Educational Institution, Family and Community.

147 *Lalonde Report (1974) passing by Alma-Ata (1978), The Ottawa Setter (1986), the Bangkok Declaration*

148 *A consortium formed by Universidad Peruana Cayetano Heredia, Yanacocha Mining Company and NGO G&C Salud y Ambiente. The experience took place in the municipalities of Cumbe Mayo, Pueblo Libre and San Vicente benefiting 4 thousand households and 20 grassroots organizations. It developed health living environments with citizens' participation and a socially responsible commitment by the public and private sector that led to an improvement of living standards of the population.*

2. CONCEPTUALIZATION

A Healthy Town is that in which all its citizens, institutions and organizations work in favor of health, well-being and quality life of its people.

The proposed Health Promotion Project seeks to mobilize organizations to improve the quality of people's lives through 5 appropriate lines of action tailored to the various local scenarios: town, the Educational Institution, Community, neighborhood and family. The lines of action are:

- Organization and Participative Management.
- Promotion of Healthy Policies
- Improvement of healthy environments and surroundings.
- Education and Communication of Healthy Life Styles.
- Reorientation of public and private services.

2.1 LINES OF ACTION

- **Organization and Participative Management.**

It is the community's capacity to decide and exercise control over the quality of life through the organization of consensus and decision forums, for example the Office for Local Development (ODL) and Local Technical Team (ETL), Neighborhood or Community Board and the Institutional Educational Council (CONEI), among others. For its part, management refers to the reorientation of the District Development Plan and Participative Budget with an approach to Health Promotion and Social Development, as well as the elaboration of a Family Development Plan, etc.

Implementation of Local Consensual Healthy Policies.

They guarantee comprehensive and coordinated action of activities in solving community problems that have great influence in health determinants through municipal rules and ordinances on health and development and community, neighborhood, school and family living standards, etc.

- **Development of Healthy Environments and Surroundings.**

Healthy environments and surroundings include treatment strategy of environments such as: conservation of rivers, forests, solid waste recycling system, cleaning of streets and squares, green and recreational areas, provision of safe drinking water and basic sanitation, municipal sanitary landfill, improvement of (school) patios and toilet rooms, drainage system and sewage treatment, etc.

- **Promotion of Healthy Life Styles.**

A life style is a set of behaviors and practices that define the way of living and interacting of persons with their surroundings. It is linked to the pursue of a better quality of life understood as the well-being and satisfaction of the individual, including service and care behavior of mother and child, women in reproductive age, school age population, the population as a whole, housing and community.

- **Reorientation of Health and Education Services.**

A reoriented service is that which provides better quality to meet the needs and expectations of internal and external users that contribute to the creation of conditions (community halls, municipal and school libraries, Municipal Advocacy Services for Women, Children and Adolescents-DEMUNA, school first aid unit or material, guidance and counseling in Healthy Educational Institutions, among others) that will allow people to develop their potential.

2.2 POLITICAL IMPACT

Under political advocacy, the Project has contributed to the achievement of the following policies:

- A MINSA policy on "Decentralization of the Health Function on a Pilot Project level" considers health promotion as a key function for primary health care to be decentralized.

- Regional Ordinance No. 002-2007-CR-GRH, of the Huanuco Region approving Certification of Regional Minimum Standards of Healthy Towns for implementation of Strategy for Healthy Towns.

- Regional Executive Order No. 115-2007 GRJ/PR of the Junin Region declares regional priority the promotion and culture of health, as well as the implementation of Certification of Minimum Standards of Healthy Towns for the promotion of Social Development and Well-being in the Region.

- Sensitization of local leaders and authorities with regards to the issue that result in:

  - Implementation of 52 Local Development Offices, ODL, responsible for the coordination of activities of institutions, authorities and community.
  - Implementation of 52 Local Technical Teams, ETL, as technical support for management
  - Organization and recognition of 504 Community Boards,
  - Creation of 60 social networks
  - Promulgation of 131 Municipal Public Policies for the implementation of their Local Development Plan
  - Design of 835 Community Plans
  - Design of 305 Family Plans

- Organization of Regional Encounters in Huanuco, Ucayali and Pasco for promoting experience exchange and strengthen relationship between Local Governments and Regional Governments.

- Incorporation of a Healthy Town Project design in the municipal political agenda under the framework of regional and district participative budget. For example:

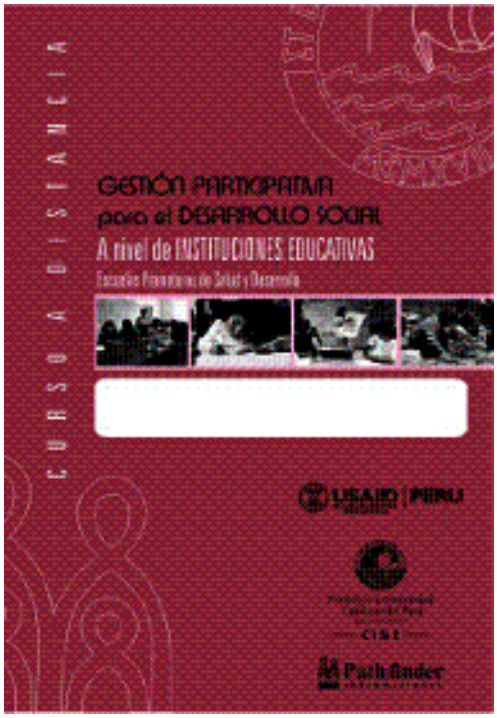
  - Junin: "Capacity Building of Local and Regional Technical Teams for Health Promotion in the Region" project approved in the Regional Participative Budget for a total amount of 337,200 nuevos soles
  - San Martin: "Promoting Participative Social Development in the Juan Guerra District" project approved for an amount of 30,000 nuevos soles.

2.3 MANAGEMENT FOR THE IMPLEMENTATION OF A HEALTHY TOWN STRATEGY

2.3.1 Training: Distance Teaching Course on Healthy Towns and Schools

The course of Participative Management for Social Development in Healthy Towns and Educational Institutions Promoters of Health and Development aimed at building local capacities for the implementation of these two health scenarios. The course was developed with the institutional support of Pontificia Universidad Catolica del Peru, sponsored by the

Social Development Management Offices and Health and Education Regional Directorates, and Local Governments.
By means of this agreement, Universidad Catolica (through its Research and Educational Services Center–CISE-), developed a Distance Teaching Training System for the Promotion of Health and Development in the 7 regions under the Project, The theoretical and practical course intended to generate abilities for the implementation of PROMSA's strategy in local scenarios. The course was addressed to members of ETLs, ODLs and educational institutions.



The different regional institutions[149] were key in disseminating the course (through the mass media, newspapers, radio stations, posters and three-leaf brochures) and its implementation

- **Characteristics of the Course**

  The course followed a group-educational feature – with 5 to 10 participants of different disciplines by group – applying a theoretical and practical modular system for the application of development plans in communities and institutions. State of the art technological tools were used for the transfer of knowledge, such as a virtual platform containing consulting material for participants. Academic monitoring to participants was permanent through a team tutor.

  Material and content preparation was entrusted to the Project Health Promotion Team.

- **Content of the course**

  The course trained participants in two contents:
  - Promotion of Social Development in Healthy Towns – SM, and
  - Promotion of Social Development in Educational Institutions Promoters of Health and Development – (IEPSyD)

  These two aspects of the course were organized in 6 modules[150] with 6-month duration as a whole.

- **Tutors**

[149] *Social Development Regional Management Offices, the Education and Health Regional Bureaus and the local governments*

[150] *The six modules were the following: Introductory Module, Participative management and organization, Health and Development policies, Promotion of healthy life styles, Generation of health environments and surroundings, Re-orientation of services (of 3-week duration each), and homework and evaluation (1-week duration each).*

Tutors are health and education professionals with experience in health promotion, residing in one of the 7 departments where the course was implemented. They were trained by the Project in tutorial work, computer science and content of the courses. They were grouped under two classifications: a) **Master Tutors**, 7 in total, who were responsible for the supervision of team tutors and of the systematization of academic performance of participants, and b) **Team tutor**, 110 in total, were responsible for academic attendance and monitoring of participants.

- **Participants**

The success of this invitation was total and is reflected by the participation of 5,160 persons of 55 provinces of the 7 regions within the project, Junin having the most participation and the least, San Martin. The levels of participation and of drop outs (which was less than 10% in average) depended on Internet access facilities. Table 24 shows the distribution of participants by province and region.

Table 24: Participants

Region	Provinces	Trained Tutors		Participants		
				Total	Course	
		Master	Team		Healthy Towns	Educational Institutions
Total	**55**	**7**	**110**	**5,160**	**2,840**	**2,320**
Ayacucho	7	1	14	1,342	791	551
Cusco	13	1	26	744	402	342
Huanuco	11	1	22	805	414	391
Ucayali	4	1	8	832	447	385
Junin	7	1	14	450	210	240
Pasco	3	1	6	645	368	277
San Martín	10	1	20	342	208	134

- **Material produced for PROMSA's strategy**

Table 25 shows a list of part of the material produced by the Health Promotion strategy for the distance teaching course for the different activities implementation phases including a household community notebook, which is an evaluation instrument of healthy habit indicators.

Table 25: Materials produced

Distance teaching course	**Manual for Healthy Towns**	Module 1: Health Promotion and Social Development. Module 2: Organization and Participative Management. Module 3: Implementation of Health Public Policies to Optimize the Local Development Plan. Module 4: Construction of Healthy Surroundings and Environments in Towns, Communities and Families. Module 5: Promotion and Communication for the achievement of Healthy Life Styles. Module 6: Reorientation of Services toward the Promotion of Health and Development.
	Manual for Educational Institutions	Module 1: Health Promotion and Social Development. Module 2: Organization and Participative Management. Module 3: Design and implementation of Healthy Policies in Educational Institutions. Module 4: Promoting Healthy Environments and Surroundings in Our Educational Institution. Module 5: Module of Health Life Styles. Module 6: Promoting Health and Education Services in Educational Institutions.
Guides for the progress of the PROMSA strategy		• Methodological Guide of Healthy Towns. • Guide for the Reorientation of the Local Development Strategic Plan (PEDL). • Diagnosis and Development Plan of my Neighborhood, Community and small village. • Building Development of our Community or Neighborhood. • Let's make Our Family one Healthy Family for Development. • Booklet: Strategy of Healthy Towns and Communities.
Videos		• Video image of Healthy Town School. • Video image of Educational Institutions Promoters of Health and Development.
Guides of Standards and Certification		• Standards of Healthy Towns. • Standards of Qualification of Healthy Communities or Neighborhoods. • Standards of Qualifications of Healthy Families. • Standards of Qualifications of Educational Institutions Promoters of Health and Development. • Guide for the Certification of Continuous Improvement Processes of Social Development in Strategy of Healthy Towns and its annexes.

2.4 HEALTH SCENARIOS

2.4.1 Healthy communities

Standards were defined by line of action for each scenario (town, neighborhood or community, schools and households) to enhance quality of life and well-being of the population, which were validated in selected districts as per the following criteria:

- Capacity of organization.

- Political commitment of authorities for development of the Local Health and Development Promotion strategy as a tool for participative management

- Willingness of grassroots organizations, public and private institutions and the mass media

- Belonging to alternative Development Program (PDA) zones and districts not under PDN zones.

At the end of the project, the strategy was developed in 72 districts, of which 32 were located in the areas of intervention of the Alternative Development Program, PDA. This part was covered by NGO PRISMA through a sub-grant together with Pathfinder International up to year 2006; later, PROMSA activities continued in the PDA zones through direct assistance to communities by MSH.

In total, the project organized the strategy in 72 districts and 689 communities. The distribution by regions and belonging or not to PDA is shown on Table 26.

Table 26. Communities intervened by the Project

REGIONS	*DISTRICTS*			*COMMUNITIES*		
	PDA	**NO PDA**	**TOTAL**	**PDA**	**NO PDA**	**TOTAL**
TOTAL	**32**	**40**	**72**	**360**	**329**	**689**
AYACUCHO	06	09	15	53	85	138
CUSCO	03	02	05	11	33	44
HUÁNUCO	08	07	15	75	49	124
JUNIN	02	11	13	20	46	66
PASCO	--	07	07	--	16	16
SAN MARTÍN	10	01	11	75	91	166
UCAYALÍ	03	03	06	126	09	135

The Healthy Communities strategy started in Huanuco through the technical assistance provided by NGO G&C in 2003 and by the end of that year, activities were extended to Ucayali. In 2004 the regions of Junin and Ayacucho were included, ending with the incorporation of San Martin, Pasco and Cusco by 2005[151]

In each intervention district, technical assistance was provided either directly or through PRISMA for the organization or strengthening of teams that would be responsible for leading the process: The Local Development Office (ODL) and the Local Technical Team (ETL). As the strategy implementation progressed, new activities were added, including the design of a participative budget that included PROMSA activities and the intervention of households and neighborhood associations for which organization is essential. Concurrently, work was done with regional and local

[151] ***Districts:***
- ***Pasco:*** *Oxapampa, Pozuso, Puerto Bermúdez, Puerto Izcozasin, Puerto Ciudad Constitución, Villa Rica and Huariaca.*
- ***Huánuco:*** *Ambo, Huacar, Pillco Marca, Aucayacu, Hermilio Valdizan, Queropalca, Llata and Puerto Inca.*
- ***Ucayali:*** *Aguaytía, Tahuanía, Callería, Irazola and Masisea.*
- ***Junin:*** *Junin, Ondores, San Luís de Shuaro, Chanchamayo, Pichanaki, Perené, Río Tambo, Sanibeni, Sincos, Llocllopampa, Acolla and Acobamba.*
- ***Ayacucho:*** *Huamanguilla, Huanta, Iguaín, Luricocha, Anco, Tambo, Chilcas, San Miguel and Luís Carranza.*
- ***San Martín:*** *Pajarillo, Huicungo, Pachiza, Campanilla, Chazuta, Tocache, Shunte, Uchiza and Nuevo Progreso,*
- ***Cusco:*** *Sicuani and Combapata.*

governments for the approval of the strategy and its lines of action, which meant the issue of municipal and regional ordinances, as seen on Table 27.

At the end of the project, in no PDA districts, the outcome of the work in healthy communities is reflected in the organization of ODLs, OTLs and other work teams.

Table 27: Lines of Action

Lines of action	Junin	Huanuco	Ayacucho	Pasco	Cusco	Ucayali	San Martin
Districts under intervention	11	7	9	7	2	3	1
Communities	46	49	85	16	33	9	91
Organization and participative budgets							
• ODL	11	6	12	12	--	6	9
• ETL	12	7	14	12	--	7	9
• CONEI	11	7	9	9	--	3	1
• Projects with participative budgets for PROMSA	24	64	90	14	--	39	72
• Family Development Plan	85	89	125	65	--	41	82
• Neighborhood Associations, organized and acknowledged	96	91	116	95	--	39	93
• Healthy Neighborhoods	45	32	13	31	01	23	14
Consensual local healthy policies							
• Regional Ordinances	1	1	--	--	--	--	1
• Municipal Ordinances	23	47	25	12	--	21	14

Once the management teams of the PROMSA strategy were constituted, the intervention in communities continued with the completion of a self-analysis (using an evaluation instrument designed by the project: Household Community Notebook) concerning the level of some healthy habit indicators:

- Malnutrition in children 6 to 9 years old
- Rate of Illiteracy
- % of households with school non-attendance (children 6 to 12 years old)
- % of inadequate housing
- % of overcrowded households (more than 3 persons per room)
- % of housing without potable water system provision
- % of households without sewerage system provision
- % of households without energy system provision

- % of households with high economic dependency
- Household per capita expenses
- % of children 0 to 12 years old
- % of households with persons 18 years old and over with incomplete primary education.

From the results of the first evaluation, a number of activities were developed in order to enhance weak indicators to attain their adequate level. A second assessment was made followed by others when needed to evaluate the progress of implemented activities.

The following are the results in the areas of intervention in the Alternative Development Project zones, PDA, developed by PRISMA through a sub-grant and in No PDA zones directly monitored by the project.

Once the project's technical assistance ended, most of the healthy habit indicators showed more than 20% increase between 2005 and 2007, exceeding the original indicator target that forecasted such an increase. With regards to children, Table 28 reports a remarkable achievement in the availability of birth certificates

Table 28. Variation of healthy habit indicators in communities that do not belong to the Alternative Development Program, PDA

Indicators	Junin		Huanuco		Pasco		San Martín	
	2005	2007	2005	2007	2005	2007	2005	2007
Children's health Indicators								
• % of children having a birth certificate	32.0	78.1	50.0	67.0	69.8	89.3	67.0	85.4
• % of children having an updated CRED card	56.7	65.6	59.0	70.0	49.0	65.0	56.3	67.1
• % of children with their immunization up dated	56.1	65.3	59.0	69.0	49.0	62.0	54.2	67.1
• % of children under 6 months under breast feeding only	90.1	92.1	93.0	98.0	93.0	95.0	91.7	95.7
Reproductive health indicators								
• % of pregnant women under prenatal control	73.0	91.0	64.0	79.3	65.0	82.0	72.0	88.0
• % of women under institutional care and/or professional child birth	46.0	65.0	45.0	57.0	56.0	78.0	60.0	67.0
• % of women in MEF who know about their fertile period	17.9	25.0	18.8	23.0	15.4	22.0	18.0	22.5

• % of MEF using contraceptives among united women
  • Modern method
  • Traditional method
	65.0
	42.0
	23.0
		68.0
		39.0
		29.0
			63.0
			40.2
			22.8
				61.6
				37.8
				23.8
					68.0
					50.0
					18.0
						70.8
						48.0
						22.8
							68.5
							48.0
							20.5
								69.1
								50.0
								19.1

Housing indicators								
• % of households drinking boiled or chlorinated water	72.5	91.0	67.0	71.6	82.0	92.7	48.2	65.0
• % of households that use a toilet connected to network or latrine	45.0	75.0	56.9	84.4	57.0	88.0	65.0	99.0

of children under three, which is a sign of the parents' awareness of providing them with identification from the time of their birth, which guarantees their rights that by law they are entitled. In fact, in all the regions, the increase was 30% in average, except for Junin where the increase was higher than 143% (it rose from 32% to 78%)

Also important was the improvement of an indicator that measures health monitoring of children 24 months old through the availability of an updated growth and development card CRED. This is even more important if one takes into account that an updated CRED card implies, as shown by the figures, that these children are also updated in their immunizations. This means that they are protected against first childhood preventable diseases that produce sequelae later in life.

As to reproductive health indicators, there is also an increase shown in all the indicators. Prenatal control and institutional childbirths have increased the most. Of the four regions under consideration, these two indicators were lower in Huanuco and higher in Junin and San Martin. However, both prenatal control by health workers and institutional childbirth registered in the communities of the area of project intervention are at times higher than in the regions when considered as a whole. According to the figures of ENDES it continues for 2006 and Table 28 shows it for the 7 regions.

In districts and communities under PDA, at the end of PRISMA's intervention, the level of some selected indicators for the measurement of healthy habits in the population are shown on Table 29.

Table 29: Indicators of healthy habits at the end of the projects under PDA

Region	Number of Districts	Communities	Indicators (%)					
			Children < 2 yrs with birth certificates	Children < 2 yrs with CRED card	MEF know FP methods	Pregnant women under prenatal control.	Children < 6 months breastfed only	Households with safe water
Ayacucho / Cusco	9	19	14.0	58.8	55.9	100.0	58.7	39.6
Ucayali	3	47	63.4	77.5	82.2	84.7	100.0	44.1
Huánuco	8	41	76.7	80.5	67.1	75.0	91.8	35.0
Junin	2	13	68.9	85.8	58.6	96.7	75.0	12.0
San Martín	10	54	70.9	88.4	76.0	86.5	100.0	21.2

Source: PRISMA: Final Project Report of Healthy Towns and Communities. July 2005-June 2006

2.4.2 Educational Institutions for Promotion and Development

The Strategy of Educational Institutions Promoters of Health and Development – (IEPSyD) promotes participative management between the educational communities (teachers, students, parents), through Institutional Educational Boards (CONEI), and their local authorities (Local Government, Health Centers, Social Organizations and others). The aim is the promotion of protective factors that will result in better learning and reduce school repetition and dropout rates

Initially, the project worked in educational institutions selected through sub-grants with NGO KALLPA in the Huanuco, Ucayali, Cusco and Pasco regions, and with NGO

TADEPA in the Ayacucho and Junin regions. Technical assistance was based on a dynamic and participative process with the educational community and the local government for the promotion and implementation of the following five lines of action:

- **Organization and participative management.**

An Institutional Educational Board (CONEI) was created and different management tools were designed: Institutional Educational Project (PEI), the Annual Work Plan (PAT) and the Educational Institutional Curricular Project (PCIE), promoting the organization of School Municipalities, Parents and Teachers Associations (APAFAs) and School Promoters or Watchers.

- **Healthy Policies**

This refers to the existence of healthy living rules (e.g.: students' safety, children non discrimination, in the case of HIV-Aids, etc) in school, according to its Institutional Educational Project (PEI) that should provide an educational environment of values, rights, responsibility, respect and trust between schoolmates, teachers and authorities.

- **Promotion of Healthy Life Styles**

These healthy styles shall be part of a curricular proposal of the educational institution where the messages are consistent with the practice, so if there are cases of stomach infections, it will not be enough to promote washing hands of children and consumption of safe water but students shall be provided with quality water, soap and towels.

- **Improvement of Healthy Environments and Surroundings**

Physical and social spaces shall be healthy, safe, free of aggression and verbal, emotional or physical violence: safe water, classrooms, patios and healthy green areas, healthy toilette rooms, adequate handling of garbage/waste, etc.

- **Reorientation and surveillance of school services.**

To adapt them to the health and development needs of the educational community, inside and outside the educational institution, for instance, cultural and recreational services, spaces for guidance and counseling, school library, school stands or cafeterias, transportation and communication.

The educational institutions (EI) in which the work was done were the following:

Huanuco: **Pillco Marca (Huánuco)** EI Juan Velasco Alvarado, EI -school Nuevo Amanecer, EI Vichaycoto, EI Huancachupa .**José Crespo y Castillo (Leoncio Prado)** EI Andres Avelino Cáceres, EI Inca Huiracocha, EI Aucayacu. **Hermilio Valdizan (Leoncio Prado)** Primary EI Sortilegio, EI Rio Azul. Higher **Llata (Huamalíes)** EI Juana Moreno de Cáceres, Primary EI 32537.

Ucayali: **Irazola (Padre Abad)** Primary-Secondary EI 64027 Juan Edison Bordoy. **Masisea (Coronel Portillo)** Primary EI 64139.

Pasco: **Oxapampa** EI San Francisco de Asis, EI Mariscal Castilla **Villa Rica (Oxapampa)** EI Rvdo Padre Egg**, Simón Bolívar de Rancas (Pasco)** EI Simón Bolívar, EI 34032, EI San Antonio de Rancas, EI Horacio Cevallos Gamez.

Junin: **San Luís de Shuaro (La Merced)** EI San Juan Santos Atahualpa.

Ayacucho: **Iguaín** EI Carlos Ch. Hiraoka.

San Martín: **Juan Guerra,** EI Belen Primary and Secondary.

Cusco: **Combapata (Quispicanchis)** EI Pre-school 578, EI Primary Nuestra Señora del Rosario, EI Primary 56044, EI Secondary Jerónimo Zavala.

STRATEGIC PRODUCT 3: PROMOTION OF HEALTH

COMPONENTS	ACHIEVEMENTS
HEALTHY TOWNS	

- Political Impact/Advocacy for the achievement of the following rules:
  - A MINSA policy on "Decentralization of the Health Function at a local level-Pilot Projects", considers Health Promotion as a key function for primary health care to be decentralized.
  - Regional Ordinance No. 002-2007-CR-GRH, of the Huanuco Region approving Certification of Regional Minimum Standards of Healthy Towns for the implementation of the Strategy of Healthy Towns
  - Regional Executive Order No. 115-2007 GRJ/PR of the Junin Region declaring the promotion and culture of health a regional priority, and the implementation of a Minimum Standard Certification of Healthy Towns for the promotion of the Social Well-being and Development in the Region.
- Sensitization of local leaders and authorities for the:
  - Implementation of 52 Local Development Offices, ODL, responsible for coordination of institutions, authorities and community.
  - Implementation of 52 Local Technical Teams, ETL, as technical support for management.
  - Organization and recognition of 504 Community Neighborhood Boards.
  - Creation of 60 social networks.
  - Promulgation of 131 Municipal Public Policies for the implementation of their Local Development Plan
  - Design of 835 Community Plans.
  - Design of 305 Family Plans.
- Regional Encounters in Huanuco, Ucayali and Pasco for the exchange of experiences and strengthening of the relationship between Local Governments and Regional Governments
- Incorporation in the municipal political agenda, Healthy Town projects under the framework of Regional (PPR) and District (PPD) Participative Budget):
  - Junin: Project, "Capacity Building of Local and Regional Technical Teams for Health Promotion in the Region" approved under Regional Participative Budget for a total amount of 337,200 nuevos soles
  - San Martin: Project, "Promoting Participative Social Development in the District of Juan Guerra" approved for an amount of 30,000 nuevos soles.

COMPONENTS	ACHIEVEMENTS
	➢ Distance Teaching Course on Healthy Town and Schools with the institutional support of the Pontificia Universidad Católica del Perú, with the sponsorship of the Social Development Management Offices, the Health and Education Regional Directorates, and Local Governments. Participating in these courses were 5,160 persons of 55 provinces of the 7 regions under the project ➢ Healthy communities: the strategy was developed in 72 districts of which 32 were located in the areas of intervention of the Alternative Development Program, PDA. In total, the project organized the strategy in 689 communities of the 72 districts. ➢ The healthy habit indicators presented an ample increase higher than the 20% proposed in the respective target.

IV. STRATEGIC PRODUCT 4: COMMUNICATIONS IN HEALTH

1. CONCEPTUALIZATION OF COMMUNICATION FOR HEALTH AND DEVELOPMENT

To inform, educate and raise awareness on various issues are necessary ingredients of communication, but not enough to change habits practiced for a long time. Strategic communication is an effective tool for habit changes and their sustainability; therefore, it is a decisive factor that connects health and social development, establishing relationships and linkages, generating actions and building collective groups and citizenship.

2. BACKGROUND INFORMATION

Communication in the health sector in Peru was born after the Cholera epidemic in the summer of 1991. That sanitary event changed health policy because of the lessons learned in all sanitary areas, among others: the significance of social communication to preserve life, the possibility of successfully facing a sanitary emergency through information; the creation of participation spaces and the transparency of political decisions on an emergency that involved the health of thousands of people.

The application of principles, methods and tools of social communication in promotional preventive health programs at an individual and collective level is in constant growth, consequently, the MINSA has designed a number of educational communication strategies of great impact in health programs and in the well-being of the people.

3. COMMUNICATION IN HEALTH IN THE FRAMEWORK OF THE PROJECT

The communication strategy in the framework of the project had different momentums and was built from lessons learned from other interventions such as the Project Change, the Consortium of Universities and the Network of Communicators in the Amazon region. It served as support for different strategies of the project: PROMSA, management of quality and the RHUS policy (basically supporting professional re-certification).

There were four coordinated cross-section strategies for communication in the health sector:

a) Strengthening of capacities for organization in the use of communication for development

b) Sensitization for the inclusion of communication in political rules
c) Creation of channels for active participation of the population in problem solution and a common view
d) Communication networks.

3.1 HEALTH COMMUNICATION MANAGEMENT

3.1.1 Institutional Communicators

The intervention requested the participation of *"institutional communicators"*[152] of the Regional Government, the Education and Health Regional Directorates, through the respective communication offices, institutional image, press and/or protocol, to which the project provided technical assistance for the preparation of a Communication Plan directly connected to the Regional Consensual Health and Education Plan.

Regional Committees of Communication or Communication Committees were prompted, without much success, in order to develop processes and communicational products in topics of health, education and development. While the idea was met with enthusiasm, their implementation is a process that has exceeded the duration of the project.

In the districts targeted by the project, support was provided to the ETL local technical teams for the conformation of their communication team and completion of activities to support the consolidation of the strategy of healthy towns and communities. The district was the ideal scenario to gather information about motivators and barriers against healthy habits, based on which communication campaigns were designed.

3.1.2 Communication in the Health Area: a NETWORK task

Communication in the health sector is based on coordinated work of all regional and local actors of the different geographic and social areas. In that sense, to give consistency, effectiveness and continuity to the activities, the project has implemented a strategy of networking, bringing together professionals and non-professionals whose activities were geared to different target audiences.

a) Network of Communicators in the Amazon Region

In 2003, there were groups of communicators formed in the regions of Ucayali (Pucallpa and Aguaytía), Ayacucho (Huamanga and in the VRAE), San Martin (Tarapoto) and Huanuco (Tingo Maria) working directly with DEVIDA (Anti-Drug Consumption Commission, "CONTRADROGAS"). The communicators that integrated the networks were empirical people (faculty, technical staff and amateurs in communication) that had not received professional training in communications. DEVIDA requested technical assistance from the project to train the networks with the purpose of making them more self-reliant and not dependent on the DEVIDA funds. The activities were focused on:

[152] *Institutional Communicators. A term designated in the project to refer to those communicators that belonged to public and private institutions, as compared to those that work in journalism.*

- strengthening the capacities of journalists, members of these networks, to generate resources for their own training, on one hand, and to develop community outreach activities aimed at social mobilization for changing habits, on the other hand

- improving the website of the network of communicators of the Amazon region and building capacities for its management.

To strengthen the capacities of communicators, the Project benefited with the services of the Consortium of Universities that developed a communication specialization program in which a total of 110 communicators participated, representing 90% of the total number of members of these networks. The website was improved with the valuable assistance of PRISMA.

b) Networks of Radio Program Correspondents

The health communication strategy selected in each region, radio stations to consolidate a radio program with social responsibility to promote habit changes based on motivators. This initiative was made possible through the coordination of a network of local social communicators. Six radio stations[153] were selected and with their communicators business strategy for the radio program was developed.

The Networks of Radio Correspondents are formed by radio communicators who were contacted by the owner of the selected radio station or the person in charge of the intervention radio program. Each selected radio team identified other allied radios that might be interested in joining these networks whose goal was the mass dissemination of health messages. Communicators elected were trained in radio production, producing radio spots, radio soap operas, radio programs and other communicational products based on motivators for promoting healthy behaviors.

Networks of correspondents were set in 7 regions of the project being more successful in the regions of Junin, Ucayali and Huanuco; in the latter, the communicator of DIRESA went from having a limited role of spreading the institutional image, to a role of integrator of a group of people within a working network to make the video "If we had only," radio and television spots for the prevention of malaria and dengue, and reorienting the health policy to suit local realities.

[153] *Huanuco: Luz y Sonido Radio Station*
Junín: Uno Radio Station of the Chanchamayo province
Ucayali: Del Progreso Radio Station in the Callería district
Cusco: Salcantay Radio Station first, and then Universal Radio Station
San Martín: PRODEMU Radio Station
Ayacucho: Atlántis Radio Station
Pasco: Universitaria Radio Station was selected, but the evaluation showed that social communication sustainability was not guaranteed

c) Communication Networks

At the end of the project, seven Communication Networks had been organized, one in each region of the area of intervention of the project, integrated by communicators, journalists, health staff, faculty members and students of the Department of Social Sciences and communications and others that operate permanently in disseminating health messages and healthy habits among different audiences. They contribute with networking between actors of the health area and mass media.

3.1.3 Training

- **Distance teaching "Communication in the Health Area"**

Under the Program framework: ***strengthening of national capacities in health communication***[154] , a training program was conducted in Health Communication with the participation of university or graduate students, professional and non-professional staff working in the areas of communication or health. The course was intended to help strengthen the capabilities of communication in the seven intervention regions of the project and was the product of a joint effort of the Consortium of Universities, with the national universities of the seven regions, State institutions, civil society, and Communicators Network for the Development of the Amazon headquartered in 7 regions.

- **Program of Specialization in Communication in the Health Area for communicators**

This has been one of the biggest tasks of the project due to its size and scope, but also by the number of participants in the program and the number of actions required to carry them out.

The program consisted of four courses, each with 15 academic hours attendance and a full month of distance course, in which participants had to work with advice from the teachers. The total hours of Agenda was 220.

The design of the specialization Program was modular. In each region four Program courses were taught with simultaneous sessions during the first three days in each module. For this, there were two teachers per course that taught similar courses in two different regions. As a result, both selected teachers were responsible for preparing the respective syllabus and the selection of teaching materials.

- **Internship experience in Radio Marañón (owners of radio stations)**

[154] *Consulting services developed from June 2005 to March 2006 in its III Stage Pathfinder assumes the coordination.*

Radio Marañón has an educational, cultural and commercial radio proposal with the participation of the population and organizations in decision-making for their development that makes and attractive model from which to draw many lessons, more so when we bear in mind that this is a strategy developed in a province that is not capital of the region. Therefore, we organized a visit to learn on site about this experience, and interact with the group of workers and employees of this radio station.

The direct contact with this successful experience motivated the internees (radio station owners and directors) of Radio "Luz y Sonido", Huanuco, radio "El Progreso", Ucayali, and radio "Uno" in Junín, and motivate them in trying a new model of radio programming that connects the commercial end with the educational end; the word with music, the information with entertainment, achieving the penetration of health messages in the population.

The experience of radio Marañón allowed selected radio stations to adjust their work to social development approach in a medium term.

"This has been an interesting experience that allowed for a new style of making radio programs, all you need is responsibility and commitment" stated Manuel Gonzáles (Programmer of Radio "Luz y Sonido"), after learning about the Marañon radio station experience. Upon his return to Huanuco, he implemented new ideas to strengthen the radio programming, specially a program named "Consultorio en la Radio".

3.1.4 Communicational Products

- **Radio Programs (radio soap-operas based on motivators)**

Prior to producing radio programs, there was an intense activity to generate local communication experiences in one radio station with social responsibility and willingness to contribute to the region's development. To that end, it was necessary to consolidate one communicational proposal aimed at changing habits based on the identification and creative address of motivators and barriers that individuals have in order to change a particular habit.

There were a number of radio programs produced, among them:

Huánuco: Program "Consultorio en la Radio/A Doctor's Office on the Radio" in Luz y Sonido radio station, is broadcasted Tuesdays and Thursdays from 10am to 12m under the name of, "In Confidence " (Between You and Me). The evaluation of the audience of this program after 3 months of having started, from an intentionally chosen sample among the persons attending the Carlos Showing HC, showed that half of the interviewees listened to the program. The sample identified topics for the radio-drama production, for example, adolescent fertility, infant- feeding and parent-child communication.

Ucayali: Program "Surcando al Progreso/In the Path of Progress" of Del Progreso Radio Station that is broadcasted from 2 to 4 pm daily. The time was chosen based on a preference study of Compañía Peruana de Estudios de Mercados y Opinión Pública CPI that placed Radio Del Progreso in 5th place of preference. A supplementary study was made to determine the times for a social communication program, and the period from 2 to 4 pm was the most indicated for all age audiences.

Junín: During the summer of 2007, a program was produced named "Together, let's rebuild Chanchamayo" to help the victims of floods. At present this program is named "The change is in each of us" and receives consultations on health from the audience and has a number of guests. After two months in the air, 400 interviews were administered in nearby districts of La Merced to identify the level of audience and preferences. This program was 5th in the rank of preference.

Cusco: Program "REDES/NETWORKS" of radio Universal, which operates with open calls from the audience on different forms of group support to face health issues. A quick study of the radio audience and preference of this program showed that 47% of interviewed adults and 30% of youngsters of the sample listened to the program. (N= 37 adults, 40 adolescents and youngsters of both genders).

- **Radio Spots**

The content of radio spots were as follows:

Medical Re-certification in the 7 regions
Maternal health and institutional childbirth deliveries in Ayacucho, Cusco and Huanuco
Healthy practices, such as hygiene, identification with students and prevention of adolescent pregnancy in Ayacucho (Iguaín), Combapata (Cusco) and San Luis de Shuaro, where prevention of child labor was added to the list

- **Televised feature reports**

In Huanuco on healthy schools, schools promoters of health, 3 feature reports,
Medical Re certification, 2 feature reports in Cusco

❖ **Communication campaign in the health sector based on motivators (Ucayali)**

In September 2006, a qualitative study was developed on motivators and barriers with regards to the use and negotiation of the condom in men that have sex with men (MSM) and sexual workers (SW), in coordination with the Communication Office of DIRESA of the Ucayali region, CERITS of the Regional Hospital of Pucallpa, the Civil Association Cayetano Heredia and the Group of Mutual Aid "Blood Brothers" GAMHESA. The enrolment of the participants was entrusted to the promoters of Universidad Cayetano Heredia and of CERITS.

The findings of the study were analyzed by the Technical Team of DIRESA and the Multi-sector Committee in November 2006, during the first meeting of preparation for the International Day against HIV-AIDS. The decision was to consider as target groups, MSM and SW and adolescents and youngsters to deal with topics of sexual diversity, exclusion and stigmatization. The suggestion was that the Education Sector should evaluate the relevance of Curricular Diversification regarding Sexual Health and Reproduction topics and the job of Counseling to parents. Finally, it was thought necessary to sensitize Human Resources to improve the quality and a warm attitude in health care services (Competence + Warm Attitude).

These decisions included coordination with different institutions interested in working the Communication Campaign with MSM and SW: Civil Assocition Cayetano Heredia and CERITS-Pucallpa, in additiona to yound promoters of APROPO, Etapa de Vida Adolescente de la DIRESA UCAYALI and Manuela Ramos.

After some days of discussions with MSM and SW promoters, the campaing products were decided. For MSM, the defined products were *a song with ambient music"* to be presented in discotheques by a choreographic show. *A key ring condom holder* to ensure the proper care of a condom and a dispenser to evaluate the use of condom in the discotheques were the ambient music is played.

For the SW the defined products were a *bar-type song* in a chicha or techno cumbia rhythm to be played in bars where they are habitués, *a calendar or poster* inviting to negotiate the use of condom with their partner and a dispenser to measure the use of condom in bars where this music theme is played.

In April 2007, the writing of the musical themes for the campaign started. Both the lyrics and the music were contributed by the MSM and SW population. While the lyrics were being written, local musicians and singers were identified to make these songs more lively. The music of both themes belongs to Anthony Guerra (Zico), and were sang by a young singer named Linda Caba.

In mid June, it was agreed with APROPO the launching of the music in discotheques and bars, together with the installation of condom dispensers.

- **Video "If we had only…"**

In the Workshop on fictional educational script writing, the communication office of DIRESA UCAYALI completed the revision of the PECE PLAN on healthy and safe pregnancy and selected the motivator fiction video production that sought to generate a change of behavior in pregnant women. The results obtained in the qualitative study served to choose the motivators. The script began to germinate with the contribution of the Workshop participants, plus the actors that would work in the video. The process included the following stages (See annex 36):

- Preparation of the Audiovisual Proposal.
- Preparation of the Video Script.
- Validation with Technical Team of DIRESA and target group.
- Preparation of the Guide for the Use and Dissemination Plan.

❖ **Bulletins**

Printed Bulletins (posters, three-leaf brochures, bulletins)

San Martín (Juan Guerra), Junín (San Luis de Shuaro), Ayacucho (Iguaín) and Cusco (Combapata) and Pasco (Oxapampa): Bulletins of Healthy Municipalities y other printed material, giant graphic murals of healthy practices on hygiene, identity, breast feeding.

Virtual Bulletins

In Ayacucho, Cusco 2, San Martín and Junín on different topics supporting the activities of the Health Regional Board, the Medical Association (on the issue of periodic certification) and the local governments

STRATEGIC PRODUCT 4: COMMUNICATIONS IN THE HEALTH AREA

COMPONENTS	ACHIEVEMENTS
COMMUNICATION IN THE HEALTH AREA	
General Achievements: • Incorporation in the political and institutional agenda of the importance of communication as a tool for change and mobilization and not only information • Strengthening of capacities of communicators in general and journalists in health for development communication • An outlook of a more holistic communication involving universities, radio stations, institutions and the community • A work proposal of health communication networking, and not disarticulated • Incorporation of communication as a strategy for motivation • The Medical Association identified communication as a tool for mobilization and participation, both for registered doctors and external stakeholders (beneficiaries of health care services). From this outlook, a web site and an exchange group (yahoo groups) were created, printed and virtual bulletins, radio spots, three-leaf brochures and banners with messages that could mobilize and attract the professionals' involvement. • The development of 7 communicators networks, one in each region	
▪ ***Network of communicators of the Amazon region, trained in Ucayali (Pucallpa and Aguaytía), Ayacucho (Humanga and in the VRAE), San Martín (Tarapoto) and in Huanuco (Tingo María) working directly with DEVIDA***	▪ Specialization in Communication: 110 communicators participated, representing 90% of the total number of members of these networks. ▪ The web site, improved with the valuable aid of PRISMA.
▪ ***Networks of Radio Program Correspondents***	▪ Networks of correspondents were established in the 7 regions of the project, being the most successful those of San Martín, Cusco and Huanuco
▪ ***Networks of communication***	▪ Seven Communication Networks formed by communicators, journalists, health personnel, faculty members, and students of the Social Sciences and Communication Departments, and others.
▪ ***Training***	▪ A Distance course "Communication in Health" ▪ A Specialization Program on Communication in Health for communicators ▪ An internship program in Radio Marañón addressed to radio

COMPONENTS	ACHIEVEMENTS
	station owners

▪ ***Communicational Products***	• Radio Programs (radio-dramas based on motivators)
	  • Huánuco: Program "Consultorio en la Radio/ A Doctor's Office on the Radio" of radio Luz y Sonido, on the air Tuesdays and Thursdays from 10am to 12m under the name of, "In Confidence ".
	  • Ucayali: Program "Surcando al Progreso/ In the Path of Progress" of radio Del Progreso.
	  • Junín: Program "The change is in each of us " under a format of conversations with women.
	  • Cusco: Program "Redes/Networks", of radio Universal
	• Radio Spots
	  • Medical Re-certification in the 7 regions.
	  • Maternal health and institutional childbirth in Ayacucho, Cusco and Huanuco.
	  • Healthy practices: hygiene, identity with students and prevention of an adolescent pregnancy in Ayacucho (Iguaín), Combapata (Cusco) and San Luis de Shuaro, where the issue of child labor was added
	• Television reports
	  ▪ Documentary reports on healthy schools in Huanuco
	  ▪ Reports on medical Re-certification, 3 in Huanuco 2 reports in Cusco
	• Campaigns of communication in health based on motivators (Ucayali) for the prevention of HIV-AIDS in MSM and SW
	• Video "If we had only..." on healthy and safe pregnancy to generate positive behavioral changes in pregnant women and the community.
	• Bulletins
	Printed Bulletins (posters, three-leaf brochures, bulletins)
	San Martín (Juan Guerra), Junín (San Luis de Shuaro), Ayacucho (Iguaín), Cusco (Combapata) and Pasco (Oxapampa): Bulletins of Healthy Municipalities and others of healthy practices in topics of hygiene, identify, infant breast feeding.
	Virtual Bulletins. In Ayacucho, Cusco 2, San Martín and Junín on different topics in support of activities of the Health Regional Board, the Medical Association (periodic certification), and local governments

I. STRATEGIC PRODUCT 1: QUALITY MANAGEMENT SYSTEM AT DIRESA

1. QUALITY DEVELOPMENT IN PERU

Concern for improving health service quality in the country became more evident since 1996 when the Ministry of Health started issuing ministerial orders approving the "Hospital Accreditation Manual"[14], the "Guideline for the application of the Hospital Accreditation Manual"[15] and, in 1998, the "Regulations and Procedures for Accreditation of Health Facilities and Support Medical Services"[16]. In 2001, the document "Quality Management System"[17] was approved, which established the principles, policies, objectives, strategies and components of such system. With these management instruments, 300 external examiners and seven accrediting bodies (agencies, institutions) were certified. The result was that in 2002, there were nine accredited hospitals (five private clinics, the Peruvian Air Force hospital and three social security hospitals). This process was essentially based on structure standards as at that time, the regulatory health system framework did not encourage suppliers to seek accreditation.

On the other hand, in 1993, USAID through the Reproductive Health Support Project, (PASARE)[18] developed by the MSH, implemented standards on different aspects of reproductive health care, counseling, technical competence, IEC, adequate organization of services, management and support services. Based on these, continuous reproductive health improvement projects were developed that involved the entire facility. This forced the other services (dentistry, pharmacy) to change too. In 1998, the MINSA and USAID 2000 Project [19] developed basic standards for maternal perinatal care quality and accredited eighty maternal perinatal hospital services. Monitoring carried out two years later determined that only 12 of these hospitals complied with those standards.

The ongoing accreditation process was designed based on lessons learned on the experiences described, which showed that:

- Accreditation should be implemented as a process within the Quality Management System
- Process and result standards should be included, in addition to structure standards

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14 *RM No. 511-96-SA/DM of August 21, 1996*

15 *RM No. 673-96-SA/DM of November 19, 1996*

16 *RM No.261-98-SA/DM of July16, 1998*

17 *RM No.768-2001.SA/DM of December 20, 2001.*

18 *Project developed at EsSalud hospitals and MINSA of the Regions of Libertadores Wari, Ancash and José Carlos Mariátegui.*

19 *Developed in the Regions of Libertadores Wari, Ancash and José Carlos Mariátegui.*

- Accreditation should trigger continuous quality improvement processes in the entire facility and not only in one service.
- It is necessary to count with quality standards for facilities at all care levels so accreditation can involve the entire health sector.
- Accreditation should comprise public and private health care services.
- Inter-relate the authorization, categorization and accreditation as complementary elements within the quality assurance framework.
- Amend legislation to include accreditation as a requirement so the facility can provide the Comprehensive Health Insurance service.
- Strengthen competences for accreditation at all levels.

The following were approved: In 2006, the "Manual for Continuous Quality Improvement"[20] and in 2007 the Technical Document on "Quality Standards and Indicators in Maternal and Perinatal Care Quality" at health facilities that comply with Obstetric and Neonatal Functions"[21] and the "Technical Health Standard for Accreditation of health facilities and support services"[22].

Quality Situation at the MINSA Central Level

A series of interventions were carried out in the country as part of the Health Sector Reform, addressed at improving quality in the delivery of services at MINSA facilities. Each on contributed with valuable models, methodologies and instruments. Unfortunately, only some of them carried this forward despite huge technical and financial efforts invested.

With financial support from USAID, Pathfinder International participated in the preparation of many of these tools through Project 2000 and Catalyst. Its technical assistance continued during the execution of the Cooperation Agreement addressed at quality improvement in services at first and second care health facilities. Various activities took place with officials and authorities of the MINSA central level and DIRESAs, with the purpose of recovering the use of the Health Quality Management System, approved by Minister's Order in 2001[23].

The Agreement contributed to socialize the standard through Macro Regional Technical Meetings and Regional Workshops[24] with DIRESA staff and health networks who received

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20 *RM No. 640-2006/MINSA of July 14, 2006.*

21 *RM No. 142-2007/MINSA of February 13, 2007*

22 *RM No.456-2007/MINSA of June 4th, 2007*

23 *Quality Management System approved in December 2001 through RM 768-2001 SA/DM. During the development of the Cooperation Agreement, this regulation was improved and updated by the Health Quality Directorate through RM 519-2006 MINSA.*

24 *The purpose of the three-day regional workshops was to train 30 facilitating experts who in turn would transmit their colleagues at micro-networks and facilities, complex concepts and skills little know at this point at operative levels. The*

training to facilitate dissemination and implementation of the standard. These activities could not be fully carried out because facilitators had other responsibilities. At the end of the process and despite all the efforts, the Regional Quality Management System could not be implemented, among other reasons, due to the absence of methodological quality management and improvement proposals encompassing all Health Sector institutions, especially those in reference to technical-administrative and service providing aspects.

Therefore, the Project focused its technical assistance on the implementation of components in the Quality Management System at the Regional Health Directorates, particularly, Assurance and Improvement. The emphasis was put on the MINSA Sub Sector due to coordination difficulties in sector activities given the characteristics and policies in each Sub Sector.

strategy prepared also included monitoring of trained staff; as well as supervision of duplications, measurement of standards and preparation and execution of improvement projects.

2. THE QUALITY MANAGEMENT SYSTEM

2.1 CONCEPTUAL FRAMEWORK

In June 2001, the Ministry of Health created an organizational unit in charge of setting up the Health Quality Management System in the country, which was defined by Minister's Order No.768-2001-SA/DM in 2001 and updated in 2006 through Minister's Order No. 519-2006/MINSA as part of the decentralization process. The latter contains the "principles, standards, methodologies and processes for the implementation of the Quality Management System addressed at quality improvement of health care services"[25]. The Quality Management System proposed by MINSA was a structure based on four components: Quality Planning, Quality Organization, Quality Assurance and Improvement and Quality Information. Even though due to their nature all of them are inseparable, for illustration purposes, the following is the individual progress made in four of the Agreement intervention regions: Junín, Huanuco, Pasco and Cusco.

2.2. QUALITY MANAGEMENT SYSTEM COMPONENTS

2.2.1 Quality Organization

In order to comply with one of the strategies of the Coordinated Regional Health Plans PRCS, that was to establish a Regional Quality Management System, the four regions were organized in the different administrative levels. The *"Regional Quality Management Technical Committee"* was established in Junín, Pasco and Cusco, the *"Quality Management Thematic Committee"* was established in Huanuco as coordination, consulting and proposal spaces[26] that depend on the Regional Health Board. At the end of the project, these were special effective in Junín y Huanuco.

Quality Management Teams[27],[28] were established at DIRESAs, networks and micro-networks. These carry out functions according to their level and scopes. For example, at micro-networks, the team's specific function is to implement continuous quality improvement projects at facilities.

Quality-related functions are continuous activities at the four levels: national, regional, local (networks and micro-networks), de-concentrated entities and health facilities. For this

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25 *Technical Document "Health Quality Management System" of May 30, 2006*

26 *These coordination spaces were made up by: the Regional Government, , DIRESA, EsSalud, Armed and Police Forces Sanitation, Professional Associations, Universities, Civil Society, among others*

27 *At DIRESA, Teams were made up by the Sub-Directorate, People's Health Directorate, Planning Directorate, Comprehensive Care and Quality Directorate, Quality Official, Human Resource Official, and Sanitary Strategies Officials*

28 *In the networks, these teams were made up by the Network Director, the Comprehensive Health Insurance Official, Sanitary Strategies Officials, Health Promotion Official, Human Resource Official and the Epidemiology Official*

purpose, in Huanuco, Junín, Pasco and Cusco, the Project took part in the preparation of Coordinated Regional Health Plans and to the establishment of Technical Committees or Thematic Committees in charge of system implementation. Meanwhile, in Ucayali y San Martín, their Health Program was prepared in a different way. These Committees were formed as structures of the Regional Health Boards.

As was previously indicated, political, organizational, technical and human resource setbacks[29] in the regions made the integration of Health Sector institutions difficult. Therefore, efforts were focused on the creation of an Institutional Quality Management System at DIRESAs to ensure the achievement of quality levels at MINSA facilities.

2.2.1.1 Quality in the Regional Government. The Regional Quality Management Technical Committee (CTR-GC)

The Regional Quality Management Technical Committee – CTRGC- was established as part of the structure of the Regional Health Boards, and was made up by representatives of various institutions[30]. In Junín the CTRGC[31] main function was to prepare coordinated technical proposals to facilitate the implementation of the Regional Quality Management System, whose strategic objective was approved by the Junín Coordinated Regional Health Plan (PRCS).

In Huanuco, the Committee was named Regional Quality Thematic Committee, established in 2003. Its members mostly belonged to different health sector institutions. In view of the refusal of the Regional President to sign the common agenda with USAID, activities were suspended (six months after having begun the PRCS implementation), right at the time of the transfer of capabilities to the team and the consolidation of the committee. Despite of this, at the initiative of key actors, activities were carried out addressed at quality improvement and the achievement of the strategic objective. For example, the thematic committee's experience was shared with the Cusco team in 2005 during the implementation of its PRCS.

The Pasco region established its CTRGC after approving the PRCS. The Committee used to meet on a monthly basis headed by the DIRESA Quality Director until the approval of its work plan in 2007 when it stopped its activities.

In Cusco, the CTRGC was quite ephemeral due to political problems between the Regional Government and DIRESA, which prevented its consolidation. The change in regional authorities in 2007 has improved the relationship between both institutions, which resulted in a better functioning of the Committee.

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[29] *Among which we can mention: lack of leadership and regulatory technical acknowledgement by DIRESA; dependency on local EsSalud branches and the Armed and Police Forces at its central office; lack of organization in the private sub-sector*

[30] *Regional Government, Regional Health Directorate (DIRESA), Regional EsSalud Management, Universities, National Police and Army Sanitation, Professional Associations, and other representatives of Civil Society*

[31] *Committee members were acknowledged through RD No.899-2006-DRSJ/OEGDRH.*

The Ucayali DIRESA is very weak. Its Regional Health Board (CRS) hardly ever meets, except during the preparation of the Regional Health Plan when a popular consultation was carried out. The Quality Management System was never placed on the CRS agenda and the weakness and low commitment of DIRESA High Management did not allow developing this initiative.

At the beginning, the San Martín region established its Regional Health Board (CRS) but due to continuous political problems between the Regional Government and the Regional Directors, the Quality Management System was not established. In addition, the old conflict between EsSalud and MINSA over the ownership of the regional hospital was an impediment for arriving at agreements. It is seemingly contradictory that a region with such an important achievement in quality at its facilities, as shown by the obtainment of two National Quality Awards from the National Industries Association, has not been able to organize a Regional Quality Management System.

2.2.1.2 Quality at Regional Health Directorates (DIRESA). Quality Management Teams

At the beginning of the Cooperation Agreement in July 2004, there was limited organization for quality management at DIRESAs. In addition, the term "quality" was associated to resources and specialists. Officials who knew more about this matter supported the intervention but the others gave little value to sanitary management, which resulted in weak political support. Added to this was the high rotation of key staff members. Only as of 2006, key positions became more stable because people were appointed by the Regional Governments. Finally, at DIRESAs there is a Quality Directorate, Unit or Office but in many cases only one person (not a team) is in charge of all the tasks, which is a limitation.

When the Project began, none of the seven regions had made progress in the establishment of its Quality Management System. Among other things, this was due to little dissemination of the standard, the lack of tools and instruments to make it operative and the absence of qualified human resources to implement it[32]. Efforts made to count with Quality Management Teams from DIRESAs were unsuccessful even though Ministerial Order 041-2005 MINSA established the guidelines for their organization and operation. At DIRESAs, these teams were authorized (see Table 7) to comply with the central level requirement, but they operated irregularly without having full knowledge that their mission was to strengthen quality at health facilities. In practice, quality is more an individual and not a group responsibility. They are people with great management capability that despite the economic, administrative and resource difficulties have managed to make DIRESAS obtain acknowledgments such as the National Quality Award, as in the case of the San Martín Region.

[32] *In the seven regions, it was verified that even though they were the beneficiaries of several projects with strong investments in health staff training, there were no qualified staff categories. Many trainees had left or simply wanted to keep a low profile due to criticisms made to their posts as officials or as persons belonging to the 1990-2000 government regime.*

Table 7: Approval of Technical Quality Management Committees

REGIONS	Directors' Orders for the establishment of the Regional Quality Management Committee and Quality Management Team DIRESA
AYACUCHO	*RD N°450-2002-DESP/DG-DIRESA*
CUSCO	*RD N°059-2007-DRSC/DG-DPH(24-07-07)*
HUANUCO	*RD 288-2007-GR-HCO-DRS-DG-DEASP (04-06-07*
JUNIN	*RD Nº 476-2007-DRSJ/OEGDRH*
PASCO	*RD Nº 204-2005-DG-DIRESA/GR PASCO*
SAN MARTIN	*RD Nº 149-2007-DIRES-SM/DEG-RR-HH*
UCAYALI	*RD N°128-2007-DG/DIRESA-UCAYALI*

2.2.1.3 Quality at Health Networks and Micro-networks. Quality Teams

The situation at the Networks and Micro-networks was not any better at DIRESAs. The fact that many networks were not Budget Executing Units was a limitation due to the technical and administrative dependency on DIRESA. At present, many networks only exist as a formal organizational structure; they do not count with staff or their own budget. Furthermore, some of them do not have a different structure from that of hospitals. The network director is also the hospital director and results in inconveniences such as lack of time to organize and manage both bodies.

On the other hand, the network head hospitals had a complicated organizational climates and efforts to solve this clashed against authoritarian management styles, absence of teamwork, conflictive interpersonal relationships, lack of trust and motivation y addition to lack of provision of equipment and staff. In many cases, the appointment of quality officials had more to do with the need to cover MOF and ROF posts rather than to develop quality functions in the network.

Hospital medical staff, but for a few exceptions, had little involvement in favor. On the contrary, they demanded solutions that were out of the hospital or network scope or accepted the leadership of activities that they did not assume in practice. The project's efforts to improve this situation had little repercussion.

As previously mentioned regarding DIRESAs, the involvement of quality officials (mainly obstetricians and nurses) was key. At the beginning of the intervention, many of them had academic limitation in quality management, which they managed to overcome through training and technical assistance provided by the project to DIRESA and networks.

At a micro-network level, a critical factor was the inexperience and high rotation of professional staff (and to a lesser extent, of technical staff). Many were carrying out their SERUMS, therefore, their permanence at the facility had a deadline, which made difficult to set up quality teams in networks and micro-networks. Senior staff members who had more knowledge about the problems in the area, had plans to further their studies, which broke up many teams that were working well, due to the initiative and leadership of these same professionals. This situation became worse in view of the absence of an incentive and motivation policy for professionals to make they stay in remote areas more attractive.

In the same way as in the networks, the level of knowledge and skills of professional staff (including the micro-network heads) on quality management at the facilities was scarce. In addition, they had difficulty in considering all the facilities in their jurisdiction as a service producing unit or basic functional unit to be supervised and taken care of, and assumed that their responsibilities were limited to the facility where they worked. They thought the problems of the other facilities in the micro-network were none of their business. Finally, they were afraid to measure quality standards because they thought this was equivalent to an evaluation and eventually, they could be sanctioned for deficient performance.

Despite what was previously mentioned, quality management teams were organized in networks and micro-networks of the seven regions (Table 8), even though in some micro-networks and facilities these teams exist just by name and quality activities are carried out by the quality official or the official in charge of the sexual health and child component strategy.

Table 8: Quality Management Teams (EGC) established in the total Networks, Micro-networks and Hospitals Intervened

Region	Networks			Micro-networks			Hospitals		
	Total	with EGC	% with EGC	Total	with EGC	% with EGC	Total	with EGC	% with EGC
TOTAL	**22**	**19**	**86**	**111**	**76**	**69**	**19**	**19**	**100**
Ayacucho	3	3	100	8	6	75	2	2	100
Cusco	3	2	67	24	18	75	2	2	100
Huánuco	2	2	100	20	14	69	2	2	100
Junín	4	3	75	18	10	38	7	7	100
Pasco	3	3	100	14	10	71	2	2	100
San Martín	4	4	100	21	15	71	2	2	100
Ucayali	3	2	67	6	3	50	2	2	100

2.2.2 Quality Planning

Quality Planning is the component that defines general quality policies that coordinate design processes and system development. It involves all institution levels, from

executives to operators and includes the definition of objectives and policies, design and preparation of strategies in all the health system bodies. One of the weakest points in the regions was the "formal" involvement of the executive level. Sometimes the support given was only limited to incorporating in the Annual Operative Plans (POA), some quality activities or signing agreements with the central office for measuring quality standards. Upon conclusion of the "planning" stage, these agreements and commitments became the responsibility of the Quality Unit, which worked without staff or resources. Despite this fact, the following progress was made.

2.2.3 Quality Assurance and Improvement

Quality Assurance is the series of actions that are deliberately and systematically carried out to establish standards and monitor and improve performance of staff and facilities in a continuous way so care service can be effective, efficient and safe. Continuous Quality Improvement is the methodology to achieve the established standards and indicators based on the application of assurance instruments. Quality Assurance and Improvement ensures users good services provided by the institution.

Quality assurance and improvement is based on defining quality standards measured through indicators. The first measurement is carried out by the quality teams through a self-evaluation to help identify gaps ("improvement opportunities") between the standard ("ideal") and the indicator observed. Then, teams should carry out interventions through the PMCC to close this gap and monitor its achievement through periodic and continuous measurements.

The project worked with the regions on maternal perinatal and infant quality standards defined by MINSA. The sequence began with training of management teams in standards and their measurement. Then, it continued with self-evaluation or first measurement and the identification of "improvement opportunity" on which continuous improvement projects (financed with own resources or local government support) were based. This was followed by technical assistance in subsequent measurements until the standard was achieved.

The implementation of continuous quality improvement projects has allowed to:

- Re-direct the purchase of products and goods through the SIGA (Information System on Administrative Management), review the request for medicines of the SISMED and direct the scheduling of purchase of supplies[33]
- Know the standards of the Referral and Counter-referral System (which the staff at the majority of facilities did not know about) as a quality standard.
- Improve the attracting system to SIS affiliations.
- Comply with comprehensive care standards for children and pregnant women.

[33] *When verifying the non-compliance of a certain standard, they would notice this depended on a product that was not being included in the purchasing schedule*

- Contribute to the compliance of standards related to lab tests by implementing them as a product foreseen in comprehensive care standards for children and pregnant women
- Coordinate the MN work with its peripheral facilities
- Link activities of PROMSA, HR, sanitary strategies, etc.
- Identify training needs of staff based on self-evaluation of standards
- Measure the effectiveness in the use of SIS resources through an evaluation of the achievement of a standard linked to a certain product
- Identify gender and infant violence problems by measuring standards in pregnant women and children
- Direct human resource policies by motivating staff with incentives to make progress in continuous improvement.

2.2.3.1 Strategy for implementing Continuous Quality Improvement processes in Micro-networks.

In 2003, the Catalyst Project incorporated information and contents on the Quality Management System of its Training Program to improve the response capability for Obstetric and Neonatal Emergencies at the micro-networks. This was not enough to improve quality at health facilities. Neither was training through regional workshops carried out by MINSA, which made it necessary to directly reach micro-network health staff through a joint work – DIRESA, Networks – to boost improvement in care service quality.

The Cooperative Agreement strategy was addressed at generating a quality measurement and improvement culture. It had two stages. In the first, health staff was organized and trained and in the second, direct technical assistance was provided to the micro-networks for monitoring activities. One of the main concerns was having a Quality Team at each micro-network, made up by workers of all facilities and not only of the head micro-network. Through horizontal involvement and democratic leadership, the goal was for everyone, professionals and non-professionals, to be involved in decision-making.

Not all network and micro-network officials agreed on the democratization of decisions, probably for fear of losing authority or of internal problems. However, in many cases the proposal created personal and institutional renewal, organization and development. For example, the Pongo de Caynarachi, Jepelacio and Huimbayoc micro-networks – winners of the Quality Award of the Industries Association – who assumed the challenge of working as a team in a coordinated and systematic way.

On the other hand, without neglecting the attendance to workshop trainings, the new strategy included direct and frequent technical assistance to micro-networks. In addition to complying with commitment and agreed tasks, this allowed interacting on problems, needs and expectations with the workers, thus creating a relationship that facilitated the establishment of a quality culture. The staff acknowledged that it was simpler to apply

maternal and infant standards after understanding the underlying logic on measurement and improvement of quality standards for first care level facilities.

2.2.3.1.a Quality Standard Chronology.

To achieve the indicator of Intermediate Result No. 1: "50% of health facilities developed quality improvement processes", an interrelation strategy was designed among all levels of the Ministry of Health. This included working with MINSA officials (especially with the Executive Health Quality Directorate, DECS, and the National Sexual and Reproductive Health Strategy, ENSSR) and DIRESA to generate political support to the micro-networks. Networks and micro-networks were also included to empower health staff on continuous improvement and service quality culture.

Between 2004 and 2005, technical assistance was provided to micro-network health facilities for the application of quality standards for first care level. When these were temporarily suspended, maternal perinatal quality standards were applied at facilities that complied with Basic Obstetric and Neonatal Functions (FONB). Later, the application of maternal perinatal quality standards were included for facilities that complied with Primary Obstetric and Neonatal Functions (FONP), quality standards for facilities that complied with Primary Infant Functions (FIP), and quality standards for facilities that complied with Essential Obstetric and Neonatal Functions (FONE).

The experience gathered allowed to duplicate the work since July 2006, when the Accreditation Regulation was passed, using the methodology and list of standards for accreditation of health facilities in a dynamic and participate way.

2.2.3.1.b Technical assistance to the regions in the application of quality standards and indicators for the first care level.

In 2004, the project and the Executive Health Quality Directorate, (DECS), of MINSA agreed on providing technical assistance to the regions in the intervention area, summarized as follows:

i. Encourage the application of Quality Standards and Indicators for the First Care Level, published in 2002 by the Quality Assurance and Accreditation Directorate.
ii. Support the dissemination and application of Quality Standards and Indicators for First Care Level of MINSA.
iii. Promote a quality culture in micro-networks based on standard measurement and their improvement through the execution of improvement projects.

b.1) Quality improvement and DIRESA

Setting up a favorable climate for quality improvement requires for health staff to acknowledge the importance of the issue and apply the tools and methodology in their daily practice. A key aspect was the commitment and support given by

the DIRESA Director and his Management Team and by the Quality Official. They were sensitized in the need to count with a quality team and organizational guidelines at DIRESA, networks and micro-networks.

A work plan was coordinated with DIRESA Quality Officials that included the following:

- Election of a Quality Official at each network and micro-network.
- Establishment of Quality Management Teams at DIRESA and networks and Quality Teams (made up by 5 workers trained in Quality Management at the micro-networks
- Involvement of training officials of DIRESA and networks, monitoring and evaluation of quality activities in the region.
- Dissemination and sensitization of all workers at the micro-network on continuous quality improvement.
- Monitoring of standard measurement and improvement at each micro-network and the involvement of staff in these activities.
- Evaluation of results obtained in the measurement and execution of improvement projects through regional technical meetings.

b.2) Implementation of activities with Micro-network health staff

Work organization at micro-networks began with the identification and selection (carried out by quality officials of DIRESA and networks) of five workers to make up the quality teams. These were trained[34] in 18 three-day Regional Workshops[35] and in which six or seven micro-networks participated. After the training, the application of standards and the preparation and execution of quality improvement projects was supervised.

b.3) The National Quality Award of the Industries Association

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[34] *The following was the training content:*
- *Introduction to health quality.*
- *The Quality Management System*
- *Tools for measuring and evaluating health quality*
- *Quality standards and indicators for first care level*
  - *Guideline for self-evaluation of quality*
  - *Internal and external users surveys*
  - *Software to enter information and data analysis*
- *Continuous Quality Improvement*
  - *Identification and prioritization of improvement opportunities.*
  - *Cause analysis of improvement opportunity.*
  - *Preparation of improvement projects.*
  - *Types of improvement projects*
  - *Planning of improvement cycles*
  - *Monitoring of improvement cycles.*

[35] *In the following regions: Ucayali 2, Huanuco 4, Junín 5, Pasco 2 and San Martín 5*

During the first quarter of 2005, The Executive Health Quality Directorate (DECS) requested the support of the Project for disseminating the methodology used by the National Industries Association in seven regions on the preparation and systematization of improvement projects, based on which it issued Minister's Order 640-2006 "Continuous Quality Improvement Manual" (July 14th, 2006). This document contains the steps and tools for continuous quality improvement in addition to the guidelines for the preparation of projects on quality improvement in order to achieve the Management of Excellency in Quality Improvement.

Five training workshops were organized in Huanuco, Junín, Pasco, San Martín and Ucayali, attended by representatives of DIRESA, networks and micro-networks. A technical meeting was carried out in each region with the network and micro-network representatives, whose quality teams had prepared and executed improvement projects in 2004-2005. The terms and conditions for the "National Quality Award and Acknowledgement of Improvement Projects 2005" were made known and the preparation of the Nomination Report of the project to the award in question was supported.

A Committee appointed by the DECS selected 34 projects around the country out of which 20 corresponded to micro-networks of five project intervention regions. The projects selected were nominated before the Institutional Development Committee of the Industries Association. They went through a strict evaluation process that included the project's documentary review, its relevance and the visit to health facilities for verifying *in situ* changes and improvements produced. The projects carried out by the Pongo del Caynarachi and Jepelacio micro-networks of the San Martín region went to the final stage fo the contest and the award was granted to the **Jepelacio Health Center for the successful results of its project "Cultural Adaptation of Maternal Health Services"**. The conviction of the staff on the importance of community and local authorities' involvement in the execution of improvement projects was crucial in this achievement.

Training of staff for "Cultural Adaptation of Maternal Health Service".

Adaptation of delivery room for attention in vertical position

Two years later, another micro-network in the San Martín region was given the "National Quality Award and Acknowledgement of Improvement Projects 2007" with the project **"Together against Malaria in Huimbayoc 2004-2007"** for having reduced the cases of malaria by *Plasmodiun vivax* from 1,217 to 8, and the cases of infection by *Plasmodiun falciparum* from 523 to zero.

Space Spraying: Fumigation

2.2.3.1.c Maternal perinatal quality standards for facilities that carry out basic obstetric and neonatal functions (FONB); primary ones (FONP) and Essential ones (FONE)

Maternal and infant mortality is a sanitary problem which needs prioritized attention in the country. Therefore, it is necessary to know the maternal perinatal care quality in health facilities, measured through standards. In the absence of the latter, the project prepared a standard proposal[36] in 2005 for facilities that carried out basic obstetric and neonatal functions (FONB). The proposal took into account the type of facility and care level, so every standard and indicator referred to the response degree the facility should offer based on the Obstetric and Neonatal Functions (FON) model that considers four types:

- Primary Obstetric Neonatal Functions (FONP)
- Basic Obstetric Neonatal Functions (FONB)
- Essential Obstetric Neonatal Functions (FONE)
- Intensive Obstetric Neonatal Functions (FONI)

After this classification by Functions, MINSA prepared a Health Facility Categorization Standard, taking into account 3 levels and 8 Categories, whose obstetric and neonatal functions are shown on Table 9.

Table 9: MINSA Health Facilities by Care Levels and Categories

Care Level	Category	Obstetric and Neonatal Function
First Level	I - 1	Primary Obstetric Neonatal Functions (FONP)
	I - 2	
	I - 3	
	I - 4	Basic Obstetric Neonatal Functions (FONB)
Second level	II - 1	Essential Obstetric Neonatal Functions (FONE)
	II - 2	
Third level	III - 1	Intensive Obstetric Neonatal Functions (FONI)
	III - 2	

Selected Standards:

[36] *The proposal received contributions developed by the Quality Assurance Project (QAP) and other tools previously prepared by Project 2000 such as the Perinatal Information System (SIP2000) and the instrument for determining the Obstetric and Neonatal Resolving Capacity of health facilities (FON). Likewise, it copied the quality model proposed by Dr. Avedis Donabedian, who in 1966, introduced the concepts of Structure, Process and Result, which constitute the dominant paradigm in the evaluation of health care quality.*

Structure:

- "Resolving Capacity of Health facilities on Resources". Facilities at all function levels (FONP, FONB, FONE and FONI), should comply with no less than 80% of its resolving capacity on resources.

Process:

- Prenatal care
- Follow up of pregnant women
- Childbirth care
- Post-partum care
- Newborn care
- Newborn Resuscitation
- Care of obstetric complications
- Care of neonatal complications
- Family planning

Result:

- User's satisfaction
- Childbirth Plan and institutional childbirth
- Institutional care coverage
- Perinatal Mortality
- Perinatal Morbidity
- Gender-based violence

In addition to standards and indicators for FONB facilities, complementary instruments were prepared to evaluate the quality in facilities: instructions with the forms for data-gathering and estimation of indicators; Excel spreadsheet for reporting and monitoring and survey of pregnant women and new mothers to measure user's satisfaction after prenatal care and childbirth, respectively.

The proposal on standards and instruments was coordinated and discussed with the National Sexual and Reproductive Health Strategy (ENSSR) and the Executive Health Quality Directorate (DECS) that took it up and disseminated it in ten regions of the country in July 2005. They provided guidelines and monitored progress directly. The project assumed its dissemination, training and monitoring in the 7 prioritized regions.

Its validation in the regions during the first stage allowed identifying inconsistencies in standards and instruments, which were discussed during the first "Technical Meeting on the Analysis of indicators in Continuous Quality Improvement in Maternal and Perinatal Health"[37], with representatives from the regions. The relevant amendments were approved and its application was started in September 2005.

[37] *The technical meeting was organized by the ENSS, with financing of the project's Coverage with Quality and technical assistance from Pathfinder International*

The successful experience in the application of FONB maternal perinatal standards resulted in the preparation in 2006 of standards for FONP, FONE and FONI facilities, again through coordinated work between DECS, the ENSSR of MINSA, and the Project's technical team. Once these were validated, MINSA approved them through Minister's Order 142-2007/MINSA through the Technical Document "Quality Standards and Indicators in Maternal and Perinatal Care at Facilities that carry out Obstetric and Neonatal Functions". It then became a basic tool to achieve quality in pregnant women and newborn care.

c.1) Application of maternal perinatal standards in the 7 regions

The application of maternal standards made it possible to coordinate the work from the central level up to the micro-network in a different way from that of the application of quality standards for the first care level. Participating in this process were the heads of the micro-networks and quality and sexual and reproductive health strategy officials. Regional training workshops[38] were carried out, with the presence of seven or eight micro-networks at each one. Monitoring and coaching mainly covered the micro-network heads, which are the ones that carry out basic obstetric and neonatal functions, including the micro-networks considered a priority by DIRESA, even though some of them requested for these standards and indicators to be measured in all their facilities.

[38] *Training included:*

- *Quality subject matters and tools*
  - *Definition of Quality and Health Quality*
  - *Paradigm and change*
  - *Quality Management System (Components, Organization /Assurance and Improvement*
  - *Continuous quality improvement: Self-evaluation, prioritization and opportunity analysis*
- *Maternal perinatal quality standards for FONB facilities*
  - *FONB Standards and indicators*
  - *Self-evaluation of FONB standards*
  - *External user opinion polls*
  - *Report sheet and monitoring of FONB standards*
- *Continuous improvement cycle*
  - *Improvement projects*
  - *Investment projects*
  - *Cooperation projects*

c.2) Maternal perinatal standards for hospitals

At the beginning of the project, only the staff of hospitals in the Ucayali, San Martín, Junín and Ayacucho regions knew about continuous quality improvement as they had participated in Project 2000. At these hospitals, even though not on a regular basis, the quality Implementing Teams in charge of measurement and improvement operated, and used Self-supervision of 25 maternal and neonatal standards used by Project 2000. During 2004 and 2005, technical assistance was provided to these teams to continue with this work and to make facilities comply with quality standards. This was a requirement to qualify as a Training Center, within the Competence Development Center model also promoted by the project.

Even though there were Implementing Teams, hospitals did not count with Quality Management Teams aimed at achieving sanitary results. In most cases, there was only one person in charge of quality activities; but they did not count with the support of the facility's High Management, and in many cases, not even with that of their own colleagues. Medical staff, especially specialists at a hospital level, had little involvement despite efforts developed. Those who did participate were obstetricians and nurses.

Out of the seven DIRESAs of the project, Ucayali, Junín and Cusco, count with hospitals (category II-2) in the capital of the department and in several support hospitals (category II-1) in their provinces. Huanuco has a regional hospital (Hermilio Valdizán) category II-2 and one (Tingo María Hospital) category II-1. Pasco, has a hospital II-1 and two facilities I-4 (Oxapampa and Villa Rica) that work as a facility II-1, they have a surgical center and are located halfway from a facility with resolving capacity to attend obstetric emergencies. San Martín has a hospital II-1, (Moyabamba Hospital) and a facility (Tarapoto

Maternal Perinatal Center), with essential maternal neonatal resolving capacity (FONE). Finally, Ayacucho only counts with a II-2 hospital; its other facilities belong to category I-4.

Table 10: Health Facilities that carry out Essential Obstetric and Neonatal Functions trained in FONE standards

Region	Hospital	Category
Ayacucho	Regional de Ayacucho	II-2
Cusco	Regional del Cusco and Antonio Lorena	II-2
Huánuco	Hermilio Valdizán	II-2
	Tingo María	II-1
	Carlos Showing Ferrari	I-4
Junín	Daniel A. Carrión and El Carmen	II-2
	Domingo Olavegoya (Jauja), La Merced (Chanchamayo, Junín (Junín), Felix Mayorga Soto (Tarma), and Manuel Higa Arakaki (Satipo)	II-1
Pasco	Daniel Carrión	II-1
	Oxapampa	I-4
San Martín	CMP de Tarapoto	I-4
	Moyabamba	II-1
Ucayali	Regional de Ucayali and San José de Yarinacocha	II-2

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After launching quality standards for FONE facilities, the preparation of a work plan was coordinated for its application that included training[39] of health staff in managing standards and indicators, instruments for obtaining them (SIP 2000 and FON), quality instruments and the methodology for preparing improvement projects. In total, 19 facilities participated in this process. Table 10.

c.3) Maternal perinatal standards for health centers

In July 2006, MINSA launched maternal perinatal quality standards for facilities that carry out primary obstetric and neonatal functions (FONP); and some months later, infant standards for facilities that carry out primary infant health functions (FIP). As a result, the staff in charge of applying them was not the

[39] *Training included:*
- *Quality Management System*
- *Maternal standards for essential facilities (FONE)*
  - *Instruments and Guidelines*
  - *User-satisfaction surveys (APN and post-partum)*
  - *SIP 2000 and FON*
- *Tools and methodologies for continuous quality improvement*
  - *Identification and prioritization of improvement opportunities.*
  - *Cause analysis of improvement opportunity.*
  - *Preparation of improvement projects.*
  - *Types of improvement projects*
  - *Planning of improvement cycles*
  - *Monitoring of improvement cycles.*

professional or technical staff of micro-network heads, but rather technical staff from the periphery, which required training them in the application methodology of standards and improvement processes.

Comprehensive Care Directors and officials in charge of the Child Component, Quality and ENSSR of DIRESAs organized training meetings[40] and technical assistance at the micro-network heads to ensure direct involvement of technical staff in the training and not through duplications.

Technical and professional staff of health posts and centers felt motivated by the training and by the presence of officials from the networks and DIRESA with whom they established a productive dialog. These officials were able to verify in situ the limitations, strengths and material conditions of facilities in the periphery, all of which resulted in proposals for solutions.

2.2.3.1.d Infant quality standards

Concern for care of children under five made possible the implementation in 1996 of Comprehensive Care of Prevalent Infant Diseases (AIEPI), at health facilities in the country and which was institutionalized in 2006[41] as an intervention strategy within the Comprehensive Health Care Model (MAIS) to reduce morbidity and mortality in children under five. As it is know, comprehensive care is addressed at the child not only for prevention but also for underlying or underestimated health problems.

d.1) New infant standards.

Infant health care quality standards point towards comprehensive care. In February 2006, coordination was carried out with the Child Component Area of the Comprehensive Care Directorate to prepare and implement infant health quality standards for facilities that carry out basic and primary infant functions (FIB and FIP). A proposal on standards, indicators and measurement instruments was presented based on the application experience of maternal perinatal quality

[40] *Training included:*
- *Introduction on health quality.*
- *Quality Management System*
- *Tools for measuring and evaluating health quality*
- *Maternal standards for primary facilities (FONP)*
  - *Instruments and Guidelines*
  - *User-satisfaction surveys (APN and post-partum)*
  - *Continuous quality improvement*
  - *Identification and prioritization of improvement opportunities.*
  - *Cause analysis of improvement opportunity.*
  - *Preparation of improvement projects.*
  - *Types of improvement projects*
  - *Planning of improvement cycles*
  - *Monitoring of improvement cycles.*

[41] *RM 506-2005/MINSA institutionalized infant care strategy AIEPI*

standards. Due to the importance the first care level has for MINSA, standards were prepared for facilities that carry out primary health functions (FIP), keeping in mind that facilities, categories I-1, I-2 and I-3, would be in charge of their application. Based on the experience of this application, standards and indicators could be prepared for facilities I-4 that carry out Basic Infant Functions (FIB); then for those who carry out Essential Infant Functions (FIE); and finally for those which carry out Intensive Infant Functions (FII). Altogether, 10 standards and indicators were defined.

Proposed standards:

Structure:

- "Resolving Capacity of health facilities on Resources". An adequate service delivery for children under 5 requires that facilities at all functional levels carry out no less than 80% of functions that correspond to them.

Process:

- Child health surveillance systems in the family and community.
- Effective referral and counter-referral of children under five.
- Comprehensive care of children under five ensured by the AIEPI methodology.
- Children under a comprehensive care plan.
- Parents and/or guardians should be informed of the child's health at the end of the medical visit in order to know what care to provide them at home.

Result:

- Children of the health facility jurisdiction with birth certificates.
- Children with adequate growth rates.
- Children with adequate development rates.
- Children with complete vaccinations.

The proposal was thoroughly discussed with central level officials and their contributions were included. At the end of May 2006, standards began to be applied in Ayacucho and Cusco and then in other regions. Management Science for Health, MSH that works in infant health in communities of the Alternative Development Program (PDA) was in charge of training and transferring health staff to these jurisdictions, the management of instruments (standards, instructions, methodology, etc.) used by the Cooperation Agreement in its improvement strategy.

d.2 Simultaneous application of primary maternal and infant standards in the micro-networks.

In September 2006, when they launched the primary infant standards, it was decided to continue with the intervention strategy that followed the primary maternal perinatal standards; the decision was to integrate the training and

monitoring processes of both lists as these would be applied by the same health staff.

In virtue of agreements between Comprehensive Care Directors and officials in charge of the Child Component, Quality Officials and the ESSR of each DIRESA, a training [42] schedule was organized, which included Technical Meetings for all micro-network health staff addressed at the application of primary maternal and infant standards, notwithstanding the professional profile. Based on deficient standards found, improvement projects were prepared and executed. Coordination was carried out with DECS of MINSA taking into account the Manual for Continuous Quality Improvement in order to apply a single methodology in preparing these projects.

2.2.3.1.e Regulations and accreditation standards.

The first known accreditation for health establishments can be traced back to 1993, when the Ministry of Health appointed an Inter-institutional Sector Committee for Hospital Accreditation. This Committee was in charge of developing accreditation instruments, such as a Hospital Accreditation Manual and Guideline, approved in 1996. Between 1997 and 1999, the regulatory framework was established as well as the elements and processes required for executing the accreditation program, which included orders approving the process for public and private hospitals, orders authorizing certifying entities, a coordination, policies and procedures office, certification entities and an order promoting self-evaluation of health facilities as a requirement for their accreditation.

After six years of preparation and two of implementation, there was little success: the Ministry of Health did not regulate the accreditation process adequately and the private Certifying and Accrediting Entities governed the process and instilled it with their self-profiting logic. Costs were too high for public or mixed management hospitals and only six large hospitals, five private ones and one of the Armed Forced were able to be accredited, with the aggravating circumstance that the first and second care levels were practically excluded. Towards 2000, this accreditation was almost

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[42] *Training included:*

- *Introduction on health quality.*
- *Quality Management System*
- *Tools for measuring and evaluating health quality*
- *Maternal and infant standards for primary facilities (FONP and FIP)*
  - *Instruments and Guidelines*
  - *User-satisfaction surveys (APN and post-partum)*
- *Continuous Quality Improvement*
  - *Identification and prioritization of improvement opportunities.*
  - *Cause analysis of improvement opportunity.*
  - *Preparation of improvement projects.*
  - *Types of improvement projects*
  - *Planning of improvement cycles*
  - *Monitoring of improvement cycles.*

extinguished due to lack of credibility and the development of alternative proposals from investment projects.

There was consensus in the health sector for improving the accreditation model, making it unitary, democratic and equal and including human resources (health executives and workers) which constitute critical elements for accreditation and quality improvement. Since the beginning of the nineties, after getting over the "lost decade" in health, investment projects and diversified international cooperation began to invest in health workers' training programs.

Between 1992 and 2000, the approach on the workers' performance improvement was consolidated in the policies and practice of the Ministry of Health. The experience achieved in clinical skill training, in the improvement of service delivery in the first care level and self-supervision of health care services were the pioneers in a new accreditation concept, which gives autonomy to the effort of the service delivery teams themselves, through self-evaluation and leaves MINSA with the role to regulate and promote self-regulation.

In December 2001, the Ministry of Health institutionalized its quality policies with the approval of the National Health Quality Management System, and identified it as a basic principle in health care. It set forth that quality can be defined as the series of technical-scientific, material and human characteristics that health care should have in the constant search for user's satisfaction. In 2002, the quality standards and indicators are prepared for the first care level, in coordination with the decentralized Health Ministry directorate team, public and private entities involved in this issue and technical cooperation entities.

It is in this context that Technical Accreditation Norm No. 050-MINSA/DGSP-V.02 was approved. It was first approved on July 26, 2006, reviewed and once again approved with very few amendments on June 4, 2007. The effective Norm gathers aspects that already existed in the first version such as self-evaluation during the first stage of the quality improvement process, accreditation committees with more than one member, the decentralized criteria of the operation and incentives for accredited facilities, among others.

Notwithstanding the progress mentioned above, the Norm and its corresponding List of Accreditation Standards was the result of a long, hard and at times, unnecessary review, involving theoretical and ideological discussions led by MINSA, whose regulating role is oftentimes paradoxical, as officials make decisions based on their own criteria and not on the needs of the country.

e.1) Application of accreditation standards for health facilities.

Since the end of 2005, the Executive Health Quality Directorate (DECS) strengthened the Quality Assurance and Improvement Component in the Quality Management System, among other things with the Accreditation of health

facilities. The project took part in the preparation and validation of Technical Health Norm No. 050-2006/MINSA/DGSP- V.1 for the Accreditation of Health Facilities and Medical Support Services, as well as in the List of Standards for accreditation of such facilities, approved by Minister's Order 703-2006/MINSA, on July 26, 2006. The second version of the Accreditation Norm was approved in June 2007 with Minister's Order 456-2007/MINSA.

The project contributed to its application in San Martín, Cusco and Huanuco DIRESAs. Through Technical Meetings, officials, internal examiners and health staff of hospitals and micro-networks were trained on the following issues:

- Care quality at health facilities in the region
- Quality Management System
- Health accreditation: Scope of the Norm and instruments
- Self-evaluation during first stage of Accreditation process
- Concepts and methodologies of accreditation evaluation techniques.
- Analysis of Self-evaluation techniques
- List of standards for internal evaluation of health facilities
- Accreditation Software
- Field experience: application of list of standards
- Preparation of plan for Self-evaluation of their health facilities
- Conclusions and commitments

e.2) Sensitization on the accreditation norm at DIRESAs.

Addressed to DIRESA officials, it included the dissemination of responsibilities and tasks arising from the Norm; and the joint preparation of a work plan for its implementation in hospitals and micro-networks. Accreditation Committees were established in hospitals and micro-networks; technical and administrative health staff was selected and Internal Examiners were trained in self-evaluation of standards according to the category of health facilities.

e.3) Initial application of the Accreditation Norm in the San Martín Region.

In San Martín, 20 micro-networks were trained on the norm. The self-evaluation processes were carried out in health facilities in four micro-networks, which applied the list of accreditation standards according to their category. As can be seen on Table 11, during this first measurement, the large majority did not even comply with 50% of standards, which shows the precarious conditions in which these facilities provide services. Only the Jepelacio Health Center, the head of the micro-network of the same name, surpassed 85% of standards required for its category (I-3). The same did not happen with the other three facilities in its jurisdiction.

Results show that the main deficiencies are found in the macro-processes related to service delivery, especially in outpatient care, hospitalization and emergency.

Next in order of importance come macro-processes on referral and counter-referral, management of medicines, information, supplies and materials, equipment and infrastructure. These results clearly show the precariousness with which first care level facilities develop their activities; and at the same time, they are an appeal for carrying out strong investments in human resource training and in the purchase and maintenance of equipment and supplies. The San Martín DIRESA continues with the process and the person in charge of quality carries out analysis meetings with the micro-networks, encouraging the preparation of improvement projects to overcome deficient standards.

Table 11: Results of self-evaluation of Accreditation standards in San Martín

Network	Micro-network	Facility	Score	Rating
San Martín	Urbana 2	HC Morales	**33**	Does not Qualify
		HP Catacachi	**37**	Does not Qualify
		HP San Antonio Río Mayo	**17**	Does not Qualify
		HP Churuzapa	**19**	Does not Qualify
		Las Flores de Río Mayo	**11**	Does not Qualify
		HP Rumizapa	**24**	Does not Qualify
		HP Maceda	**18**	Does not Qualify
		HP Panchilla	**12**	Does not Qualify
		HP Santa Ana Río Mayo	**10**	Does not Qualify
	Cuñumbuque	HC Cuñumbuque	**39**	Does not Qualify
		HP San Rafael de Río Mayo	**6**	Does not Qualify
		HC Zapatero	**39**	Does not Qualify
		HP Nuevo Celendin	**46**	Does not Qualify
		HP Progreso	**11**	Does not Qualify
		HP Uchumullaca	**22**	Does not Qualify
		HP Carañayacu	**12**	Does not Qualify
		HP Santa Cruz de Shitarayacu	**20**	Does not Qualify
		HP Bagazan	**5**	Does not Qualify
		HP Nuevo Mundo	**32**	Does not Qualify
		HP San Juan de Talliquihui	**28**	Does not Qualify
		HP Alto Andino	**25**	Does not Qualify
Rioja	San Fernando	HP Atumplaya	**42**	Does not Qualify
		HP Perla Mayo	**39**	Does not Qualify
		HC San Fernando	**29**	Does not Qualify
Moyobamba	Jepelacio	HC Jepelacio	**89**	Qualifies
		HP Carrizal	**36**	Does not Qualify
		HP Shucshuyacu	**48**	Does not Qualify
		HP Nuevo San Miguel	**53**	Does not Qualify

e.4) The Accreditation process of health facilities in the Cusco region.

In Cusco, Accreditation in the Regional and Antonio Lorena hospitals and in the micro-networks of the La Convención and Cusco Norte networks was assumed by the Quality and Sanitary Management Directorate of DIRESA. The staff[43] responded in a heterogeneous way. Even though they acknowledged the importance of accreditation, they were unsure of their capacity to achieve it.

[43] *Directors and Deputy Directors; management teams, quality teams and department and service management*

Added to this was the dissatisfaction with the current hospital categorization, deficiencies in infrastructure and equipment, the ineffectiveness of some arrangements, loss of identity with the institution, frustration and dissatisfaction of workers, and a deteriorated organizational climate, among others.

Progress was slow. It took many weeks to choose the Accreditation Committees and the Internal Examiners and much more time to organize and conduct self-evaluation. Despite of this, little by little workers and executives are assuming the challenge of improving care quality in the two hospitals with greater resolving capacity in the region.

Work with the micro-networks was less complicated. A schedule was established with the La Convención and Cusco Norte networks for informing staff and training internal examiners at each micro-network. The first self-evaluation results were foreseen for November 2007. The schedule included monitoring and supervision of the Self-evaluation processes, the implementation of improvement cycles by the networks as well as the final supervision by DIRESA.

2.2.3.1.f The Technical Norm on Referral and Counter-referral

In 2004, MINSA published the "Technical Norm on Referral and Counter-referral of the Ministry of Health Facilities"[44], to ensure continuity in care within the Comprehensive Health Care Model by organizing facilities into networks, in the context of Decentralization and citizens' right to health. The Norm includes processes and procedures of the National Referral and Counter-referral System.

During 2005 and 2006, the norm was disseminated in various macro-regional workshops to which staff from DIRESAs and networks attended. Each region in turn organized the necessary structures and procedures for referral and counter-referral, coordinated with the Maternal Infant Insurance (SMI) and to the Comprehensive Health Insurance (SIS).

f.1) Referral and Counter-referral, SRC, a macro quality process for accreditation of health facilities.

The fifteenth Macro-process of the Accreditation Norm for Health Facilities and Medical Support Services is the Referral and Counter-referral[45] whose objective is to ensure continuity in health care in a service network, including community

[44] *RM 751-2004/MINSA that approves the NTS 018/MINSA/DGSP-V01 of July 26th, 2004 whose implementation shall be carried out by the Executive Service Managements of the central level and DIRESAs.*

[45] *The Comprehensive Health Care Model of the Ministry of Health is based on universal principles of equal opportunities, care comprehensiveness, quality, efficiency, respect of people's rights, decentralization and citizen involvement. Consequently, all services – promotion, prevention, recovery or rehabilitation – a person receives at the facility or other spaces should be inter-related in continuity so the user can be recruited, identified ,evaluated and followed up within an orderly system, integrating promotional, preventive and recovery care coordinated by resolution levels.*

involvement. This macro-process has four standards and thirteen evaluation criteria. Their compliance ensures users that the health services provide good care.

f.2) Implementation of the Referral and Counter-referral Norm.

The Executive Service Directorates of DIRESAs, with the support of MINSA, organized the administrative and service part of health staff by complexity levels of facilities in the regions for the Referral and Counter-referral System. This task was complicated due to the little resources assigned and high staff rotation. The Project provided technical assistance for the analysis of the system in each region and for the exchange of experiences. It was found that at the level of hospitals, networks and DIRESA the system implementation was good, but that in the micro-networks it was necessary to strengthen the community organization regarding referrals. This is precisely one of the indicators of the management agreements subscribed by DIRESAs.

During the implementation of the Norm, the need arose to count with a computer tool to register RC quantitative and qualitative indicators. Pasco, Cusco, Junín and Huánuco each prepared local software, using various strategies to share lessons learned: regional macro workshops for exchanging progress in computer designs for the SRC, radio conferences to share experiences in hospitals and operative units in the application of a care quality measurement instrument of referrals and internships (Oxapampa network) for learning "in situ" about the system documentation. The Project and DIRESAs selected pilot networks (see Table 12) in the 7 regions to ensure the full implementation of the system, updating their flow maps and list of services provided for health facilities that make up the network.

Table 12: Prioritized networks for the implementation of the Referral and Counter-referral System

Region	Network	No. of Micro-networks
Ayacucho	Huanta	2
Cusco	Cusco NorthNetwork	12
Huanuco	Leoncio Prado	10
Junín	Chanchamayo	4
Pasco	Oxapampa	7
San Martín	San Martín	9
Ucayali	Coronel Portillo	5

Of all the projects prepared for continuous quality improvement, 22% had the purpose of putting into effect and implementing the referral and counter-referral system at health facilities intervened in the project.

2.2.4 Quality Information: Instruments

The Cooperation Agreement has contributed to quality information with computer instruments that pursue the progress of Project 2000 and the Catalyst project in this field:

2.2.4.1 For accrediting health facilities

2.2.4.1.a Accreditation System for Health Facilities and Support Medical Services. Accreditation Application 1.0

The ACCREDITATION Application 1.0 is an instrument for the timely digital compilation and storage of data registered in the "Evaluation forms for accrediting facilities", useful for decision-making of health networks, DIRESAS and MINSA. The Accreditation Application includes a visual, intuitive and user-friendly interface and an internal management of business rules (validations) with help messages and options to facilitate the use of the keyboard. It is easy to use and adapts to the different users, cutting down learning time on its use and training costs. The characteristics and requirements of the system are found in Annex 7.

2.2.4.2 For maternal perinatal standards

2.2.4.2.a Improved Maternal Perinatal Information System (SIP2000)

Care of pregnant women and newborns use the Maternal Perinatal Information System (SIP2000) to register data on health conditions of pregnant women or new mothers, the development of the fetus and newborn, as well as other diagnostic, therapeutical and maternal perinatal management information, from beginning to end. Patients' development is monitored and assessed individually for decision-making based on evidence as part of continuous improvement.

Through the SIP 2000, permanent indicators are obtained about a certain condition or situation during the different stages of pregnancy: prenatal, childbirth, care of incomplete abortion, care of pregnancy complications, mother's discharge, care of newborn and discharge status of newborn. Automation of clinical information facilitates timely processing of data and is useful for the facility, health staff and patients.

The SIP 2000 was approved by Minister's Order No. 008-2000-SA/DM of January 17, 2000 (see Annex 8) that orders its obligatory use at all facilities of the Regional and Sub-Regional Health Directorates, and the Maternal Perinatal Institute and

entrusts the General People's Health Directorate with its implementation. SIP 2000 instruments are:

- Maternal Perinatal Clinical Record
- Prenatal Control Card, and
- Analytical Application of Maternal Perinatal Production and Service Quality Indicators

These instruments replace the Base Perinatal Clinical Record and the Analytical Application of the Latin American Center for Perinatology and Human Development (CLAP)[46] based on which these were developed. Over the last three years, this system was optimized with COMPLEMENTARY MODULES that allow the automatic cross reference of variables.

a.1) System Components

1. Maternal Perinatal Clinical Record (HCMP)

The Maternal Perinatal Clinical Record registers data provided by the patient and what the examiner observes at each visit, from the first prenatal visit.

Structure of the HCMP (See Annex 9)

The Record is made up of four pages with the following:

Page 1	Page 2	Page 3	Page 4
Particulars and background	Main observations of prenatal care.	Childbirth care / Post-abortion care	Discharges and Re-admissions
Baseline data of current pregnancy	Specific indications of prenatal care	Care of newborn	Discharge indications
	Maternal Pathologies, with date and diagnose of diseases or events experienced by pregnant woman following the CIE10 coding.	Puerperium	Epicrisis
	Principal and more frequent pathologies related to pregnancy, delivery and puerperium.	Principal and more frequent pathologies related to newborns.	Principal indicators of operative delivery or induction and medication

2. Maternal Perinatal Card (CMP), see annex 10.

[46] *The Maternal Perinatal Clinical Record was developed based on the CLAP Basic Perinatal Clinical Record. Participants were: health staff that provides maternal and perinatal care at all levels and categories in facilities; national experts as well as members of the Obstetrics and Gynecology Association and the Pediatrics Association through multi-skilled National Workshops. It was validated in 18 Hospitals, 32 Health Centers and 72 Health Posts and at present its use has extended to more than 80% of facilities of the Ministry of Health.*

To systematically register data of each pre natal care visit. The idea is for each pregnant woman to carry updated information with her on her pregnancy development to be used in case she goes to another health facility. The card contains the curves on "Uterine Height per Gestational Age" (percentiles 10 to 90) and the curves on "Weight Gain by Gestational Age" (percentiles 25 to 90) developed by the CLAP.

3. Analytical Application of Maternal Perinatal Production and Service Quality Indicators

The Analytical Application software is used for digitally compiling and storing data registered in the Maternal Perinatal Clinical Record (HCMP) based on which timely and reliable information can be generated to build indicators in maternal perinatal care to help make decisions based on evidence in the different care levels of the health system.

This Application was developed prioritizing a user-friendly interface. Data is entered from the first prenatal care visit and systematically at each visit, so there is permanent follow up of the pregnant woman. Each stage of the pregnancy, delivery, puerperium, fetus development and newborn care process is evaluated. It allows to program house calls for pregnant women who do not attend their doctor's appointments, or in view of some risk factor, they need closer supervision.

4. Parts of the Application

Part I: Particulars and Background: To enter data on particulars, obstetric background, family and personal background and previous pregnancy data, if it were the case. Data considered as ALERT appear in yellow.

Part II: Baseline Data of Current Pregnancy: Data on normal, current weight, height, date of last menstruation, previous and current anti-tetanus vaccine doses, blood type of pregnant woman, emergency hospitalization or care, luetic serology and hemoglobin tests according to MINSA regulations, psychoprofilaxis and general clinical test, as well as some special analyses.

Part III: Pre-natal Controls/Checkups: To enter data of each checkup and to have access to them. It plots the uterine height in relation to the gestational age and weight gains based on normal weight following the Tables prepared by the CLAP.

Part IV: Maternal Pathologies: Helps enter diagnoses of the different maternal pathologies according to the CIE 10 and the date such diagnose is carried out

Part V: Delivery and Post-abortion:

Part VI: Neo-natal Pathologies: Helps enter diagnoses of the different newborn pathologies according to the CIE 10, including diagnosing date

Part VII: Newborn, Discharges and Re-admissions:

5. Application Structure (See Annex 11)

When the Application is opened, some icons appear on the screen for each type of reports that can be obtained, such as:

- Database: Contains information on the total number of pregnant women attended at the facility during their different pregnancies, the number of existing Clinical Records in relation to prenatal and childbirth care, including appointment dates.
- Editing: Helps add new care of a same pregnancy and multiple pregnancies (twins, triplets, etc). You can look up Clinical Records of patients who have already given birth or that are still undergoing their checkups.
- Quality: Shows reports related to information quality, for example filling out or inconsistency Control.
- Indicators: Shows reports on the frequency of pathologies, its distribution and a group of pre-established care quality indicators
- Analysis: Contains health statistics, cross-reference of variables and risk assessment
- Tools: Helps configure the facility, network and staff that works in the maternal infant area. It shows the Tables used in preparing the System
- Reports: Provides data on pregnant women with critical pathologies, that come in or not for their checkups, causes of mortality, and information on pregnant women whose measurement parameters do not agree with the gestational age
- Help: Part of the system that responds to doubts on the management of the System

a.2) Complementary Module BABIES[47]

The name of the modules is the plural form of the word baby in English, BABIES, and includes two variables: a) weight at birth, and b) age at death of the fetus or newborn considered as indicatives of maternal health condition, social condition of women and neonatal survival forecast. Both indicators are combined in the BABIES matrix, which turns it into a simple yet powerful tool to help determine the problem, assess performance, choose the intervention and monitor and evaluate the process.

[47] *Built for SIP 2000 based on a group of indicators developed at the Atlanta CDC with support from CARE and successfully used in Tanzania.*

B: BIRTHWEIGHT
A: AGE OF DEATH
B: BOXES
I: INTERVENTION
E: EVALUATION
S: SYSTEM

BABIES orders the weight group at birth and age of death in the boxes resulting from these two variables. Cases are grouped by intervention categories, therefore they are a useful tool for informed decision-making that can be used at all levels: community, health centers, hospitals and DIRESAS.

From the SIP 2000 database, BABIES uses the variables of weight at birth and age of death to obtain death frequencies and specific mortality rates per one thousand born in an established group. This changes the normal one-dimensional look on mortality (per weight or per gestational age) to a two-dimensional one where the weight and age are cross-referenced. Comparison in time of indicators resulting from these combined variables will allow knowing the main causes of death and determine interventions to prevent maternal infant death.

BABIES Module Report (See Annex 12)

a.3) Probable Delivery Module

Provides a list of childbirths that should occur within a certain period of time in the jurisdiction of the facility to help identify pregnant women who are close to giving birth in order to carry out a follow up so the delivery can be institutional. The module warns about anything in the pregnant woman's background that should be taken in mind during care (for example, cesarean operations, how many, multiple pregnancies, etc.) to act correctly and carry out a reference to prevent harm in the patient. The report of this module indicates the probable delivery date based on Walt's rule or Nagele's rule, clinical record number, name of pregnant woman, address and important background information.

Probable Delivery Module Report (See Annex 13)

a.4) Complementary Referral and Counter-referral Module:

It helps to identify the causes why a pregnant woman is referred to a certain facility following the diagnose decision established in the CIE X.

a.5) Deceased Newborns Module

Provides specific information on newborns born alive that die. The report indicates the newborn's clinical report number, its name, mother's clinical

record number, mother's name, date of birth, pregnancy termination date, newborn's weight upon birth, gestational age at birth and main reason for death.

Deceased Newborns Report (See Annex 14)

a.6) Report Module for Production of Maternal Perinatal Services

Provides information for MINSA's Reproductive Health Strategy on health service production. It includes all care levels and contributes to significantly cut down data-gathering time to optimize time engaged in health service delivery. Information gathered refers to the type of pregnancy (low risk, high risk), house calls provided, frequency of prenatal care, adolescent care, clinical tests, place for birth deliveries, and type of personnel in charge of this and newborn conditions. It also provides information on critical pathologies related to pregnancies and that could have repercussion in the newborn.

Service Production Module Report (See Annex 15)

2.2.4.2.b Obstetric and Neonatal Functions

In order to register the compliance of obstetric and neonatal functions at facilities, the FON Application is used. This is software with which data registered in the "FON Forms" is digitally gathered and stored. Its purpose is to gather timely and quality information to generate management indicators for decision-making in the networks, DISAS, and MINSA's Central level regarding allotment of resources to facilities. It was developed using a visual, intuitive and user-friendly interface, with an internal management of business rules (validations) that facilitates its use for all users. Its management training is simple and low cost.

The characteristics of the FON Application, system requirements and form of use are shown in Annex 16.

2.2.4.3 For Infant Standards

Infant Standards for facilities that comply with Primary Infant Functions were developed and disseminated at Level I-1, I-2 and I-3 Facilities (Basically, Health Posts and Health Centers without admission) where they were validated.

The main data source used is the Child's Clinical Report approved in the Care Regulations for Children. The Project worked in coordination with the MSH and MINSA for developing the Computer Application. Activities included:

- Adaptation of the development methodology of the maternal perinatal computer application (SIP2000) to the infant area.
- Evaluation of variables of clinical record to process data.
- Transfer of the application design to the MSH for its development

The Child's Clinical Report was modified by MINSA, which made it necessary to carry out changes in the application under the charge of the MSH.

Upon termination of the Cooperation Agreement, Basic Infant Standards and Indicators (FIB) were prepared for type I-4 Health Centers, which were in the validation phase in October 2007. The Child's Clinical Record shall be used as a data source.

2.2.4.4 For Referral and Counter-referral

Upon termination of the Project, there is software for data gathering on referrals and counter-referrals of patients, whose final version was revised in September 2006.

The development of the software began between April and July 2006, with a failed intent for Pasco and Junín DIRESAS to work in coordination in order for the five other regions of the project to implement this software and subsequently, MINSA in the rest of the country. As this idea was not successful, they chose to work with the Pasco DIRESA software, this being simpler and more viable to duplicate in other regions.

In-person observations made in Oxapampa, Villa Rica (and those carried out in Satipo, Chanchamayo and Tarma; coordination with DIRESAS Huancavelica and Cusco) and coordination with MINSA, reveal that the main limitations for counting with referral and counter-referral indicators have to do with meager financial and staff resources, which prevents the timely registration of data, its analysis and decision-making based on them.

The application developed by the Pasco region has a local approach. However, it can be implemented in other regions as an initial stage in order not to delay more the registration of referrals and counter-referrals and to efficiently obtain indicators. For the future, this application should be adapted to MINSA's software standards.

At the closing of the project, Pasco and Junín are implementing the software each developed, while Huancavelica created a monitoring instrument for referrals and counter-referrals in EXCEL.

2.2.4.5 For periodic Certification of Medical Professionals

For registering files of applicants for re-certification as general practitioners or specialists, an information system has been designed called Certification and Re-certification System of the Medical Association of Peru. It is a data processing tool in which the evaluation of each applicant is compiled and processed by the Review Committee of the Medical Association of Peru. For more details on this instrument see Annex 17.

It consists of the following icons:

Main Menu

Used to register files, status (Received, Being Reviewed, Passed, Failed), the Review Committees and Users who operate the SISTCERE System.

Files (Data Entry)

Used to register data of files received, once entered, users who operate the SISTCERE, can register the evaluation status (Being Reviewed, Passed, Failed) according to the file case.

STRATEGIC PRODUCT 1: QUALITY MANAGEMENT SYSTEM

ACHIEVEMENTS	
QUALITY PLANNING	
➢ Work Plans of Quality Directorates and/or Quality Units of the Junín, Pasco, Huánuco, Cusco, San Martín and Ucayali DIRESAs approved by the respective General Directorates. ➢ Measurement and continuous improvement of maternal – perinatal quality standards included in the Annual Operative Plans (POA) of the Junín, Pasco, Huánuco, Cusco, San Martín and Ucayali DIRESAs. ➢ Self-evaluation of Accreditation standards in the pilot MN included in the 2007 Management Agreements between the DECS of MINSA and the Junín, Pasco, Huánuco, Ayacucho, Cusco, San Martín and Ucayali DIRESAs. ➢ 100% of micro-networks (12) of the Tarma, Chanchamayo and Satipo networks, and the El Carmen Hospital of the Junín region took part in the Validation of Accreditation Standards pilot for categories I-1; I-2; I-3; I-4; II-1 and II-2 included in Technical Norm 050-MINSA/DGSP-V.01 2006.	
QUALITY ORGANIZATION	
Region	➢ 04 Regional Technical Committees of the Quality Management System (CTR-SGC) established and approved: Junín, Pasco, Huánuco and Cusco. ➢ 90% of the members of the Regional Technical Committees of Junín, Pasco, Huánuco and Cusco trained in Quality Management and Continuous Improvement
DIRESA	➢ Establishment and approval of Quality Management Teams in the Junín, Pasco, Huánuco, Cusco, San Martín and Ucayali DIRESAs. ➢ Establishment of Accreditation Committees and Internal Self-evaluation Teams for accreditation standards at the Antonio Lorena Hospital and the Regional Hospital in Cusco. ➢ 100% of the San Martín DIRESA officials and 40% of officials from the Junín, Pasco, Huánuco, Cusco and Ucayali DIRESAs trained in Quality Management and Continuous Improvement.
Networks	➢ 86% (19) networks taking part in the 7 regions with Quality Teams (made up by officials in charge of quality, sexual and reproductive health strategy and child component) ➢ 100% (19) hospitals of the 7 regions with Quality Teams (made up by staff from the maternal and neonatology services) ➢ 70% of staff from the maternal and neonatology services of hospitals in the 7 regions (that comply with FONE) trained in measurement and improvement of maternal standards
Micro-networks	➢ 69% (76) micro-networks taking part in the 7 regions count with a Quality Team made up by officials in charge of quality, sexual and reproductive health strategy and child component. ➢ 69% (76) of the Quality Teams of participating micro-networks in the 7 regions trained in quality improvement and measurement of first level and basic, primary maternal perinatal and infant standards ➢ 50% (20) micro-networks of the San Martín region have Accreditation Committees and Internal Evaluation Teams trained in the first Accreditation phase (Self-evaluation). ➢ 45% (17) micro-networks in the Cusco region have Accreditation Committees and Internal Evaluation Teams trained in the first Accreditation phase (Self-

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	evaluation).
QUALITY ASSURANCE AND IMPROVEMENT	
DIRESA	➢ Quality Teams of the San Martín, Huánuco and Ayacucho DIRESAs execute improvement projects at their facilities. Some of their facilities have deserved first place at the National Meetings on Successful Experiences in Quality organized by the DECS of MINSA between the years 2004 and 2006.
Networks	➢ 100% (19) of the Junín, Pasco, Huánuco, Ayacucho, Cusco, San Martín and Ucayali hospitals evaluated maternal quality standards for facilities that carry out essential obstetrical and neonatal functions (FONE). ➢ 100% (19) hospitals in Junín, Pasco, Huánuco, Ayacucho, Cusco, San Martín and Ucayali prepared maternal quality standard improvement projects for facilities that carry out essential obstetrical and neonatal functions (FONE).
Micro-networks	➢ 70% (79) of the micro-networks in Junín, Pasco, Huánuco and San Martín evaluated first care level standards at their facilities. ➢ 90% ((174) of the micro-networks in Junín, Pasco, Huánuco, Ayacucho, Cusco, San Martín and Ucayali evaluated maternal and perinatal quality standards in facilities that carry out basic obstetrical and neonatal functions (FONB). ➢ 80% (155) of the micro-networks in Junín, Pasco, Huánuco, Ayacucho, Cusco, San Martín and Ucayali evaluated maternal and perinatal quality standards in facilities that carry out primary obstetrical and neonatal functions (FONP). ➢ 63% (70) of participating micro-networks in the regions of Junín, Pasco, Huánuco, Ayacucho, Cusco, San Martín and Ucayali evaluated infant quality standards for facilities that carry out primary infant functions (FIP) ➢ 20% (4) of the micro-networks in the San Martín region count with results from the first self-evaluation of accreditation standards. ➢ 2 micro-networks in San Martín (Jepelacio in 2005 and Huimbayoc in 2007) won the Acknowledgement for Management of Improvement Projects awarded by the National Industries Association.
QUALITY INFORMATION SYSTEM	
National	➢ 31 of the 34 health regions in the country (except Puno, Ica, Callao, including the 7 of the project) used the FON to analyze their resolving capacity based on resources. ➢ 30 of the 34 health regions in the country (except Puno, Ica, Callao, including the 7 of the project) use the SIP2000 to register information from maternal and perinatal clinical records in their main hospitals. ➢ 20 of the 34 health regions in the country (including the 7 of the project) have trained staff at their DIRESAs in the use of the ACCREDITATION Application for processing self-evaluations of Accreditation standards. ➢ 850 health facilities report and/or register maternal and perinatal clinical records in the SIP2000. ➢ The Medical Association of Peru keeps a registry of recertified doctors at a national level in the SISTECERE Application.

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DIRESA	➢ The Pasco and Junín DIRESAs have developed an application to register referrals and counter-referrals in their regions. These were proposed to MINSA for use at a national level in order to obtain indicators of the Referral and Counter-referral System.

II. STRATEGIC PRODUCT 2: POLICY ON HEALTH HUMAN RESOURCES

1. CONCEPTUAL FRAMEWORK OF THE RHUS POLICY

Since 2001, the National Health Policy in Peru explicitly included in the sector's agenda the development of human resources as a condition for enhancing equal opportunities and quality in health care. This happened ten years after a previous reform that failed to include the State's responsibility on various public health functions[48]. Here relies the importance of the 2002-2012 Health Policy Guidelines that comprise the Human Resource Sector Policy and the National Policy Guidelines for Development of Health Human Resources[49] [50] based on competences.

Technical assistance of the Cooperation Agreement in this area was directed to the regions of Huánuco, Junín, Pasco and Cusco whose Development Plans included health human resource management and served as a framework for preparing their Regional Coordinated Health Plans PRCS[51]. Each of them included specific activities for the implementation of National Policy Guidelines for Development of Health Human Resources based on competences according to regional health needs.

48 *Bases for guidance of decentralized management of Health Human Resources, IDREH, 2004.*

49 *National Policy Guidelines for development of Health Human Resources, IDREH 2005*

50 *Minister's Order. RM No. 1007-2005/MINSA of September 2005.*

51 *One of the strategic objectives of the Huanuco PRCS is to improve health human resources at all care levels. The Junín PRCS in its regional policy No. 12 and the Pasco PRCS in its regional policy No. 11 make reference to the development of health human resources based on competences. In its Policy No. 15, the Cusco PRCS indicates the development of human resource competences regarding respect and dignity in comprehensive health care.*

2. PREPARATION OF REGIONAL POLICIES

The Ministry of Health implemented the national policy guidelines through the Human Resource Development Institute, IDREH, based on the creation and consolidation of coordination spaces between social actors in different levels. Guidelines were adapted to the regions through coordinated actions with the Social Development Management of Regional Governments.

2.1 ORGANIZATION OF REGIONAL TEAMS

During a first stage, the strategic importance of the RHUS was disseminated and its connection with sanitary results among staff from EsSalud, Armed Forces and Police Forces Sanitation, private clinics; public and private universities and higher education institutes, regional offices of professional associations and others, summoned by the Regional Health Boards. Afterwards, Regional Human Resource Technical Committees CTR-RHUS were established in Junín and Pasco[52], as well as the Thematic Human Resource Committee, MT-RHUS, in Huanuco[53] [54], approved through Regional Orders, which were in charge of preparing an analysis on the RHUS situation and to adapt and legitimize RHUS national policies in its region.

At the Huánuco, Junín and Pasco DIRESAs [55], (and in some of their health networks[56]) Human Resource Teams were made up to lead the implementation of RHUS policies: the design of work competences, work competence regulations for the first care level, incentives and motivation, selection and hiring of staff, among others. In Cusco, the leadership befell on the Management Team.

The analysis of the RHUS showed similar results in all regions that can be summarized as follows:

- Lack, almost in general, of the competence profile in the creation of RHUS.
- Inexistence of a RHUS Managerial Information System with the involvement of regional actors

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52 *Conformation of the RHUS Regional Technical Committee: Junín, Regional Ordinance No. 047-GRJ/CR; Pasco, Regional Ordinance No. 091-2006-GRP/CR and Regional Executive Order No. 073-2007-GR-PASCO/PRES*

53 *RHUS Development Thematic Committee in Huanuco. Technical coordination instance, advisory services and analysis of RHUS Regional Policies in which educational institutions, public and non-public health service providers, professional associations, regional government and local government participate.*

54 *Conformation of the RHUS Thematic Committee in Huanuco: and Regional Executive Order No. 312-2003/PR (April 30th, 2003) and Re-composition of the RHUS Thematic Committee, Regional Managerial Order No. 334-2006-GRH/GRDS (21 August 21st, 2006)*

55 *Conformation of the Human Resource Committee in the Junín DIRESA: Director's Order No. 235-2006-DRS/OEGDRH; Pasco: Director's Order No.065-2006-DG/CR*

56 *Human Resource Committee of the Oxapampa Network (Pasco) approved by Director's Order No.067-07-DE/RSS-OXAPAMPA and the Chanchamayo Network (Junin approved by Director's Order No.090-06-GR-JUNIN-UTES Chanhcy and re-structuring of the committee by Director's Order No.119-06/GR-JUNIN/UTES CH*

- Lack of coordination of RHUS competences, roles and functions from the regional level to the operative levels (Network, MN).
- Lack of training evaluation instruments to measure its impact at a regional and local level
- Lack of approval mechanisms and acknowledgement of health community agents, notwithstanding their social importance in health actions.
- Lack of specific regulations of RHUS management in the evaluation, selection and hiring process of staff based on competences.
- Limited acknowledgement, motivation and well-being actions for health staff.
- Lack of strategic alliances between the employer and the health worker in the regional and local scope.

Based on these results, an agreement or social pact was prepared among the institutions in the Region (see Annex 18, Agreements Document) for executing the RHUS Policy Implementation Plan (see Annex 19, Work Plan).

3. REGIONAL POLICIES

3.1 POLICY 1: CREATION OF RHUS

The educational supply in Peru continues on the rise but lacks coordination with health care requirements and needs of the population. Policy 1 seeks to reconcile efforts, demands and products from educational institutions that train health professionals, health care service delivery facilities, professional associations, trade associations, civil society and other institutions in the regional scope to guide training of human resources based on occupational profiles required by the Health Care Model currently effective in the country. In this sense, the Cooperation Agreement has contributed with activities detailed below:

❖ **SINEACE Law and Regulation**

Since 2003, several actions were carried out to regulate training and professional exercise through laws:

- March: Technical Meeting[57], of school and faculty associations and professional associations organized by CAFME to discuss a preliminary document on the University Educational System on accreditation and other strategies.
- May: Technical Meeting [58] with politicians and academic authorities to inform them about the experience of the Medical Schools Accreditation Committee (CAFME) and the proposal of the Peruvian Association of Nursing Faculties and Schools (ASPEFEEN), gathering suggestions for the accreditation of universities.
- July: Enactment of the General Law on Education (Law 28044) that included the creation of the National Evaluation, Accreditation and Certification System for Educational Quality (SINEACE) and that made professional certification obligatory in the health field.
- October: Establishment of a Quality Initiative Group in Higher Education, GICES[59], at the request of the Cooperation Agreement to submit proposals and supervise the preparation

GICES
Grupo de Iniciativas para la Calidad de la Educación Superior

[57] *Technical Meeting: "Bill on the National University Educational System and the Future of the Accreditation of Medical Faculties or Schools". Participants were: 35 professionals from CAFME, ASPEFAM, ASPEFEEN, ASPOFOBST, Nurses, Obstetricians, Doctors Associations and cooperating and bilateral agencies.*

[58] *Meeting: "Quality Assurance in University Education" in which academics and experts informed Congress people on the experience of the Medical Faculties Accreditation Committee (CAFME) and on the proposal of Nursing Schools and Faculties, ASPEFEEN.*

[59] *In the last quarter 2003, Pathfinder International summoned professionals to work on the General Law on Education regarding SINEACE, with the establishment of the tasks and initiatives group, GICES.*

of SINEACE's Law and Regulations, together with other institutions[60]. In 2004, the Executive submitted such Bill to Congress, which included elements from the GICES proposal. It was enacted[61], in May 2006, and a year later, the Regulation on July 10, 2007.

3.1.1 Accreditation of Schools and Faculties

3.1.1.1 Accreditation of Medical Schools and Faculties

3.1.1.1.a National Medical Exam (ENAM)

The National Medical Exam is a key instrument for accreditation of Medical schools and faculties. It was developed by the Peruvian Medical School Association, ASPEFAM, to the end of evaluating undergraduate medical education quality in Peru. The Ministry of Health considered it beneficial for the Health Sector and approved its annual application at all medical schools in the country through a Minister's Order[62]. It also ordered MINSA authorities to give facilities to medical interns in scheduling their shifts and service activities in order to take this exam. On its part, the National Medical Internship Committee, CONAREME, established taking this exam (ENAM) as a requirement to apply to the medical internship program for graduates in 2006.

In 2003, after a meeting on National Evaluation Exams Experiences for Medical Students, the Medical Education Committee submitted to the Association Board the proposal for the implementation of the ENAM, which was approved taking into account that the 1st National Medical Exam of 2003[63], should be considered as an operative research applied to students in their 6th and 7th year of study during its pilot phase. Places for taking the exam were at 4 school facilities that offered to participate voluntarily: North (1), Lima (2), and South (1).

The second ENAM took place on November 13th, 2005. Those participating were 1,565 students from internships of 19 faculties or medical schools and 120 professionals and students from other grades.

On November 26th, 2006, the third National Medical Exam was successfully developed in 22 medical schools, members of ASPEFAM, in which 2,306 applicants, including interns (98%), doctors and students, participated.

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60 *Universidad Nacional Mayor de San Marcos (San Marcos National University), National Rectors Assembly, Universidad Nacional de Cajamarca (National University of Cajamarca) and others.*

61 *Annex 20: Law No. 28740. Law on the National Evaluation, Accreditation and Certification System for Educational Quality (SINEACE). May 19th, 2006. It regulates the evaluation, accreditation and certification processes of educational quality, defines the participation of the State and regulates the scope, organization and operation of SINEACE, referred to in articles 14 and 16 of the General Law on Education No. 28044.*

62 *Annex 21: Minister's Order No. 620-2006/MINSA, July 6th, 2006 (published in the El Peruano Newsletter on July 10th, 2007). National Medical Exam.*

63 *Up to then, the only experience on a National Exam in the country was the one from ASPEFAM for the two last years of education.*

3.1.1.1.b Strengthening and consolidation of CAFME: accreditation standards, standard verifiers and external verification.

In 1999, the first University Accreditation System was created in the country through the Committee for Accreditation of Medical Faculties or Schools, CAFME. During that year, in view of the excessive growth of these faculties, a work group was formed sponsored by MINSA with the involvement of the Medical School, the National University of San Marcos, the Cayetano Heredia Peruvian University, the National Medical Academy and the Peruvian Association of Medical Faculties. This group designed a bill, which was enacted as Law No. 27154[64], which created CAFME as an autonomous entity.[65]

CAFME[66] has prepared minimum standards for accrediting Medical Schools or Faculties, approved by Supreme Order No. 013-2001-SA of January 5th, 2001. It selected and trained a first group of verifiers of these minimum standards and included all Medical Faculties and Schools in the accreditation process. Between April and October 2002, the first seven faculties were accredited while the CAFME's work continued in updating and improving current regulations on accreditation, revision, restructuring and validation of minimum accreditation standards and in increasing the number of trained verifiers. At the end of the Project, minimum accreditation

64 *Annex 22: Law No. 27154 - CAFME*

65 *CAFME is headed by a MINSA delegate and made up by representatives of the Ministry of Education, the National Rectors Assembly, CONAFU and the Doctors Association. .Their advisors come from the National Medical Academy and the Peruvian Medical Faculties Association, ASPEFAM.*

66 *Procedures Manual approved by Minister's Order No. 196-2002-SA-DM, of January 23rd, 2002.*

standards were reviewed and updated in 2003[67], to include contents of the AIEPI strategy, and again in 2006[68].

The Ruling of the SINEACE Law [69] published in 2007, orders ceasing of CAFME functions, which up to then was in charge of accrediting medical schools and faculties, transferring such functions to higher university education institutions (CONEAU).

During its life, CAFME managed to:

- *Accredit 23 out of the 29 medical faculties and schools in the entire country.*
- *Stop the creation of new medical faculties*

3.1.1.1.c Experimental Laboratory for Evaluating Health Science Competences

In 2004, ASPEFAM decided it was necessary to have an evaluation system for medical students that not only included theoretical knowledge but also practical experience on clinical competence. The model chosen was an Experimental Clinical Competence Evaluation Laboratory (LEEC) created as the main nodule of a network made up by evaluation centers for specific issues (regional epidemiological situation) in different parts of the country. The LEEC focus is on the medical student's training evaluation at a first moment and on other health professions in the future. It counts with a technical team made up by teaching doctors and representatives of the obstetrics and nursing school associations.

The idea of the LEEC sprung from a visit made by ASPEFAM members in 2003 to the National Board of Medical Examiners, NBME, in the U.S. In 2005, its cooperative design[70] and implementation began with a first technical nucleus in ASPEFAM that consolidated in 2005-2006 with the carrying out of two important workshops[71].

Upon conclusion of the Cooperation Agreement, the Laboratory has managed to:

- ✓ Motivate and make associations and faculties interested in the use of the LEEC for competence evaluation.
- ✓ Train 18 teachers in the evaluation methodology of clinical skills developed by FAIMER, and
- ✓ Prepare 11 cases of simulated patients for the validation process

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67 *Annex 23: Supreme Order No. 004-2003-SA CAFME Standards – July 24, 2003 (AIEPI Strategy: indicator 49.1 of variable 49).*

68 *Supreme Order No. 007-2006-SA approved on July 24, 2006.*

69 *Annex 24: Regulation of the SINEACE Law published on page 348782 of El Peruano Newsletter on July 10, 2007).*

70 *Technical assistance comes from NBME and the Foundation for Advancement of International Medical Education and Research (FAIMER), with the participation of members of technical committees from ASPEFAM and representatives from ASPEFEEN, ASPEFOBST and the Cooperation Agreement.*

71 *2005 Workshop "Clinical Skills Evaluation Exam". 2006 Workshop "Experimental Laboratory for Evaluation by Competences." Participants were: 18 Peruvian teaching doctors that constitute the specialist technical team on this issue and NBME and FAIMER professionals.*

Based on the progress made in the National Medical Exam and the Laboratory, the Project contributed to the first stage[72] with the implementation of a Health Teachers Training Center, CEDS, to strengthen teachers' skills in medical faculties and schools to train and evaluate by competences. The current scenario is favorable as a result of the regulation of the SINEACE Law.

3.1.1.1.d Medical Faculties Management School

A study made by ASPEFAM revealed limitations in the academic management of medical faculties. Therefore, it was decided to establish a Medical Faculties Management School addressed at creating high and intermediate management teams with the purpose of increasing efficiency and quality in the operation of their programs, improving management capacities of the university system as a whole and consolidating a self-evaluation university model to guarantee quality in medical education and health care for the Peruvian population[73].

The School's activities began in 2003 with Faculty Deans and Medical School Directors. From then on, the target group comprised officials from various levels who were trained on critical management knots: Clinical field management and Curriculum by Competences, research methodology in medical education and academic supervision, among others.

Upon conclusion of the Cooperation Agreement, the following achievements can be highlighted:

- ✓ Development and validation of a curriculum for team training
- ✓ Preparation of video or printed teaching aids
- ✓ Development of the virtual course "ProMédicos Perú "[74]

3.1.1.2 Accreditation of Nursing Faculties and Schools

3.1.1.2.a Basic curricula for education in obstetrics and nursing: A valid Methodology for improving educational quality

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72 *The first stage included the preparation of: a) an analytical report on instruments developed by the ENAM and the LEEC and methodologies for evaluation of competences at medical faculties and schools; b) conceptual, methodological and instrumental bases for the CEDS project, and c) report on the prospective analysis for the inclusion of evaluation by competences at ASPEFAM member faculties.*

73 *Competences of School graduate*
- *Use of a strategic approach in understanding problems and opportunities of its Faculty and in the preparation of proposals for institutional development.*
- *Use of own administration concepts and theories for proposing innovative quality improvement strategies at the School*
- *Proactive management of its organization*
- *Use of theoretical and regulatory instruments for administrative management for upgrading management at the Faculty.*
- *Ethical attitude and leadership in university and sanitary management in their sphere.*

74 *Has financial sponsorship from the Merck Foundation*

The discrepancy between higher health education and the needs of the population and the sanitary system motivated the obstetrics, nursing and medical schools and faculties to undergo at different times and with different styles, reforms in their curricula to provide their respective schools and faculties with updated and standardized study programs in tune with health sector guidelines and reality.

This effort for improving quality in professional education was started at the obstetrics schools and faculties (under the direction of the Peruvian Association of Obstetrics Schools and Faculties - ASPEFOBST) and spread to the nursing and medical faculties under the name of nuclear curriculum. Previously, nursing and obstetrics education was based on a bio-medical health perspective when working requirements included higher grades in the preventive-promotional area. In this sense, the curricular reform (based on competence approach) in obstetrics and nursing is a self-adaptation educational exercise to labor market requirements – especially those of the Ministry of Health, which is the principal employer – in the absence of a regulating authority, through the definition of performance standards for each professional by level of complexity.

The preparation of the basic obstetrics and nursing curriculum by ASPEFOBST and ASPEFEEN and educational institutions comprised the analysis of the main actors' setting, the updating of approaches and the demographic, social and cultural health trends, labor market, professional competence and educational supply, among others. Workshops and technical meetings were carried out and the process also included the creation of committees, work teams and interest groups. In addition, it comprised the conceptual, contextual and organizational strengthening of schools and faculties.

Basic nursing curriculum. In nursing, ASPEFEEN's decision resulted from self-evaluation and external evaluation in 2004. It received technical assistance from ASPEFOBST (and from the National Learning Service from Colombia, SENA), for developing skills in the preparation methodology of the basic competence approach curriculum for continuous improvement of educational quality. ASPEFEEN and ASPEFOBST's joint interest shows a unique technical assistance form for strengthening each other and sharing experiences and lessons learned in addition to implementing strategies to mobilize resources more efficiently.

Self-management is an element worth mentioning in this process, especially for updating issues such as child and adolescent care, the AIEPI strategy (included through a strategic alliance with PAHO together with other health promotion strategies to decrease infant and maternal morbi-mortality), progress in public health, adult and elderly health, management and administration, women health and gender and research. The project contributed to strengthening the inclusion of AIEPI components.

The final version of the basic curriculum was approved at a general dean's assembly in 2006. It includes competences in maternal perinatal health, AIEPI and communication and health promotion. Two National Exams have been carried out. The standardized curriculum contains competences every nursing student should acquire during his or her education at any faculty or school in the country. Its purpose is to close the gap between what the demand requires and academic preparation. It is headed at each university by the Curricular Committees that self-evaluate the status at each one regarding the basic curriculum and work towards achieving an education that is compatible with the demand.

3.1.1.2.b National Nursing Exam (ENAE)

In the absence of standardized procedural and methodological criteria for evaluating nursing graduates, in 2004, the Peruvian Association of Nursing Schools and Faculties, ASPEFEEN, approved the "National Nursing Exam", ENAE, in 2005.

Similarly to the ENAM, the ENAE has also been designed to contribute to quality improvement in undergraduate programs. It provides educational quality assurance in Nursing and it is an instrument for evaluating the competence of graduates using appropriate technologies to assess comprehensive learning, including the knowledge, technology and values in caring for people, the family and the community. Competences include skills for solving complexity problems in various scenarios; combining knowledge and practice, ethics and critical standing in face of reality and proposing improvement in comprehensive Nursing care.

3.1.1.2.c Profile by competences of nursing graduates, self-evaluation Committees, Training of external Examiners

Between 2002 and 2003, ASPEFEEN, with technical and financial support from USAID, prepared the educational profile of graduates from the Undergraduate Programs of the Nursing Faculties/Schools [75] that describes competences students should have upon finishing their educational process to ensure good working performance, which is efficient, rational, critical, ethical and scientifically and technological trained. The definition of competences was based on functional areas and the vital cycle stages included cross-curricular topics such as mental health, health communication and education.

[75] *Annex 25: Workshops for the Educational Profile of Nursing Graduate in the Under-graduate Programs:*
- ✓ *Comprehensive Contextual Analysis for the Preparation of the Educational Profile of the Peruvian nurse at an undergraduate level.*
- ✓ *Methodology for the Preparation of the Nursing Educational Profile at an undergraduate level based on Competences.*
- ✓ *Preparation of the Nursing Educational Profile at an undergraduate level based on Competences.*
- ✓ *Workshop on the Integration of the Nursing Educational Proposal at an undergraduate level based on Competences.*

At the same time, quality standards were prepared for the accreditation of Nursing Schools and Faculties[76], focused on basic criteria for institutional operation. Then, quality criteria in teaching were initially included based on the Colombian model, which consists of a two-level system:

- Basic Quality Standards of essential program operation aspects assessed through documents and that originate continuous improvement plans
- Quality Standards for the Nursing Undergraduate Program[77] based on the Graduate Profile. These assess results of Improvement Plans resulting from the evaluation of Basic Standards.

ASPEFEEN's Basic Quality Standards comprise 9 areas. They include 32 variables and 68 indicators and their respective verification sources in a continuous improvement sequence[78] ranging from self-evaluation to accreditation.

A group of teachers from different institutions of the country were trained as external examiners or evaluating peers. Training of the first 26 examiners (from 12 universities), was in 2006[79] and of other 43 (from 18 universities) in May 2007. To September 2007, 44 out of 47 nursing schools and faculties nationwide had concluded their self-evaluation and 30 had had external evaluation visits. The preparation of second level standards is still ongoing.

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[76] *Five macro-regional workshops were developed to socialize the proposal on Basic Quality Standards with the participation of representatives from nursing faculties and schools nationwide.*

[77] *Annex 26: Basic Quality Standards for Nursing Undergraduate Programs*

[78] *Sequence for accreditation: a) Self-evaluation of Basic Quality Standards, b) Continuous Improvement Proposals, c) External Peer Visiting, d) Continuous Improvement Proposals, e) Self-evaluation of second level Quality Standards, f) Continuous Improvement Proposals, g) External Peer Visiting and h) Accreditation.*

[79] *Was in charge of an Advisor of the National Accreditation Committee from Colombia, CNA*

3.1.1.3 Accreditation of Obstetrics Schools and Faculties

3.1.1.3.a Basic Curriculum

The Peruvian Association of Obstetrics Schools and Faculties, ASPEFOBST, began quality assurance activities in 2003 with a national study[80] on maternal perinatal health. Based on this data and the analysis of different study curricula, it prepared a basic curriculum that contained essential aspects to be complemented with the needs of each institution and each region. Representatives from all obstetric schools in the country were involved.

The above mentioned study and three macro-regional workshops helped identify local gaps between the reproductive health situation, competences required by the obstetrician and the needs of reproductive health care which gave way to care strategies according to the demand.[81]

At the beginning of 2005, the preparation of the basic obstetrics curriculum was finished and validated in pilot obstetric faculties and schools.

3.1.1.3.b Accreditation of obstetrics faculties and schools

At the end of 2006, when the standardized basic curriculum and profile of the obstetrics career graduate were finished, ASPEFOBST prepared quality standards for the accreditation of obstetrics faculties and schools and a guideline for self-evaluation of standards[82] for accreditation. These were validated in 6 faculties in different regions and at a workshop to which 24 out of the 25 obstetrics faculties/schools from all over the country attended. Its final version was finished in July 2007. Twenty-six examiners were trained at 10 pilot faculties and schools; these in turn formed peer or external evaluating teams. In September 2007, self-evaluation started at the 10 pilot faculties/schools and at other non-pilot ones at their own initiative with technical assistance from ASPEFOBST.

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80 *The study included the application of two surveys, one addressed at users and the other to professionals in obstetrics in departments that count with faculties or schools that train obstetricians*

81 *Annex 27: ASPEFOBST SR Analysis and Strategy. Report on 3 macro-regional Workshops*

82 *Annex 28: Self-evaluation and accreditation guideline for obstetrics schools and faculties*

3.1.1.3.c Results of self-evaluation carried out at pilot faculties/schools:

- ✓ Only two (out of 10) schools/faculties complied with 16 of the 19 standards required for accreditation. Of the remaining 8, one shall be re-evaluated in 4 months and 7 should start an improvement process before being re-evaluated, as their score is below 40% (8 out of 19) of standards qualified as acceptable.
- ✓ In the series of institutions evaluated, 33% of standards qualify as acceptable, 46 % in process and 21% as deficient.
- ✓ Standards with higher compliance level were found in the educational project and human resource management; lower level ones were admission, research and financial management managed by the university, without involvement from schools/faculties.
- ✓ The 10 schools/faculties have prepared their self-evaluation plans including the cost of technical assistance from ASPEFOBST.

3.1.2 Periodic Certification

On August 3rd, 2004, the National Board of the Medical Association of Peru, CMP approved the regulation of the Certification and Re-certification System with the purpose of ensuring society that the services provided by doctors have a sufficiency level according to the regulations. Article one of the new regulation indicates: «*The Medical Association of Peru, based on the attributions granted by law, bylaws and other effective norms, administer a certification and re-certification system that allows –within reasonable limits- a good competence level in the medical professional »*

At present, re-certification of the Medical Association goes from an academic credit-based model to one that includes work competences, in a model that combines continuous professional development in the classroom, in-service learning and indirect performance evaluation.

Medical re-certification responds to the pursuit of care quality, measured through international standards. A university degree awarded at the beginning of the professional exercise is not valid forever. It requires periodic renewal that implies acquiring new knowledge, evaluated through standards prepared by scientific societies that define and group competences. These are minimum competences, different from those of developed

countries and differentiated by regions. The certification of the general practitioner is different from that of a specialist and those among specialists.

Process is slow at the Peruvian Medical Association, among other things due to the lack of continuity of teams in charge of re-certification, even though this is obligatory, as has been acknowledged by private and social security institutions that require such re-certification for selection and hiring of doctors.

A good number of doctors do not have access to re-certification, especially those who work in the peripheral and urban areas, where there is limited possibility of courses and information not to mention the high cost, in addition to the difficulty in obtaining paid leaves of absence for training. This can be due to the "resistance" observed in many medical sectors and not to an opposition to the process.

On its part, the Obstetricians Association of Peru, COP, (unlike the CMP model, in which certification is automatic) assumed the re-certification process in two stages: certification and re-certification, both with a competence approach through an exam testing knowledge and proof of basic performances.

The COP created the SINADEPRO (System for Professional Development in Obstetrics) for certification and re-certification, in charge of the design and organization of the system, the design of instruments for evaluating professional competences, training of examiners, as well as the start up of certification and re-certification [83].

An aspect worth mentioning is the speed with which certification and re-certification are developed. In only two years (2005-2007), they have prepared: the competence profile, the Continuous Education Program (with health promotion modules, care, management, research, teaching), in addition to the decentralized structure in regions and national sensitization and mobilization.

The SINADEPRO heads certification by generating guidelines and instruments for professional performance evaluation adapted to each care level and to each region. Its success factors are: leadership and dynamism of the National Board of the Obstetricians Association of Peru and Regional Boards, the involvement of young professionals, the creation of an autonomous and technical system in charge of certification, strengthening of regional structures and an advanced professional certification model.

Certification at the Nurses Association of Peru, CEP, (regulated by Law No. 27669) is the closest experience to what is established in the SINEACE Law, with a competence-based approach and standardized evaluation.

The three periodic certification experiences seek to achieve the best professional performance. The Medical Association has gone from a mixed model of documentary evidence to another that incorporates performance evaluation. The Nurses Association,

[83] *With technical assistance from the Agreement and SENA Colombia.*

whose model is similar to a performance evaluation based on competence standards, should overcome functional dependency on bodies responsible for certification. The Obstetricians Association has an advanced competence certification system model, but internal management problems have hindered its progress.

Lessons learned from periodic certification:

1. Self-regulation as key factor of the periodic certification process.
2. Inter-institutional coordination to make processes and innovations feasible.
3. Systematic and cooperative work to further the improvement of professional exercise.
4. Voluntary certification linked to incentives or obligatory certification but linked to the creation of a quality evaluation culture.
5. Control of processes and social supervision of those involved.
6. Accreditation of effectors of educational alternatives and training programs for updating competences.
7. Inter-institutional and international relationships for process standardization.

3.1.3 Research in Health

Policy 1 includes, in addition to the regulation of health education, research in health. In this sense, the experience of a region is briefly described.

Pasco Region

In the framework of RHUS' Policy 1, the First Workshop on Prioritization of **Health Research Lines and RHUS** was addressed at establishing Health Research Lines to improve quality and the level of regional research and contributing to the development of quality improvement in health services. Those involved were regional representatives and members of the RHUS Regional Technical Team[84].

Criteria were prioritized for research (scope of the problem, institutional importance, feasibility and sustainability, impact, pertinence, vulnerability, cost and relevance[85]) and research lines:

- Effectiveness of analysis methods, treatment and prevention of prevalent infectious diseases
- Evaluation of interventions in diseases of high prevalence, incidence or lethality
- Academic research in prevalent diseases according to life stages
- Research on non-transmissible diseases by life stages
- Local continuous information systems to integrate notification and research systems

Upon conclusion of the workshop, a regional agenda on health research was defined[86], but still pending is the definition of strategies and activities and their approval by the regional government. Likewise, recommendation was made to count with an organized Research and Ethics unit in the DIRESA to head health research, its financing and systematization, and the implementation of the RHUS educational policy.

The Regulation for the operation of the Regional Health Research and Human Resource Committee of the region was prepared. Its purpose is to promote academic levels through scientific and social Research Projects; regulate procedures and guidelines for the acknowledgement of research work; incentive workers' research work acknowledging their initiatives, intellectual productions and monographic works.

This regulation project is found on DIRESA's Webpage on contributions and comments and is being reviewed by the Health Service Networks of the Pasco DIRESA (see the executive proposal in Annex 29).

84 *Made up by representatives of the Regional Government, DIRESA, Health Sciences Faculties (Obstetrics, Nursing and Dentistry) and the Research Institute of the Daniel A. Carrión University, Von Humboldt Higher Technological Institute, EsSALUD, Dentistry, Obstetrics and Nursing Professional Associations and worker representatives.*

85 *Prioritization criteria also take into account social, cultural and educational factors with a comprehensive and multi-skilled approach, research of natural focal points, and study on effectiveness, germ-fighting resistance and evaluation of interventions.*

86 *Document: Workshop for preparation of Health Research Lines in the Pasco Region, 2007.*

3.2 POLICY 2: RHUS STRATEGIC PLANNING

The knowledge of aspects linked to the availability and distribution of RHUS originated as a need for policy 2 on human resource strategic planning with equal rights taking into account demographic, socio-cultural and epidemiological profiles, as well as health needs of the population, especially the most deprived.

To the end of knowing the supply, demand and need of doctors in the country in the near future, the Medical Association of Peru carried out a study called "Current and Prospective Analysis of Supply, Demand and Need of Doctors in Peru 2005 – 2011"

3.2.1 Lack of Proper Regulation in Medical Training

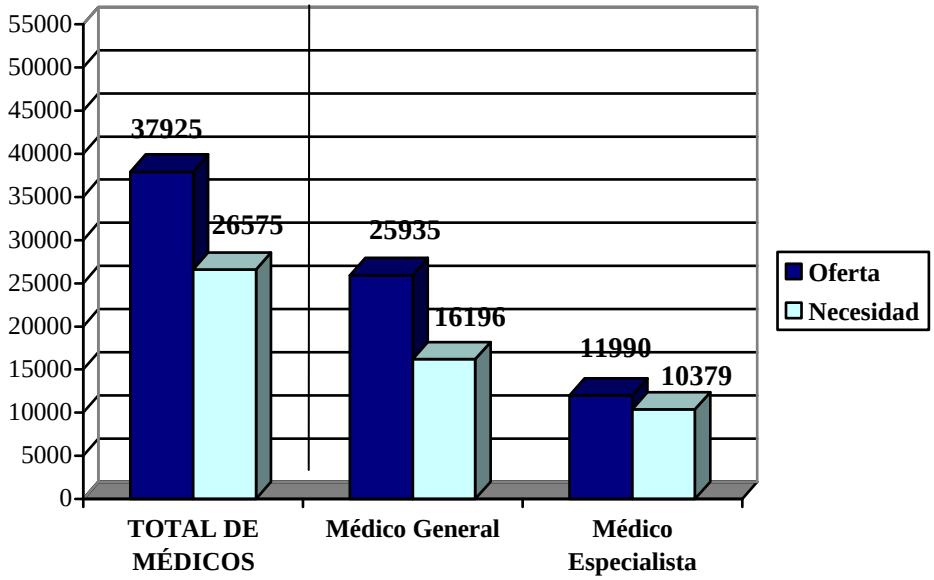
There is a significant increase of medicine graduates (current and projected) mainly in private universities. According to the projection based on the trend of the last few years (2.8% in public universities and 12.7% in private universities) nationwide, we will go from 2,156 graduates in 2005 to 3,218 in 2011. This increase shall happen even though Medical Faculties of public universities (and some private ones) adapted the number of vacancies to the standards established by the Medical Faculties Accreditation Committee and kept them during the accreditation validity period; while most Medical Faculties in private universities increased the number of vacancies after their accreditation.

Vacancies are still increasing due to the opening of some branches of Medical Faculties and the unauthorized operation of others. The little effectiveness of the regulation does not only obey to university autonomy but also to the Law on Investment Promotion in Education (LD No. 882 of November 1996) that in Article 2 establishes: "every natural or legal person has the right to free private initiative for educational activities. It hereby authorized to found, promote, conduct and manage profit and non-profit Private Educational Institutions." Based on this Law, several universities ignore educational regulations and profit from education. The educational quality is doubtful, even though practically all existing medical faculties have been accredited for complying with minimum standards.

3.2.2 Over-supply of Doctors

The current supply of general practitioners (graduated and with a degree) is 25,935, higher than the demand estimated at 16,196 (based on the use of services). There would be an over-supply of 9,739 general practitioners and also of specialists estimated at 1,611 by comparing a supply of 11,990 with a demand of 10,379. This is due to the expansion of health services, especially public, that despite this expansion, it only covers 52% of those who need health care. Diagram 4.

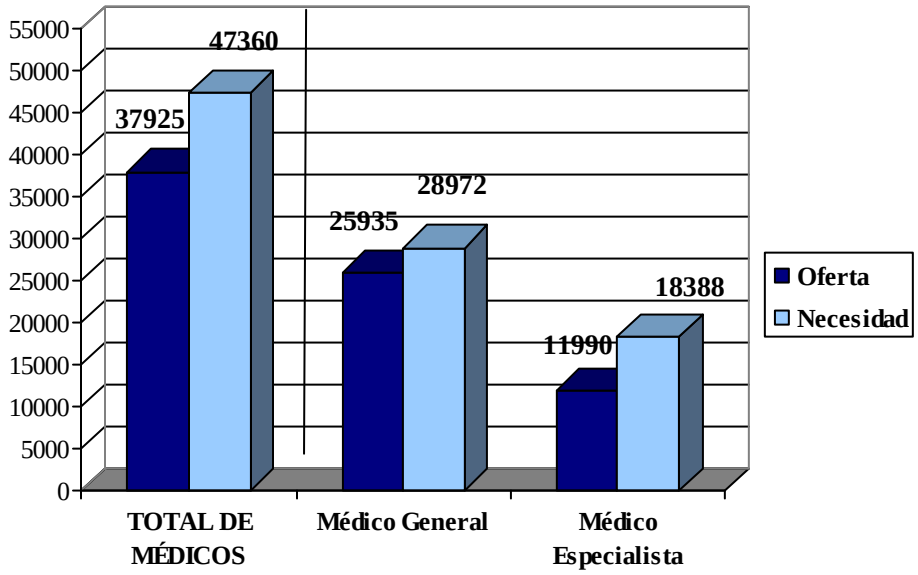
Diagram 4: Supply and Demand of Doctors



TOTAL DE MÉDICOS – TOTAL NUMBER OF DOCTORS
Médico General – General Practitioner
Médico Especialista – Specialist Doctor
Oferta – Supply
Necesidad - Need

If services were expanded to cover 48% of the remaining population that requires them and do not have them, the need for general practitioners would be 28,977. If the supply is for 25,935, there would be a deficit of 3,044. In the case of specialists, such deficit is of 6,398, estimated by comparing the supply of 11,990 with the need for 18,388. Diagram 5.

Diagram 5: Supply and Need for Doctors



(igual que arriba)

Special fields with more deficits are the four basic ones: gynecology and obstetrics, pediatrics, internal medicine and surgery; in addition to orthopedics and traumatology, ophthalmology, cardiology, gastroenterology and psychiatry.

3.2.3 Centralized and Unequal Distribution

The supply of doctors in Lima exceeds both the demand and the estimated and projected need, which shows the centralism of these professionals. Departments with the highest supply deficits of general practitioners in relation to the demand are: Cajamarca, Puno, San Martín, Huanuco and Huancavelica; on the other hand, the highest over-supply is found in Lima, Arequipa and Ica. Regarding specialists, the departments with the highest deficits are: Puno, Cajamarca, Cusco and Ayacucho; while those with an over-supply are Lima, Callao, Arequipa and Lambayeque.

3.2.4 Supply, Demand and Need Trends of Doctors in Various Scenarios

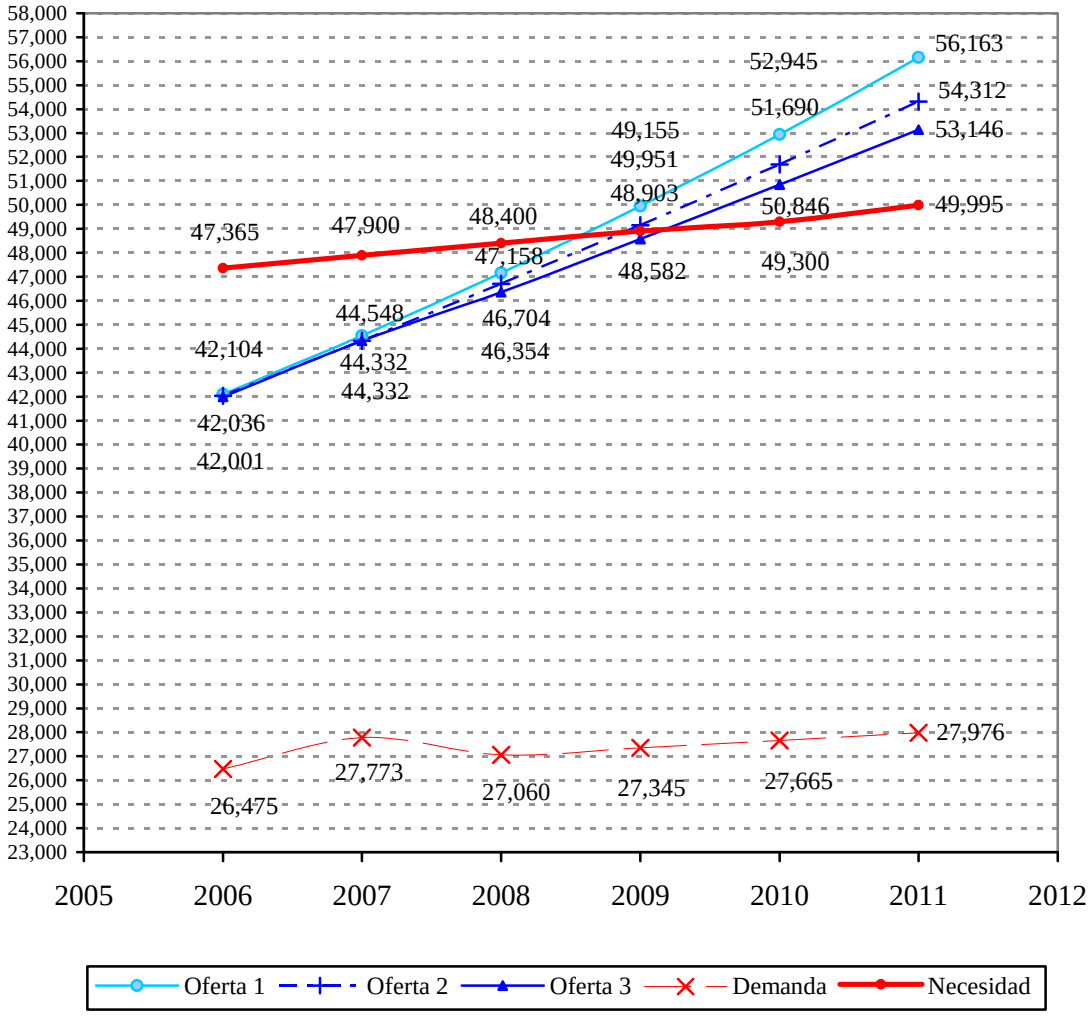
The gap between supply and demand of doctors in the next few years will continue to grow according to the different scenarios:

Scenario 1: The current supply growth trend is kept. The gap between supply and demand in 2011 shall be 28,187.

Scenario 2: Supply is cut down to half: The gap in 2011 shall be 26,336.

Scenario 3: The supply is cut down to one fourth. The gap in 2011 shall be 25,170 (Diagram 6).

Diagram 6: Supply, Demand and Need for Doctors in Three Scenarios



Oferta – Supply Demanda – Demand Necesidad – Need

In all cases, over-supply is high and this is due to the large number of graduates from Medical Faculties of private universities, some recently created. In relation to the number of necessary doctors to attend the entire population, projections indicate this would be covered between 2009 and 2010 (Diagram 6).

3.2.5 Future of professional medical education and exercise is not too encouraging according to Experts' prospective Analyses

According to experts, the future supply of medical studies shall be characterized by the following:

- An over-educational supply in private universities, while public supply remains the same,
- The Peruvian Association of Medical Faculties (ASPEFAM) shall exercise a weak regulation of medical studies. Greater influence shall be exerted by the National

Evaluation, Accreditation and Certification System for Higher Education - SINEACE.

On the other hand, the amount and distribution of doctors in the country shall be characterized by the excessive number of general practitioners and a centralized and unequal distribution (the same distribution for specialists).

Finally, the future labor situation of surgeons shall be characterized by:

- medical under-employment, unemployment and multi-employment in average proportion
- absence of health human resource planning
- average income of doctors in the public sector, way below what they deserve and in the private sector, below average.

3.3 POLICY 4: DEVELOPMENT OF RHUS COMPETENCES

Permanent training and education constitute strategic tools which are supported by good training management and the use of ideal instruments for developing health staff skills to make them effective and efficient. The following is the experience of Competence Development Centers.

3.3.1 Competence Development Centers. Regional bodies for improving competences of health professionals.

During 2002 and 2003, the Project "Improving the Health of Peruvians" carried out training programs in Obstetrics and Neonatal Emergency care, EMOB, for all professionals (doctors, obstetricians and nurses) of micro-networks in the health regions of Huanuco, Ucayali and San Martín. A Training Module was prepared that included management of hemorrhagic and non-hemorrhagic obstetric emergencies; immediate care and neonatal resuscitation, in addition to sexual and reproductive rights, gender-based violence and health care quality.

Post-training supervisions in Huanuco and Ucayali revealed that even though the trainees had trained their micro-network colleagues and had made progress in the guidelines for first care level, there were still issues that needed to be solved, among which were:

- High rotation of trained staff
- Little use of the active management of childbirth as a strategy for preventing post-partum hemorrhages, key training issue
- No use of FON and SIP 2000 as information instruments
- Absence of a Local Health Committee and regulations for patient referral.

The need to coach micro-networks in EMOB initial care up to their referral to hospitals was identified.

At the beginning of 2004, MINSA, in answer to the proposal of the Health Sector Reform Support Program, PARSALUD, designated the following hospitals as internship teaching places in EMOB: Maternidad de Lima (Lima Maternity Hospital), San Bartolomé, Ayacucho Regional Hospital and Maternal Perinatal Center in Tarapoto. However, it lacked instruments to evaluate the teaching quality at such places and insisted on training micro-network staff at Hospitals in Lima (due to the larger resolving capacity of these in face of hospitals in the regions), which was quite costly.

Based on the Regulation that establishes the functions of the Human Resource Management Offices[87], and based on the findings of supervisions, the Project proposed the creation of Competence Development Centers, CDC, to train professionals of micro-networks using a competence approach.

3.3.1.1 Strategy Phases at Competence Development Centers, CDC

1. **Cooperative Agreement Proposal on Competence Development Centers. March 2004**

   One of the purposes of the Competence Development Centers, CDC, was to develop skills of regional officials, especially of the Human Resource Executive Office to manage training processes by training tutors in hospitals of each region. The idea was to train micro-network staff in comprehensive care of the main mother child health problems to reduce maternal perinatal morbi-mortality.

   The CDC includes two instances:

   - **Regional CDC**: ruling instance for training management (planning, execution and evaluation of competence improvement processes of health professionals) within the Human Resource Management and Development Office of DIRESA. Headed by a Committee[88].

   - **Hospital CDC**: regional and/or support hospitals, training places selected for complying with minimum quality standards and other requirements[89] .

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87 *Supreme Decree No. 023-2005-SA*

88 *The Committee in charge of the Regional CDC is made up by the Head of the Executive HR Management Office headed by DIRESA. A representative of the People's Health Directorate, the DIRESA Training Coordinator, the DIRESA Quality Coordinator, the DIRESA Community Participation Coordinator, Director(s) of hospital(s) in the Region, a representative from the Network Managers, and a representative from the Training Offices of Facilities -CDC.*

89 *a. Comply with standards and indicators of a "CDC Facility".*
b. Encourage development of Continuous Quality Improvement processes in facilities in the region.
c. Manage and dispose of resources for developing planned activities.
d. Update syllabus and protocols.
e. Include permanent health education methodology.
f. Select tutors
g. Develop updating programs for tutors including internships in the IMP.
h. Train staff of networks and micro-networks according to a regional Training Program.
i. Organize together with the regional CDC, activities for follow up, monitoring and evaluation of trained staff at each facility.

The CDCs strategy was presented at a multi-sector and mult-regional meeting in May 2004 within the framework of the ***Healthy and Safe Maternity Week*** with the subscription of ***Commitment Documents*** to be executed by participating institutions[90].

In July 2004, the CDC strategy was reviewed at two ***Technical Meetings***[91]. The preliminary version of the "***Guideline for the evaluation of standards and indicators at CDC Facilities"*** was prepared for service training of EMOB as well as a plan for the implementation of CDC facilities, to ensure training quality.

In August 2004, a new version of the Evaluation Guideline was ordered and CDC Committees of Health Directorates in Huanuco, San Martín, Ucayali, Junín, Pasco, Ayacucho and Cusco were created.

2. Creation of Regional CDCs

In 2005, Regional Technical Committees of CDCs at DIRESAs were created in 6 regions according to the following Director's Orders (RD):

- Junín: RD No. 028-2005 DRSJ/OP of January 17, 2005
- Huanuco: RD No. 027-2005-GR-HCO/DRS-DG-DEA-OP of January 24, 2005
- Ucayali: RD No. 024-05-GRU-DRSU-OA of January 26, 2005
- Pasco: RD No.033-2005 DG-DIRESA GR PASCO of March 16, 2005
- Cusco: RD No.0336-2005 DRSC-DEGORH of April 21, 2005
- San Martín: RD-DG-DIRESA-SM/01/10/2005

[90] *General People's Health Directorate of the Ministry of Health, Regional Governments: Huanuco, San Martín, Ucayali, Junín, Pasco, Ayacucho and Cusco, Health Directorates of the Regions: Huanuco, San Martín, Ucayali, Junín, Pasco, Ayacucho and Cusco, Specialized Maternal Perinatal Institute and Pathfinder International*

[91] *12 institutions took part: Regional Government of Ayacucho, Ayacucho Health Directorate, Regional Hospital of Ayacucho, Femme Perú – Car, Regional Government of San Martín, San Martín Health Directorate, Tarapoto Maternal Perinatal Center, Ministry of Health: Comprehensive Reproductive Health Care Directorate, Ministry of Health: Family Care Directorate, Human Resource Development Institute, Specialized Maternal Perinatal Institute, Catalyst Consortium - Pathfinder International*

These Committees were made up by staff from DIRESAS and hospitals[92] and were in charge of rating hospitals as CDC-Hospitals. During the first semester of the same year, 7 Regional Competence Development Centers were opened in the 7 regions [93] through the designation of physical areas in DIRESA facilities, to which the project donated audiovisual equipment, mannequins, instruments and furniture. Rating and evaluation of Regional CDCs was made jointly with the IDREH.

CDCs strengthened DIRESA's managing function in training their professionals by improving their relationship with the facilities. Later on, when the facilities were categorized as hospital- CDC or CDC-MN, they showed they counted with ideal professionals to improve competences in their colleagues in their own regions.

3. Technical assistance for evaluating CDC - Hospitals

A technical team[94] evaluated 12 hospitals (see Diagram 7) with the purpose of verifying if they could become CDC - Hospitals. The evaluation was made by applying the five-component Evaluation Guide: Resource management and availability, standardized Management, Competences acquired by interns, permanent education in health, and use of data.

4. First evaluation of CDC - Hospitals

Of the 12 hospitals evaluated, none achieved the minimum score needed to qualify (80%). Diagram 7. Only the Ayacucho Regional Hospital and the Tarapoto Maternal Perinatal Center, that had already been teaching centers, managed to comply with 70% of standards.

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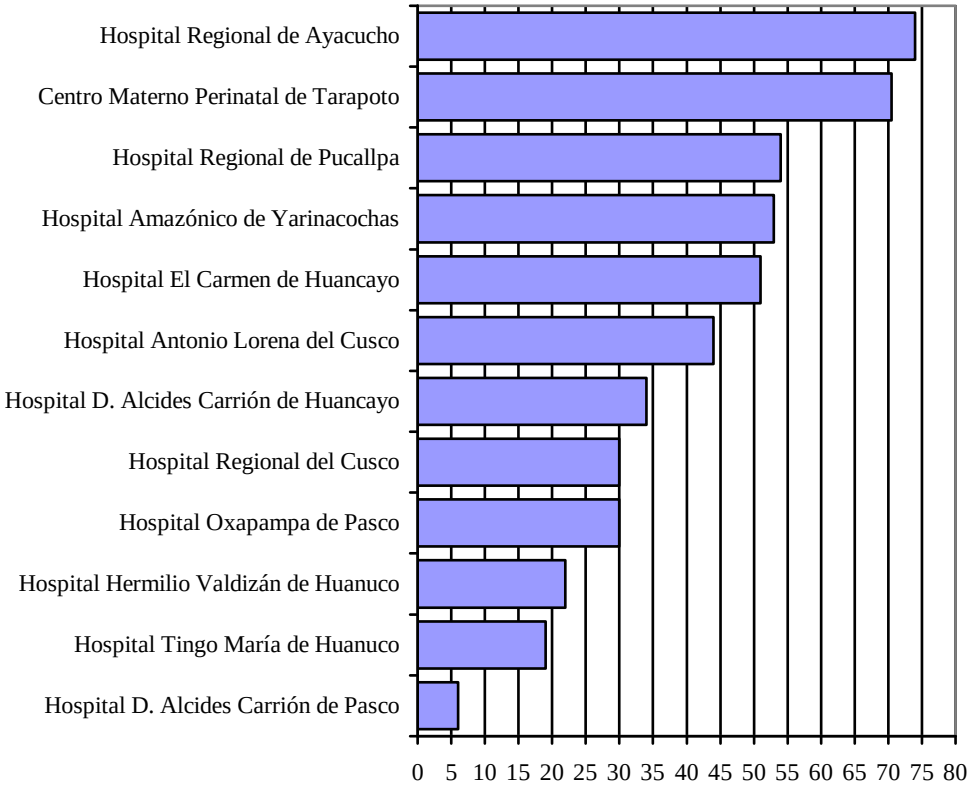
92 *Regional Technical Committees of the CDCs are made up by the Director of the DISA Human Resource Management and Development Office, the DISA Quality Director, Director of the DISA Health Promotion, DIRESA's Training and Women Area Officials, Director of the CDC Facility, Heads of the Gynecology-Obstetrics and Pediatrics or Neonatology Departments of CDC Facility, Training and Quality Official of the CD Facility"*

93 *Opened in San Martín, Junín and Ucayali in February 2005, in Huanuco in April, and in Cusco, Ayacucho and Pasco, in May.*

94 *The Technical Evaluation Team of the DCD-Hospital was made up by MINSA (Comprehensive Reproductive Health Care Directorate, Family Care Directorate, and Human Resource Development Institute), the Specialized Maternal Perinatal Institute, Pathfinder International and the Competence Development Center Committee of the Health Directorate in each region.*

Diagram 7: Score obtained by the 12 facilities CDC in the first evaluation



At the beginning of 2005, a Technical Committee counseled by the Project helped improved standards at the evaluated hospitals that did not qualify as CDC - Hospitals. Guidelines were prepared for EMOB care, maternal perinatal indicators were updated, tutors were trained and training programs were prepared.

5. Second evaluation of CDC - Hospitals

In 2005, 10 hospitals out of the 12 evaluated were qualified by DIRESA, with technical assistance from the Project, as CDC – Hospitals through the self-evaluation of standards. The process was conducted by staff from the same facilities, grouped into CDC-Hospital Technical Committees. Results showed that these facilities had optimum academic and administrative evidences for training. Facilities that were rated were:

- Tarapoto Maternal Perinatal Center
- Pucallpa Regional Hospital
- Yarinacochas Amazon Hospital
- Huancayo El Carmen Hospital
- Cusco Antonio Lorena Hospital
- Huanuco Hermilio Valdizán Hospital
- Tingo María Support Hospital

- Oxapampa Support Hospital
- Ayacucho Regional Hospital
- Huancayo Carrión Hospital

3.3.1.2 Training of Tutors for CDCs and health service Suppliers in EMOB

In the second semester 2005, the IDREH and other organizations[95] systematized the CDC - Hospital experience by preparing the document ***"Methodology and Instruments for Rating Regional Teaching Centers for Training under the modality of Obstetrics and Neonatal Emergency Internships"***, validated in Huancavelica and Andahuaylas. This methodology was used to prepare other instruments for Rating Regional Teaching Centers for Training for internships in Clinical Laboratory and Blood Bank. The name was changed from CDC Hospital to Teaching Centers for Training.

In 2006, the IDREH, with technical support from the Project, prepared the ***"Methodological Guideline for Evaluating competences in care of pregnant women and newborns"*** used to evaluate interns.

During the project, 96 tutors from 6 regions (Ayacucho did not take part in this training program) were trained at the Maternal Perinatal Institute of Lima. Likewise, training on EMOB care was carried out in regional hospitals for a total of 1,163 health service suppliers through workshops organized directly by the Project or through duplications carried out by professional previously trained by the Project. Their distribution by region and special field of expertise is shown on Table 13.

Table 13: Professionals trained in EMOB care. 2003–2006

Trained Professionals		TOTAL	Ayacu-cho	Cusco	Hua-nuco	Junín	Pasco	San Martín	Ucayali
Tutors trained at the National Maternal Perinatal Institute of Lima:									
TOTAL		96	0	19	18	8	8	22	21
Doctors		35	0	6	6	2	3	7	11
Obstetricians		35	0	8	8	3	3	8	5
Nurses		26	0	5	4	3	2	7	5
Suppliers trained at workshops carried out by Pathfinder and through duplications:									
TOTAL	Total	1,163	30	118	647	20	82	74	192
	At workshops	433	30	60	177	20	16	39	91
	through duplications	730	0	58	470	0	66	35	101
Doctors	Total	185	0	18	82	3	12	20	50

[95] *MINSA's National Sexual and Reproductive Health Strategy, National Maternal Perinatal Institute, San Bartolomé Maternal Infant Teaching Hospital, PARSalud, and Pathfinder International*

	At workshops	98	0	10	29	3	5	17	34
	through duplications	87	0	8	53	0	7	3	16
Obstetricians	Total	316	0	25	187	6	16	20	62
	At workshops	149	0	10	79	6	5	15	34
	through duplications	167	0	15	108	0	11	5	28
Nurses	Total	262	0	20	155	11	19	10	47
	At workshops	126	0	10	69	11	6	7	23
	through duplications	136	0	10	86	0	13	3	24
Technicians	Total	391	30	55	215	0	35	24	32
	At workshops	60	30	30	0	0	0	0	0
	through duplications	331	0	25	215	0	35	24	32
Others	Total	9	0	0	8	0	0	0	1
	through duplications	9	0	0	8	0	0	0	1

Micro-network staff was also trained at CDC - Hospitals through 39 internships in 6 regions. As can be seen in Table 14, there were 177 trained persons, mostly nurses. The most active CDC - Hospital was the Carrión Hospital in Junín with a total of 14 internships and 70 trained persons.

Table 14. Number of micro-network internships and interns

Region	Internships	Interns			
		Total	Doctors	Nurses	Obstetricians
TOTAL	**39**	**177**	**48**	**74**	**55**
San Martín	8	33	11	12	10
Ucayali	6	27	9	9	9
Huanuco	6	25	5	10	10
Junín	14	70	16	32	22
Pasco	1	2	1	1	0
Cusco	4	20	6	10	4

In 2006, the IDREH carried out a rating of the same 12 hospitals that had previously been evaluated by the Project (Diagram 7). As a result, there are currently four CDC - Hospitals qualified by the Institute as Teaching Centers for Internships in Obstetric and Neonatal Emergencies. The rest are in an on-going improvement process of their standards and administrative procedures for a new evaluation. Table 15.

Table 15: Situation of Hospitals evaluated by the IDREH to qualify as CDC upon conclusion of the Cooperative Agreement

Region	Hospital	Rating by the IDREH
Ucayali	Pucallpa Regional Hospital	On-going
	Yarinacocha Amazon Hospital	On-going
Junín	**Carrión Hospital**	**Qualified**
	El Carmen Hospital	On-going
San Martín	**Tarapoto Maternal Perinatal Center**	**Qualified**
Huanuco	**Hermilio Valdizán Hospital**	**Qualified**
	Tingo María Hospital	On-going
Cusco	Regional Hospital	On-going
	Antonio Lorena Hospital	**Qualified**
Pasco	Carrión Hospital	On-going
	Oxapampa Hospital	On-going
Ayacucho	**Regional Hospital**	**Qualified**

3.3.1.3 Competence Development Center in Micro-networks – CDC-MN- as a local strategy

The successful strategy of Competence Development Centers -CDC – Hospitals, at a regional level, was also implemented as a pilot experience in micro-networks through Competence Development Centers in Micro-networks (CDC-MN) to improve access to training of staff that works at health posts in Huanuco, Cusco, Junín and Pasco.

3.3.1.3.a Access to training at micro-networks

The problem of access to health training at a local level can be summarized in three aspects: local training needs, demand and supply.

Training needs: maternal-neonatal-infant morbi-mortality and chronic infant malnutrition are regional and local sanitary priorities in micro-networks that have determined the pilot CDC-MN training program topics[96].

Huanuco: At the Margos Micro-network, childbirth care was key to re-direct the primary obstetric-neonatal services at levels I-1 and I-2 (FONP) facilities and basic facilities (FONB) and training needs. Between2002 and 2006, there was an increase in institutional childbirth deliveries at all health post in the micro-network at an average of 186% (from 97 to 278 childbirth deliveries). The increase was greater at the Margos Health Center, but figures only cover 54% of the total expected childbirths. The ratio, (46%), of home childbirth deliveries is still high[97]. Infant chronic malnutrition is also high (56%) compared to that of the region (42.8%) and the country's (25.4%)[98].

There is a paradox; on one hand, a large proportion of childbirth deliveries occur at homes, which brings difficulties in the childbirth delivery community reference. On the other, there is an increase of childbirth deliveries at health posts that do not ensure basic obstetric and neonatal functions, therefore, pregnant women and newborns could be at risk if complications should arise.

Facilities type I-1 and I-2 are more in contact with communities and attend approximately 75% of the demand, especially in scattered and rural towns. This service demand in turn generates a need for effective training hours for health staff and community agents of these facilities, which expand and promote coverage of these health facilities.

At the Margos (rural) and Amarilis (peri-urban) micro-networks in Huanuco, the training demand of community agents is ten times greater than that of health staff. The

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96 *Huanuco PRCS, Pasco PRCS, Junín PRSC, Cusco PRCS*

97 *Source: Indicators RMMN-SIS DIRESA Huanuco*

98 *ENDES 2000*

situation is more critical in rural areas due to scattered location, less population density and larger number of towns. As can be seen in Table 16, in the two micro-networks, if you include all staff of health facilities I-1 and I-2, the number of municipal agents to be trained is 1,245 versus 65 health service suppliers.

Table 16: Estimated training demand at the Margos and Amarilis Micro-networks

TRAINEES	MARGOS MN	AMARILIS MN
Total	980	440
Health Staff : Technicians	12	21
Health Staff: Professional	18	14
Municipal Authorities (deciders)	25	20
Community agents: 55 per town	895	350

According to the INEI (2005) the Margos Micro-network has179 towns and the Amarilis Micro-network, 70

The training supply is critical in the rural and semi-urban area. Health staff at health posts type I-1 and I-2 do not have access to training programs that ensure minimum maternal infant care quality, clinical-preventive and health promotion standards. The average training hours for technical staff in the last year was 10 hours, a meager number if compared to the standard recommended by the Medical Association of Peru, which is 48 hours.[99]

To make up for this deficiency and taking into account the importance of facilities I-1 and I-2[100], the strategy Competence Development Centers – Micro-network was implemented. A CDC-MN is a health facility in a micro-network that complies with specific standards and indicators to train and generate competences (particularly in maternal-infant health) in professionals, technicians, municipal managers and community leaders to ensure quality health care.

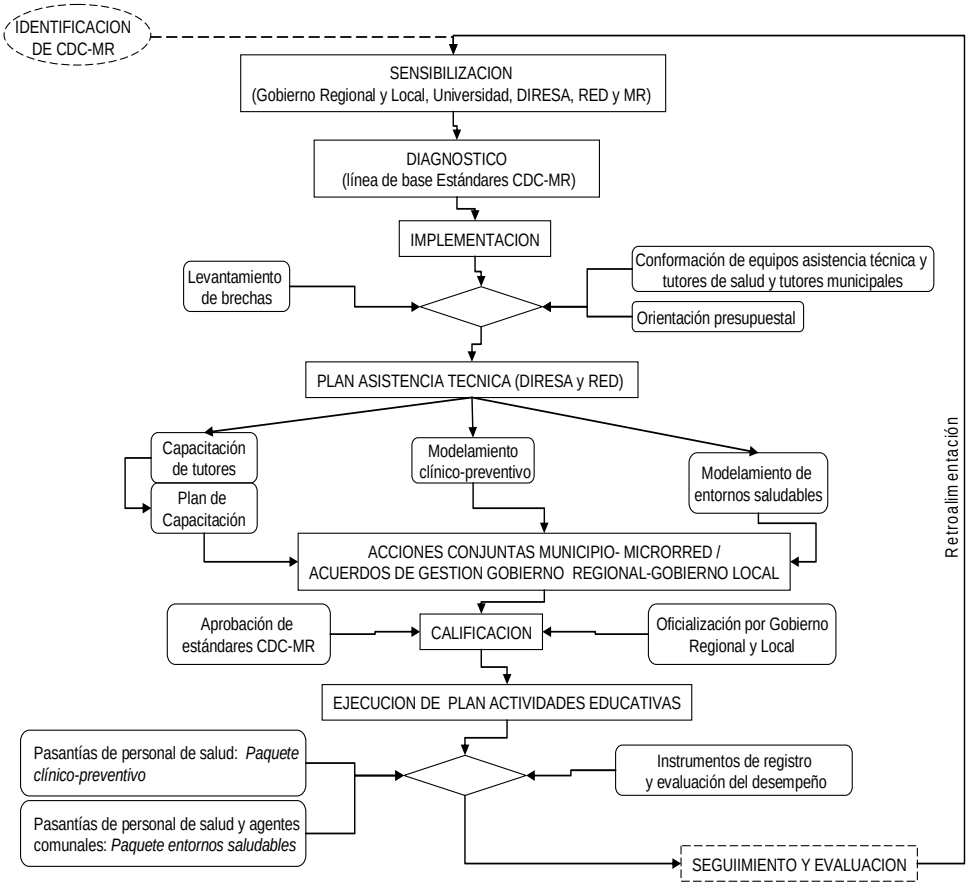
[99] www.cmp.org.pe *Professional re-certification process.*

[100] *According to MINSA (EE.SS database., 2005), health posts type I-1 and I-2, represent 87% of all facilities at the Margos Micro-network and 95% of the Amarilis MN; while facilities I-1, under the charge of technicians are 50% and 38%, respectively.*

3.3.1.3.b The Management Process of CDC-MN

The outline indicates the route for the successful implementation of a CDC-MN, which includes activities shown in diagram 8.

Diagram 8: Route for the implementation of Competence Development Centers in Micro-networks, CDC-MN



b.1) Preparation of the proposal for the Competence Development Center CDC-MN

The same methodology for the preparation of standards and indicators for rating of CDC-Hospitals developed by the IDREH was used, but clinical training at the CDC-MN emphasizes comprehensive maternal infant care training with a preventive approach adapted at a local level[101].

[101] - *Evidence 01. Methodology and Instruments for Rating of Training Teaching Places at Health MN*

- *Evidence 02. "Standards and Indicators for Rating CDC- MICRO-NETWORK, as Competence Development Centers in Maternal Perinatal and Infant Care Quality."*

The following was prepared: a) a record sheet "Standard and Indicators for Rating CDC-MICRO-NETWORK, as Competence Development Centers for Maternal Perinatal and Infant Care Quality" made up by 4 elements[102], 8 standards and 40 indicators, b) a package of instruments to know the learning-teaching capacity (designed instruments) and care quality in the micro-network (gathered instruments), c) checklists to evaluate tutorial skills of tutors (model classes and in-service training), and their performance in comprehensive care of pregnant women, newborns, children and health promotion.

Quality management instruments were used to evaluate care quality at the micro-network: analysis sheet of FONB resolving capacity, quality standards for FONB, FONP, FIP facilities; performance evaluation checklists per work competence in pregnant women and newborns, technical maternal infant care guidelines and promotion guidelines for healthy surroundings.

CDC-MN standards were validated by experts from the DG-PROMSA, IDREH, DIRESAS, Hospitals and Micro-networks from Ayacucho, Junín, Cusco, San Martín and Huanuco, who validated a series of performance evidence proposed in the model. In addition, the CDC-MN was included as a third component of the CDC- Management (DIRESA and Network) and CDC-Hospital platform so policies on competence development would reach the local level. Validation was comprehensive, which enabled the adjustment of standards, indicators, verification items and other tools.[103]

Table 17: Criteria for identifying a CDC-MN

✓ Health Center (category (I-3/ I-4) micro-network reference nucleus
✓ Compliance of basic obstetric and neonatal functions
✓ Located 2 hours away from a FONE facility
✓ Availability of trained professional staff 24 hours a day
✓ Micro-network with 7 or more health posts
✓ Population of the jurisdiction: approximately 10,000 inhabitants
✓ Potential demand above 300 annual childbirth deliveries
✓ Greater or equal to 75 daily average care services
✓ District Municipality with jurisdiction on the majority of Health Post in the micro-network
✓ Communities with average health interventions

Based on criteria shown on Table 17 to determine micro-networks as CDC-MN, 6 micro-networks were selected for pilot interventions: Margos MN and

[102] *Components of the record sheet are: resource management and availability, permanent health education (EPS), standardized clinical – preventive management and actions with the community*

[103] *Evidence 03. Document on Experts Meeting CDC-MR- IDREH Meeting 04-18-07*

Amarilis MN (Huanuco), Pichanaki MN (Junín), Villa Rica MN (Pasco), Urubamba MN and Santo Tomás MN (Cusco).

b.2) Implementation of the proposal "Competence Development Center CDC-MN"

There were three stages in the implementation: institutional arrangements, identification and closing of gap based on standards and rating of the CDC-Micro-network:

Institutional Arrangements. In order to implement the proposal, it was necessary to reach political and institutional agreements at a regional (Regional Government, DIRESA and Network) and local (district Municipality, Network, Micro-network and University) level to ensure resource availability[104]. The Technical Quality and Human Resource Team of the Network was key as a local operator as well as the team of tutors from the health center (health tutors) and from the district municipality (municipal tutors).

Analysis of Facilities for CDC-MN. Each pilot CDC-MN was evaluated by applying[105] the record sheet "Standards and Indicators for Rating CDC-MICRO-NETWORK, as a CDC in Maternal Perinatal and Infant Care Quality". Participative techniques (DIRESAS, District Municipality and technical team) were used for evaluating and verifying information sources[106].

The evaluation helped identify gaps in standards, which were later closed through different activities:

- Training in teaching-learning-evaluating techniques for health and municipal tutors, including skills for model classes, functional map design and validation of work competence regulation for managing training at facilities I-1 and I-2[107]
- Clinical-preventive training of health tutors through the standardized management of cases as well as the use of clinical practice guidelines for EMOB and infant emergency care[108].
- Strengthening of model healthy surroundings (successful housing-classroom-community neighbor association) focused in homes with

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104 *Evidence 04. Document on Institutional Arrangements-Level DIRESA-RED – List of Participants*

105 *The analysis was similar in Margos, Villa Rica and Pichanaki. In Amarilis, capacities were transferred to DIRESA and to the Huanuco Network for managing the process. In the Cusco region, only the analysis phase was reached.*

106 *Evidence 60, 07, and 08: Analysis of Development Capacity of Educational Activities of Micro-networks Margos, Villa Rica and Pichanaki, respectively.*

107 *Evidence 10. Training Material for Tutors-Model Class Videos-Certificate. Tutor evaluation sheets. Functional Map. Checklists*

108 *Evidence 11. Tutor training lists CDC-MN*

pregnant women and children under 3, educational institutions and neighbor associations[109].

- Preparation of a "Training program in basic care and emergency in pregnant women, newborns and children (technical level)" for organizing educational activities in the CDC-MN.
- Organization and rating of the CDC-MN through Agreements[110] between the Municipality and the Micro-network.[111]

The intervention did not succeed in making a work performance baseline of staff at Facilities I-1 and I-2, but it ensured the availability of instruments for future evaluations[112].

Rating of CDC –MN: Rating of CDC-MN was operative and technical-regulatory. An evaluating team made up by DIRESA–Network facilitators and university teaching advisors[113], rated the CDC-MN and issued a regulatory technical report. The CDC-Margos (with sanitary influence in the districts of Yacus, Chaulan), was approved by the Social Development Management of the Huanuco Region.

[109] *Evidence 12. Performance evidence record sheets of healthy surroundings model. Technical guidelines of schools, families-housing and healthy communities implemented in the service were used as well as technical record sheets for follow up of interventions*

[110] *Evidence 09. Agreements Document between the CDC-MN and the Municipality. In the Huanuco Region, the implementation of the CDC-MN Amarilis was considered in the Management Agreement between the Regional Government and the Municipalities of Amarilis and Cayran. The Subscription of these Agreements has been extended to the district of Margos*

[111] *Evidence 14. CDC-MN Rating Report. Technical reports from the Network and DIRESA*

[112] *Evidence 13. Training program for basic care and emergencies in pregnant women, newborns and children (technical level) CDC-MN Margos*

[113] *Evidence.15. Functions of University Teaching Advisors. Agreement between the Hermilio Valdizán University and the Social Development Management for Teaching Assistance at Competence Development Centers CDC-MN.*

b.3) Execution of educational activities in the "Competence Development Center CDC-MN"

Educational activities prioritized quarterly training[114] programs for micro-network health technicians, offering two packages:

- Clinical-preventive training (six days long)
- Training on healthy surroundings (six days long)

Of all pilot CDC-MN, only Margos executed active teaching-learning activities, the execution of "Training Programs" is pending in the others.

Results obtained. 04 Competence Development Centers, CDC-MN, implemented and acknowledged (02 operative) by the Social Development Management, with 96 training hours in the clinical-preventive package (on pregnant women, newborns, children) and in family-housing-community promotion. The development of both is variable; for example, the clinical-preventive package was predominant in Margos, while in Villa Rica and Pichanaki it was the Healthy Surroundings Promotion. Table 18.

Table 18: Competence Development Centers CDC-MN

COMPETENCE DEVELOPMENT CENTERS –MN	Number
CDC-MN Evaluated	04
• Operative CDC-MN *(Margos Health Center and Carlos Showing Health Center, Amarilis, Huanuco)*	02
• CDC- in analysis phase (Villarrica Health Center in Pasco and Pichanaki Health Center in Junín)	02

- Trained health professionals and municipal officers (see Table 19) and organized in teams for developing activities in teaching-learning, implementation, follow up and evaluation of training programs in the CDC-MN).

Table 19: Training carried out in the CDC-MN

COMPETENCE DEVELOPMENT CENTERS –MN	Number
Certified health tutors	30
Approved health tutors	28
Approved municipal tutors	24
Technicians programmed for training to Dec. 2007	96

[114] *Evidence 16. Educational Activities Program CDC-MR September 2007-08-23*

- Joint municipal-micro-network actions for promoting healthy practices in mothers and children and developing educational activities with community agents in the Margos, Villa Rica and Pichanaki CDC-MN. At the Amarilis CDC-MN, these actions are part of the Management Agreement between the Regional and Local Governments.

- Investment of SIS resources from the Margos Micro-network to finance training: mobilization and food for staff and community agents, educational materials and supplies for training, among others.

3.4 POLICY 6: NEW LABOR REGULATORY FRAMEWORK

The new comprehensive labor regulatory framework should consider hiring based on occupational profiles by competences. Policy 6 points towards this basic RHUS regulation aspect. The following has been carried out:

3.4.1 Identification of Work Competences for Care Level I: Categories I-1 and I-2. Competence Profiles

Technical teams were established in each region headed by RHUS Management Teams of DIRESA, made up by representatives of service delivery entities, educational entities (universities and higher education institutes), professional associations and other institutions.

Upon conclusion of the Project, there will be a minimum competence profile proposal for Care Level I, Category I-2 and working profiles by competences for health workers at facilities Category I-2: Doctor, Nurse, Obstetrician and Nursing Technician. (See Annex 30: work competence profiles in Huanuco).

3.4.2 Regulation of Competences, for Care Level I, Categories I-1 and I-2

Technical teams in Huánuco, Junín and Pasco designed the Work Competence Regulations, NCL, which were discussed and approved at macro-regional workshops to obtain a final NCL version of prioritized competence units for pregnant women and children areas and training management. (See Annex 31, NCLs).

3.4.3 Evaluation of Performance by Competences for Care Level I, Categories I-1 and I-2

Following the same methodology of internal workshops and technical meetings, evaluation instruments were prepared (15 checklists and 10 questionnaires) of competences for final NCL in the areas: pregnant women, children and management. The instruments are being applied and validated by technical teams in the following selected micro-networks:

Amarilis, in Huánuco; Villa Rica Network, in Pasco, and Pichanaki in Junín. (See Annex 31, evaluation instruments).

3.4.4 In the Regions.

- **Pasco.** DIRESA's **Work Competence Regulatory Committee**[115] was established to conduct the implementation of Work Competence Regulations in the region. The DIRESA Human Resource Committee prepared the **Induction Guideline** (approved by the Committee and currently posted on DIRESA's Webpage) for the health worker (appointed, under contract, SERUMS, Resident). Its purpose is to establish an effective and efficient institutional dynamics with the commitment of all workers. It also prepared a proposal for a **Selection and hiring guideline** (currently posted on DIRESA's Webpage) of the health worker that standardizes mechanisms and criteria and speeds up procedures to recruit, select and hire health workers based on competences[116]. This proposal does not include progress made in the Occupational Profiles and Work Competence Regulations currently being prepared[117].

- **Huanuco.** An incentives proposal has been designed through the Human Resource Thematic Committee.

3.5 POLICY 7: IMPROVEMENT OF WORKING CONDITIONS, MOTIVATION AND COMMITMENT

The purpose of Policy Guideline No. 7 for Development of Health Human Resources is to: *"improve working conditions, motivation and commitment of the worker to contribute to a renewed organizational culture and make feasible the delivery of quality services"*. The Project prioritized the regions of Pasco, Junín and Huanuco to implement this guideline because it counts with a Coordinated Regional Health Plan and with Regional Health Human Resource Policies approved by the Regional government.

Policy 7 includes 2 strategies: a) promote the development of incentive and motivation mechanisms based on performance for staff in the different sub-sectors, and b) incorporation of staff's well-being service as part of the comprehensive human resource development management. The following gives detail of the intervention in the three regions.

3.5.1 Pasco Region

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115 *The NCL Committee was approved by the Regional Government on September 12th, 2007 through Regional Executive Order No. 0640-2007-GR Pasco/Pres. It is made up by representatives of the Regional Government's Social Development Management, DIRESA, DIRESA's HR Management and Development Executive Office, health education institutions, Professional Associations, health workers' representatives and Nursing Technicians, among others.*

116 *This Guideline is applied to appointed workers and workers under contract under Legislative Decrees DL 276, DL 728, respectively, and also to staff under service providing contracts of the Pasco DIRESA, in compliance with the effective regulation.*

117 *Report of the Macro-regional workshop "Towards the Evaluation and Certification of Health Work Competences", carried out on September 5th, 6th and 7th, 2007.*

The Villa Rica micro-network was chosen as the initial intervention place. Even though they had a management team, their members had multiple functions, which weakened their organization. Their priorities were sanitary ones and had limited RHUS development.

The Local Development Office in the district, which was in charge of implementing the effective regulation, was unaware of the existence of the Coordinated Regional Health Plan 2005-2015 and of regional policies in Human Resources. The local Government and the MN worked together in promoting healthy surroundings, but not in the area of incentives and motivation of health workers. On the other hand, DIRESA's, network's and MN's management teams lacked coordinated actions for motivating and providing incentive to the health worker. Finally, the community did not know about regional and local regulations on motivation and incentives of health human resources. Added to this was the existence of weak local coordination spaces.

It is in this framework that Regional Policy 7 on health workers' motivation and incentives (non-monetary) was implemented in the Villa Rica district (Pasco Region) in September 2006. To September 2007, progress made has been remarkable.

Implementation Activities

1. Information and training

At DIRESA, *the Human Resource Committee was created*[118] that, together with a representative from the local government and the organized community, was in charge of the implementation of RHUS Policies. The Villa Rica MN was selected and prioritized by Director's Order[119] and support was sought from the Oxapampa Network Management Team, to which Villa Rica belongs. A "*NETWORK Human Resource Committee"*, created by Headship Order [120] , was sensitized in RHUS management, mainly in the incentives policy.

In the local government, sensitization was aimed at the mayor and councilpersons who were unaware that public health management includes RHUS management and that this should be implemented by the local government.

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118 *The RHUS Committee of the Pasco DIRESA was approved by Director's Order No. 065-2006-DG/CR*

119 *Director's Order No. 040-2007-DG. "Designation of the initial intervention place for the implementation of Health Human Resource Policies".*

120 *Departmental Order No. 010-DE/HRVE-2006 "Conformation of the Management Team of the Villa Rica MN Departmental Order No. 007-DE/HRVE-2007 "Re-structuring of the Management Team of the Villa Rica MN".*

Table 20: Number of Trained People in the Pasco Region

INSTANCE	TRAINED	NUMBER OF TRAINED PERSONS	
		Pasco	Junín
TOTAL		**82**	**63**
REGIONAL GOVERNMENT	Regional Development Manager Regional Health Board Regional Human Resource Committee	01 08	
DIRESA	Management Team Human Resource Committee	08	07
	Human Resource Office	03	03
OXAPAMPA NETWORK	Human Resource Committee	22	08
VILLA RICA MN	Management Team	08	16*
LOCAL GOVERNMENT	Councilpersons Board	06	06
	In charge of the Local Development Office	01	01
COMMUNITY		25	23

** trained, 6 members of the San Luis de Shuaro MN management team and 10 from the Pichanaki MN*

In order to know the situation of health human resources in the district, a participative analysis was carried out, which is detailed in the following section. The organized community was key in citizen surveillance actions of local RHUS policies. During this phase, 82 key actors were trained in the Pasco Region and 63 in Junín. (See Table 20).

2. Local Participative Analysis of RHUS Management

The analysis was jointly prepared by health staff, local government, community and the organized civil society[121] to find out about the situation of RHUS management, its main problems, strengths and weaknesses, existing resources and opportunities for problem solving. Results are the ones shown on Table 21.

Table 21. Results of participative analysis

Problems identified: • Lack of a local labor incentives program at an inter-sector level • Lack of acknowledgement for work carried out • Lack of motivation for achievement of goals • Low pay. No incentives for workers with good working performance. • Staff clock-off work at the exact going out time • Staff not identified with their work • Lack of motivation meetings and fraternization at work • Little interest on the part of health facility in workers' problems, on family and social well-being issues. • Lack of incentives for working health staff • No incentives for most hard-working people
Two prioritized problems: 1. Inexistence of an institutional proposal/local annual plan/program of incentives for the appointed worker or worker under contract. 2. Little interest on the part of the health facility in workers' problems on family and social well-

[121] *Participants in the analysis were: representatives from the Villa Rica MN, Oxapampa Network, DIRESA, health posts and centers of the MN jurisdiction, local government, community and neighbor associations, community agents, Von Humboldt Higher Technological Institute, National Police, Committees of people displaced by Political Violence, among others*

being issues.
Problem Causes: • Inadequate communication • Work overload due to small number of staff • No true value is given to workers as human beings (they are just another resource) • Deficient inter-personal relationships • Health staff with multiple functions
Prioritized Activities: 1. Institutionalization of a non-monetary incentives proposal[122] with the involvement of the organized community and local government in designing such, where the local government and the MN assume shared management responsibility. 2. Preparation of an institutional Social Well-being proposal with the involvement of DIRESA, Network and MN, whose responsibility would befall on the MN and the Oxapampa Network.
Responsibilities of prioritized activities: 1. Health incentives Policy: Local Government's responsibility 2. Health worker Social Well-being Policy: Oxapampa Network and Villa Rica MN's responsibility

The analysis allowed reaching agreements and commitments and defining the role of each actor in the institutionalization of a non-monetary incentives policy in the local sphere. Each actor assumed their functions: the local government (officials and board of councilpersons) in charge of managing public health and organizing the community in the district sphere[123] and neighbor and community associations in charge of citizen surveillance and involvement as a key element for strengthening public and community management.

3. Participative and coordinated design of regulatory proposals. Approval.

Those who participated in the design of incentives policies were: *The Villa Rica MN management team, the Villa Rica Technical-District Committee -COTEDI*[124] *and Neighbor and Community Associations*, instances officially acknowledged[125]. Together, they prepared the Acknowledgement Guideline for the Ministry of Health's Health Workers[126], the Guideline on the best worker approved by the Pasco Regional Government[127] and the Coordinated Health Program that respond to Policy 11, Regional Health Policies[128] and Policy 7. It contains the incentives issue at an

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122 *Document on agreements for the implementation of the Work Plan for the Incentives Policy, 2006.*

123 *Law No. 27972, "Framework Law on Municipalities"*

124 *Mayor's Order No. 076-2007-MDVR/A "Conformation of the Villa Rica District Technical Committee*

125 *Report No. 084-007-OSCS-MDVR submitted by the Head of Community and Social Services informing on the appointment of Ms. Amelia Peralta Torres as representative of the neighbor associations of the Villa Rica district on August 21st at the neighbor association board meeting.*

126 *R.M. 954-2005/MINSA, approving Administrative Guideline No. 072-MINSA/OGGRH-V.01- "Procedure for selecting the Best Worker at the Ministry of Health's departments".*

127 *Regional Executive Ordinance No. 0295-2007-GR Pasco "Procedures for the designation of the Best Health Worker in the Pasco Region"*

128 *Regional Ordinance No. 091-2006-GRP/C "Health Human Resource Policies in the Pasco Region".*

Benefits and incentives for Best Worker:

individual and group level. For the former, the selection of the best worker has been proposed, and for the latter, well-being actions for workers and their families.

Three meetings were carried out to comply with the individual incentives guideline and **to choose the best worker**: the first was with MINSA staff (Villa Rica MN management team, representatives from the RHUS Committee from the Oxapampa Network and DIRESA) to adapt the best worker guideline of the Regional Government to the local sphere. The second meeting was with the Local Government, to review the guideline and establish an Evaluating Committee including delegates from neighbor and community Associations. The third meeting was with COTEDI and education, health and national police representatives and delegates from Neighbor and Community Associations to review benefits and incentives[129].

- **Institutionalization of the proposal.**

The institutionalization of guidelines on Best Health Worker and Social Well-being was carried out at different levels. In the case of the Best Health Worker Guideline, a technical dossier was prepared. The ODL supervised the preparation of a technical opinion document and the file was followed up until the guideline was approved[130].

The Social Well-being Guideline was first reviewed at the Villa Rica MN and then at the Oxapampa Network by the RHUS Committee. It was approved by the NETWORK Director[131].

4. Initial implementation of the regulation

After both the BEST WORKER AND SOCIAL WELL-BEING incentive guidelines were approved, a roadmap (see Annex 32) was prepared with the local government, COTEDI and MN, which includes the following steps:

√ Establishment of an evaluating committee by Mayor's Order[132].
√ Summoning all health facilities to participate in the process.

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129 - *Written acknowledgement or congratulations through a Mayor's Order and a copy of such for the records*
- *Diploma, medal and merit badges, scholarships and/or training programs.*
- *Tourism Programs*
- *Public acknowledgement (through loudspeakers), expressing the respective personal achievements,*
- *Granting of paid leave of absences,*
- *Acknowledgement through publications and photographs in institutional magazines and news boards,*
- *Conformation of work teams with institutional responsibility.*

130 *Mayor's Order No. 230-2006 -MDVR/A- "Procedures for the designation of the Best Health Worker of the district of Villa Rica".*

131 *Director's Order No. 020-07-DE-RSS-OXAMP "Guideline on Social Well-being of the Oxapampa Network Health Workers"*

132 *Mayor's Order No. 174-2007-MDVR/A "Conformation of the Evaluating and Rating Committee for the Designation of the Best Health Worker in the district of Villa Rica.*

- √ Setting up of the evaluating and rating Committee.
- √ Rating and evaluation of candidates
- √ Organization for acknowledgement and award-giving to the Best Worker
- √ Evaluation of the process and report on results

The Social Well-being guideline, (see roadmap in Annex 32) was reviewed by the Villa Rica MN management team, the RHUS Committee representative of the Oxapampa Network and the DIRESA representative. The guideline establishes short and medium term benefits.

Short-term benefits:

- √ Appointment of a person in charge of Social Well-being.
- √ Approval and execution of the Recreation, Culture and Sports Program
- √ Sending of Birthday greetings
- √ Health campaign for workers
- √ Reading room
- √ Creation and approval of an Institutional Choir.
- √ Multi-sport Championship, etc.

Long-term benefits:

- √ Breast-pumping room.
- √ Workers integration room during breaks.

- **Budget for individual and group incentives**

  COTEDI members succeeded in making the local government include the Best Health Worker guideline in the 2008 participative budget, consisting in a tourism and training scholarship.

  For the Social Well-being guideline, the Oxapampa Network has allotted 2% from the directly collected resource funding source. This percentage has been included in the bill for the Operative and Budget Plan, POI, 2008.

- **Process results at the Villa Rica Micro-network**

  - Upon conclusion of the Project, there is great interest on the part of the Villa Rica MN and local government to continue with the health incentives policy, currently in its pilot stage.
  - DIRESA, Network and MN Human Resource Offices are committed to the development of an incentives policy for best worker.
  - Local spaces have been officially constituted to analyze and discuss RHUS policies, especially incentive ones.
  - There is health staff capable of developing continuous improvement of RHUS management with the purpose of improving care quality.

- Citizen coordination and participation spaces have been created with mechanisms for community representation through community agents and COTEDI members.

3.5.2 Junín Region

The experience on the incentives policy carried out at the Villa Rica MN was duplicated at the San Luis de Shuaro MN and the Pichanaki MN in the Junín region. The difference in these MNs was that there was greater coordination between MINSA health facilities and the Local Government. This was due to Health Promotion activities previously carried out by the Project, which facilitated its implementation. Lessons learned at Villa Rica were used, enabling to shorten some stages, such as sensitization.

3.5.3 Huanuco Region

In the framework of the Regional Human Resource Policies implementation in the Huanuco Region[133] and after having made the analysis of the RHUS situation[134], the problems shown on Table 22 were discovered.

Table 22. Problems for implementing regional RHUS Policies in Huanuco

[133] *Agreements of the Regional Board of the Regional Government approved on October 19, 2007*

[134] *Baseline Report on the situation of RHUS Policies in the regional and local sphere of the Huanuco region 2006*

- Lack of incentives for staff under contract
- Lack of incentives for Health Community Agents
- Little accessibility to training programs.
- Unequal distribution of incentives between administrative and service staff.
- Inadequate management of stationed staff permanence.
- Non-compliance of workers' medical checkup.
- Non-rewarded practice of values.
- Change initiatives ignored by supervisors.
- Inadequate staff management.
- Lack of incentives policies (written acknowledgements, medals)
- Constant staff rotation.
- Non-rewarded or unpaid overtime hours.
- Staff promotions not complied with.

In order to solve these problems, an Incentives Guideline was proposed, in which the Speaker team and key regional and local actors took part in its preparation. Among these, were members of the Thematic Committee for the Development of Health Human Resources, the Regional Health Board and Local Government[135]. This team was trained (Table 23) on incentive issues, and specifically, on non-monetary incentives[136].

Table 23: Trainees in the design of incentives guideline Huanuco

Level	Number of Trainees
Total	**134**
Regional	**50**
• Regional Government	7
• Thematic Committee on RHUS Development	23
• DIRESA	13
• Hermilio Valdizán National University	4
• Hermilio Valdizán Regional Hospital	2
• Higher Technological Institute Aparicio Pomares	1
Local	**84**
• Huanuco provincial Municipality	1
• Amarilis district Municipality	2
• Huanuco health network	11
• Carlos Showing Health Center	33
• Perú – Korea HC	2
• La Esperanza HP	3
• Llicua HP	3
• Paucar HP	1
• Malconga HP	2
• Health Promoters	26

135 *Technical Speaker Team for Health Human Resources, Huanuco, 2007*

136 *Bases for guidance of Human Resource Decentralization management, IDREH, 2004*

The design of the Incentives Guideline[137] was based on the effective national and regional regulations, defining the objective, application scope, legal bases, procedures, criteria for appointment and responsibility levels. Incentives are similar to those of the Best Worker Guideline from the Villa Rica district[138] and the Well-being Guideline[139] from the Pasco DIRESA. Criteria were established for granting incentives, such as for example, to be a role model for all workers in the sense of social values that are beneficial for the entity, among others.

3.5.3.1 Results in the regions

The following has been achieved between 2006 and October 2007:

- In May 2007, the Best Worker Guideline was approved in the Pasco Region; and at the DIRESA level, the Social Well-being Guideline.
- In the Villa Rica district, the best worker of the year was chosen, to be publicly acknowledged by the Mayor in November, during the city's anniversary.
- The Chanchamayo Network in Junín has publicly acknowledged 8 health workers. The Pichanaki and San Luis de Shuaro local governments have approved the best worker guideline and an Evaluating and Rating Committee is being implemented.
- The Villa Rica District Technical Committee has included in its Functions Regulation, aspects related to health human resources.
- In Pasco, Junín and Huanuco, the HR Offices of DIRESA, Networks and MN has ideal professionals for developing continuous management improvement of HR in order to count with motivated, acknowledged and skilled workers to improve care quality.
- Local authorities from the regions intervened have included in their working agendas the need to improve conditions and technical competences of health human resources, to solve the main health problems in the population.

3.5.4 Suggestions and Recommendations

1. The NETWORK AND MN's Operative Plan and the local government participative budget should include activities for the implementation of the RHUS policy.

2. Promote community involvement for an effective supervision of RHUS policies and their consolidation.

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137 *The incentives guideline is pending approval by the Huanuco DIRESA because it is awaiting the Work Competence Regulations (being prepared) to which they will be adapted. (See Annex 33 of the Incentives Guideline Proposal)*

138 *Mayor's Order No. 230-2006-MDVR/A-Villa Rica "Procedure for the designation of the best health worker"*

139 *Director's Order No.003-07-DG-DIRESA Pasco/GR*

3. Link the RHUS policy to the Healthy Towns strategy to facilitate for health staff that successfully participates in PROMSA to be proposed as a best health worker candidate.

4. Permanent technical coaching of DIRESA to the Network and MN to carry out RHUS policies.

5. Implementation of the RHUS policy as a technical and political strategy, because the regulation, organization and summoning of the community are inherent roles of the local government.

6. Technical assistance should be comprehensive in Promotion, Quality and RHUS processes and not isolated in RHUS Policies, to have a more efficient participation of those involved.

7. The RHUS Manager should assume responsibilities in achieving equal opportunities, quality and efficiency in comprehensive health care and quality in working conditions for health staff.

3.6 POLICY 8: WORKING RELATIONSHIPS BASED ON RESPECT

The working environment should allow the development of human resources through appropriate personal relationships. This implies the development of competences for timely detection of conflicts and skills, among others. The Project carried out a couple of studies on the organizational climate with the purpose of implementing policy 8.

3.6.1 Organizational Climate in Huanuco

Conflicts among the staff are common at the Huánuco DIRESA and its health facilities. There are several causes but the ones that stand out are communication deficiencies, cutthroat competition and rivalry that weaken the organization and damage creativity and productivity.

Therefore, DIRESA and the RHUS Management Team conducted an organizational climate study at the Carlos Showing Ferrari health center. It included a skill-strengthening workshop for 17 persons (3 from DIRESA, 2 from the Huanuco Network and 12 from the Amarilis Micro-network). Among four possible organizational climate measuring instruments[140], the WES was chosen (See Annex 34) because it adapts better to the study area and provides evaluation scales: Inter-personal relationships, self-realization and

[140] *- Organizational climate questionnaire, adapted from the East Lima DISA.*
- Organizational climate Test from TECLA Colombia.
- WES organizational climate survey.
- Organizational climate questionnaire, adapted from Mc Gregor and Schein.

stability/change. Surveys were carried out by University students in three shifts. Seventy-nine workers were interviewed out of a total of 126; the rest refused to provide information.

The results of the organizational climate study can be summarized as follows:

1. Occupational Profile: By occupational group, workers are classified into: medical professionals 32%, medical technicians 31% and medical assistants 15%. Its working regime is: 66% appointed y 22% under contract. 25% with 16 to 20 years of service.

2. Inter-personal Relationships: 75% of workers state there is little voluntary work at the facility, 72% say work in very interesting, 68% state people often create problems by talking about others behind their backs. On the other hand, 53% states that bosses do not encourage critical spirit in workers, but rather criticize them for unimportant things (56%).

3. Self-realization: 70% say too much time is wasted due to lack of effectiveness and 73% of workers say they are always bumping into routine work or against a barrier when they want to do something (positive).

4. Stability/change: 73% of workers indicate things are too disorganized; but if the health center were to be innovated; they would be the first to try out new things (76%).

5. Personal Development: 82% considers it is important to undergo training to move up to higher positions and 87% feels motivated to do so.

Based on these results, the Head of the Amarilis MN together with the management team decided to work on the organizational climate by prioritizing the stability/change dimension as a continuous improvement process and incorporating it into the CDC – MN, for changing the organizational culture.

6. Lessons learned: the sensitization stage is key for other stages. The importance of the study should have been stressed in order to have 100% of the workers participate.

3.6.2 Organizational Climate in San Martín

At the beginning of 2007, technical assistance was provided to DIRESA to strengthen its quality management system, with the purpose of solving some problems related to ill-treatment by workers of the periphery to the population that attend the facilities.

A 180-day Plan was proposed that included a campaign for **No Queues and Fair Treatment,** with the purpose of joining regional, administrative and medical workers under the same objectives and strategies established by DIRESA's managing team. It began by measuring the organizational climate (with the participation of 68% of workers) at DIRESA's central office, and with a survey on the perception of the working climate at that office. Results were later analyzed and workers were sensitized on this issue through six workshops. Therefore, an analysis of needs and perception of workers was obtained together with a solution proposal under the charge of DIRESA. Later, training in quality

management and inter-personal relationships was carried out to support work at networks and micro-networks, with efficiency and quality.

Workers' response to this initiative was favorable. They showed their willingness to support DIRESA's General Directorate and its management team. In turn, DIRESA committed itself to solve problems set forth by the workers during the organizational climate measuring according to its real possibilities.

On their part, workers and the DIRESA management team proposed an Action Plan for the campaign "No Queues and Fair Treatment" carried out at the Morales HC and at the Banda Hospital in Shilcayo. At the end of the experience, complaints from the population dropped down by 50% and 60% of service users were satisfied. A team of psychologists from the health networks participated in this experience. This facilitated the continuation of the experience at other networks and facilities in the region. The result was the strengthening of activities, measurements and quality improvement proposals for the region at DIRESA's Quality Unit.

3.6.3 Other aspects worked on regarding RHUS in the Pasco region

1. DIRESA's management team, with technical assistance from the project, prepared a proposal for a Suggestion Box guideline, to regulate criteria and procedures for its use in agreement with the Quality Management and RHUS Management implementation process. The guideline was reviewed by the Oxapampa Network RHUS team and the Villa Rica MN. It was approved by Director's Order No. 002-07-DG-DIRESA Pasco/GR in January 2007. This Guideline was adapted at the Oxapampa Health Service Network and approved by Director's Order No. 068-07-DE-RSS-OXAMP of April 2007 for its application at the Villa Rica MN.

2. The Pasco DIRESA management Team and the RHUS Committee proposed the institutionalization of the Health Human Resource Manager's Day (as an

[141] on this issue.

3. DIRESA's RHUS Committee has proposed an organization design and another on functions of the RHUS Office[142], which are being analyzed by the General Directorate and the Planning and Budget Office.

4. The Pasco Regional Directorate, through Director's Order No. 144-2007-DG-DIRESA/GR Pasco[143], of June 2007, acknowledged the work carried out by members of the RHUS Committee, the Regional Health Board and PATHFINDER INTERNATIONAL for the technical assistance provided.

5. Banners were prepared as a communication strategy for the implementation of RHUS Policies (approved by USAID[144]) to disseminate RHUS actions in the regions (see Annex 35):

    - Banner 01: Health Human Resource Message/motto "Motivated, acknowledged and competent health workers for the development and well-being of the community

    - Banner 02: Steps for the implementation of RHUS Policies

[141] *Minister's Order No. 960-2005/MINSA del 13/12/2005 "Establish December 11th as the Ministry of Health Staff System Day"*

[142] *Report No. 015-2007-DEGRHH-DIRESA Pasco-Proposal for the Organizational Design of the Pasco DIRESA Human Resource Office of March 22nd, 2007.*

[143] *Director's Order No.144-2007-DG-DIRESA/GR Pasco "Acknowledgement and congratulations to the members of the RHUS Regional Committee of the Health Regional Board of the Pasco Regional Government and to PATHFINDER INTERNATIONAL.*

[144] *- PI-AC-007/2007 in which USAID approves the making of giant posters for dissemination of the central message "Motivated, acknowledged and competent health workers for the development and well-being of the community".*

- PI-AC-13/2007 in which USAID approves the making of giant posters for dissemination of the central message from RHUS in the framework of the implementation of the RHUS Policy in the Pasco Region as well as the authorization for the USAID logo.

STRATEGIC PRODUCT 2: HEALTH HUMAN RESOURCES

COMPONENTS	ACHIEVEMENTS
PREPARATION OF POLICIES	
Adaptation of National Policy Guidelines for RHUS Development to regional reality.	• Establishment and approval of RHUS Technical Committees in Junín, Pasco and Cusco. • Re-structuring and approval of the Development Thematic Committee RHUS Huanuco[145] • Approval through Regional Ordinance of RHUS Regional Policies in four regions: Huánuco, Junín, Pasco and Huanuco.
IMPLEMENTATION OF POLICIES	
ORGANIZATION	• Participative analysis of RHUS situation in 3 districts: Villa Rica (Pasco), San Luis de Shuaro (Junín), Amarilis (Huanuco) and (Cusco) • Establishment and approval of RHUS-DIRESA Management Teams in Huanuco, Junín and Pasco. • Establishment and approval of Management Teams at RHUS-Oxapampa (Pasco) and Chanchamayo (Junín) in the Pasco and Junín regions, respectively • Director's Order No. 040-2007-DG-DIRESA/Pasco to "Select the Villa Rica MN as an initial intervention place for implementing RHUS Regional Policies".
POLICY 1. Education According to the Needs of the Country	
• General Law on Education (Law 28044) enacted in 2006 and regulated in 2007. • Establishment of the Initiatives Group for Quality in Higher Education (GICES) • Law No. 28740 for the Creation of the National Quality in Education Evaluation, Accreditation and Certification System (SINEACE), May 2006 and Regulation of the SINEACE Law (07/10/2007).	
Accreditation of Medical Schools and Faculties	• National Medical Exam (ENAM) acknowledged by Minister's Order No. 620–2006/MINSA, that makes its application compulsory at all medical faculties in the country. • First ENAM (2003) applied to students in their 6th and 7th year of studies. Second ENAM (2005), with the participation of 1,565 internship students and 120 professionals and students from other years. Third ENAM (2006) applied in 22 medical faculties members of the ASPEFAM. • The National Medical Resident Committee (CONAREME) establishes the ENAM as a requirement for medical residents (for graduates as of 2006 on). • Creation of CAFME as an autonomous entity by Law No. 271548. • CAFME standards include AIEPI strategy contents, by Supreme Order No. 004-2003-SA24. July 2003 • Accreditation of 23 out of 29 medical faculties and schools in the country. • CAFME stopped the creation of new medical faculties. • Implementation of the Experimental Laboratory for the Evaluation of Competences in Health Sciences, with a first technical nucleus in ASPEFAM, 2005 –2006. • Creation of the Medical Faculty Management Association to form high and

[145] *The RHUS Thematic Committee in Huanuco was created in 2003 for the implementation of the Coordinated Health Plan 2003–2006. In June 2006, it was re-structured to develop regional RHUS policies.*

COMPONENTS	ACHIEVEMENTS
	intermediate management teams, 2003. • Document on Research Lines in Health and Human Resources of the Pasco Region
Accreditation of Nursing Schools and Faculties	• Basic Nursing Curriculum finished and approved at general deans assembly. It included maternal perinatal health competences, AIEPI and health communication and promotion • National Nursing Exam (ENAE), approved in 2005. Two National pilot Exams carried out. • Competence Profile of nursing graduate • Quality standards for accreditation of nursing schools and faculties. Self-evaluation guideline.
Accreditation of Obstetrics Schools and Faculties	• Basic Obstetrics Curriculum based on competences, approved in pilot obstetrics faculties and schools. • Competence Profile of obstetrics graduate • Basic quality Standards for operation of nursing school or faculty • Quality Standards for the Undergraduate Nursing Program
Periodic Certification	• SISTCERE: New medical re-certification model linked to practice. • National Periodic Nursing Certification System and its ruling. • Permanent Nursing Education Program Model (PEPE). • SINADEPRO • Continuous Obstetrics Education Program (PECO).
Health and RHUS Research	• Document on Research Lines in Health and Human Resources of the Pasco Region
POLICY 2: RHUS Strategic Planning	
• Study: "Current and prospective analysis of supply, demand and the need for doctors in Peru 2005 – 2011.	
POLICY 4: Development of Competences	
• Guidelines for evaluation of standards and indicators at CDC facilities containing five components: Management and availability of resources, standardized management, intern competence, permanent health education and data use. • 433 (doctors, obstetricians, nurses and technicians) trained in EMOB care. • 96 tutors (doctors, nurses and obstetricians) Huánuco, San Martín, Ucayali, Junín, Pasco and Cusco trained at the Maternal Perinatal Institute of Lima • CDC Facilities: Pucallpa Regional Hospital, Yarinacochas Amazon Hospital, El Carmen Hospital of Huancayo, Antonio Lorena Hospital in Cusco, Hermilio Valdizán Hospital in Huánuco, Tingo María Support Hospital, Oxapampa Support Hospital. • Conformation of 10 Technical Committees CDC -facility at qualified hospitals in the seven regions of the project. • Standards and indicators for rating CDC–MN, as Competence Development Centers for maternal perinatal and infant care. • 04 CDC – MR qualified, 02 operative (Margos and Amarilis in Huánuco) and 04 and currently being analyzed. (Villa Rica in Pasco and Pichanaki in Junín). • CDC-MR: 30 certified health tutors and 28 approved, 24 approved municipal tutors and 96 technicians scheduled for training to December 2007.	

COMPONENTS	ACHIEVEMENTS
POLICY 6: New Working Regulatory Framework	
• Work competence (29 productive functions) profile (minimum) for Care Level I, category I-2. • Work profile by competences for workers (doctor, nurse, obstetrician and technician) for category I-2 facility • Work Competence Regulations of prioritized competence units in the areas: children, pregnant women and management (training management). • Evaluation instruments for work competences: 15 checklists and 10 questionnaires. • Occupational Profile and Work Competence Regulations in the areas: person (children, adolescents, pregnant women and elderly), family, community and management approved in Huánuco (Director's Order No. 272-07-GR-HCO/DRS-DG-OEGDRH-DESP of May 2007. • Conformation of the Work Competence Regulatory Committee of the Pasco Region, approved by Regional Executive Order No. 640-2007-GR Pasco/Pres on 9/12/07. • Staff selection guideline designed in Huanuco and Pasco, pending its adaptation to a competence approach. • Management Agreements (July 2007) between the Regional Government and local governments of Amarilis and San Francisco de Cayrán (Huánuco), to improve health human resource work competences in the maternal infant area. • Expansion of Management Agreements between the Regional Government and eight local governments of the CRECER Plan (in September 2007) • Design of Health Worker Induction Guideline of the Pasco DIRESA	
***POLICY* 7: Working Conditions, motivation and Worker's Commitment**	
• Training for 279 persons in Pasco, Junín and Huánuco in RHUS Management – incentives sub-process, for designing the guideline. • Regional Executive Order No. 0295-2007-GR Pasco "Procedures for appointing the Best Health Worker in the Pasco Region". • Mayor's Order No. 230-2006-MDVR/A "Procedures for appointing the Best Health Worker in the Villa Rica district". • Mayor's Order No. 0143-2007 A/MDSLSH "Procedures for appointing the Best Health Worker in the San Luis de Shuaro district". • Mayor's Order No. 099-2007 A/MD Pichanaki "Procedures for appointing the Best Health Worker in the Pichanaki district". • Director's Order No. 792-2006-DRSJ/OEGDRH that approves Administrative Guideline No. 04-2006-"Procedures for appointing the Best Health Worker" of Junin DIRESA • Director's Order No. 011-0GR/JUNIN/ Chanchamayo Network "Procedures for appointing the Best Health Worker". • Director's Order No. 003-07-DG-DIRESA Pasco/GR "Social Well-being Guideline for health worker of the Pasco DIRESA" • Director's Order No. 020-07-DE-RSS-OXAMP "Social Well-being Guideline for health worker of the Oxapampa Network". • Director's Order No. 027-DRSJ/OEGDRH which approves Administrative Guideline No. 01-2007-" Social Well-being Guideline for health worker of the Junín DIRESA • Director's Order No. 097-07-GR/JUNIN/ Chanchamayo Network, of August 23, 2007 "Social Well-being Guideline for health worker of the Chanchamayo Network". • Director's Order No. 074-07-GR/JUNIN/RS Chanchamayo "approves work plan for the 1st Multi-sport Games, Dance Contest as part of Social Well-being activities.	

COMPONENTS	ACHIEVEMENTS
• Mayor's Order No. 174-2007-MDVR/A "Conformation of the Evaluating and Rating Committee for Appointing the Best Health Worker in the Villa Rica district". • Mayor's Order No. 181-A/MDSLSH "Conformation of the Evaluating and Rating Committee for Appointing the Best Health Worker in the San Luis de Shuaro district". • Director's Order No. 091-07-GR/JUNIN/ Chanchamayo Network "Best Worker Acknowledgement during 2006 made to Ms. Graciela Maria Minaya Quezada, nursing technician I- from the Chanchamayo health service Network". • Director's Order No. 002-07-DG-DIRESA Pasco/GR "Suggestion Box", January 18th, 2007- Pasco DIRESA • Director's Order No. 068-07-DE-RSS-OXAMP, "Suggestion Box", April 9th, 2007- Oxapampa Network • Conformation of the Speaker Team in Huanuco for designing incentive, selection and performance evaluation guidelines based on competences. • DIRESA Incentives Guideline –Huanuco and Pasco, currently being adapted to the competence approach.	
POLICY 8: Working Relationships Based on Respect and Dignity	
• Training of 17 persons for the organizational climate study at the Carlos Showing Ferrari HC of the Amarilis – Huanuco MN. • Measurement of the organizational climate at the Carlos Showing Ferrari HC. 79 out of 126 workers took part. • Prioritization of the stability/change aspect for the continuous improvement cycle coordinated to the CDC – MN for changing the organizational culture. • Measurement of the organizational climate at the San Martín DIRESA with the participation of 68% of workers. • Execution of the Action Plan "No Queues and Fair Treatment" executed at the Morales HC and at the Banda Hospital in Shilcayo (San Martín). • Drop in 50% of the number of complaints by service users. 60% of satisfied users (San Martín).	

III. STRATEGIC PRODUCT 3: HEALTHY TOWNS

1. BACKGROUND INFORMATION

A number of institutions and documents[147] argue that the population's health is promoted by providing it with control over their social determinants identified as causes of the disease. Health promotion is based on this as a key strategy of public health

In Peru, health promotion has moved toward a modern orientation through social communication which commits individuals to a change of habits. The challenge is to link the actions of regional authorities, local communities and individuals to build healthy scenarios as an expression of citizens' participation and the exercise of rights and responsibilities in health.

The initial experience of healthy municipalities was in Cajamarca (2002-2003) through a consortium[148] that developed a project called Building Healthy Neighborhoods in neighboring towns of Cumbe Mayo, Pueblo Libre and San Vicente. This experience was visited at the beginning of the Project by various local government authorities with the idea of duplicating it in the 7 regions under the Agreement.

The strategy of health towns included different approaches:

- Healthy Development and Well-being is being not only disease-free but includes also social, economic, cultural, environmental, political and educational appropriate conditions for a comprehensive development: personal, family, community, district and regional wise.
- An approach toward health and development determinants.
- An empowerment, organizational and participative management approach. Health promotion is everybody's responsibility not the health sector's alone.
- A health decentralization approach: through a Healthy Town, local governments are given the responsibility of promoting development in their areas.
- An integral and interdependent coordination of various scenarios: Town, Educational Institution, Family and Community.

147 *Lalonde Report (1974) passing by Alma-Ata (1978), The Ottawa Setter (1986), the Bangkok Declaration*

148 *A consortium formed by Universidad Peruana Cayetano Heredia, Yanacocha Mining Company and NGO G&C Salud y Ambiente. The experience took place in the municipalities of Cumbe Mayo, Pueblo Libre and San Vicente benefiting 4 thousand households and 20 grassroots organizations. It developed health living environments with citizens' participation and a socially responsible commitment by the public and private sector that led to an improvement of living standards of the population.*

2. CONCEPTUALIZATION

A Healthy Town is that in which all its citizens, institutions and organizations work in favor of health, well-being and quality life of its people.

The proposed Health Promotion Project seeks to mobilize organizations to improve the quality of people's lives through 5 appropriate lines of action tailored to the various local scenarios: town, the Educational Institution, Community, neighborhood and family. The lines of action are:

- Organization and Participative Management.
- Promotion of Healthy Policies
- Improvement of healthy environments and surroundings.
- Education and Communication of Healthy Life Styles.
- Reorientation of public and private services.

2.1 LINES OF ACTION

- **Organization and Participative Management.**

It is the community's capacity to decide and exercise control over the quality of life through the organization of consensus and decision forums, for example the Office for Local Development (ODL) and Local Technical Team (ETL), Neighborhood or Community Board and the Institutional Educational Council (CONEI), among others. For its part, management refers to the reorientation of the District Development Plan and Participative Budget with an approach to Health Promotion and Social Development, as well as the elaboration of a Family Development Plan, etc.

Implementation of Local Consensual Healthy Policies.

They guarantee comprehensive and coordinated action of activities in solving community problems that have great influence in health determinants through municipal rules and ordinances on health and development and community, neighborhood, school and family living standards, etc.

- **Development of Healthy Environments and Surroundings.**

Healthy environments and surroundings include treatment strategy of environments such as: conservation of rivers, forests, solid waste recycling system, cleaning of streets and squares, green and recreational areas, provision of safe drinking water and basic sanitation, municipal sanitary landfill, improvement of (school) patios and toilet rooms, drainage system and sewage treatment, etc.

- **Promotion of Healthy Life Styles.**

A life style is a set of behaviors and practices that define the way of living and interacting of persons with their surroundings. It is linked to the pursue of a better quality of life understood as the well-being and satisfaction of the individual, including service and care behavior of mother and child, women in reproductive age, school age population, the population as a whole, housing and community.

- **Reorientation of Health and Education Services.**

A reoriented service is that which provides better quality to meet the needs and expectations of internal and external users that contribute to the creation of conditions (community halls, municipal and school libraries, Municipal Advocacy Services for Women, Children and Adolescents-DEMUNA, school first aid unit or material, guidance and counseling in Healthy Educational Institutions, among others) that will allow people to develop their potential.

2.2 POLITICAL IMPACT

Under political advocacy, the Project has contributed to the achievement of the following policies:

- A MINSA policy on "Decentralization of the Health Function on a Pilot Project level" considers health promotion as a key function for primary health care to be decentralized.

- Regional Ordinance No. 002-2007-CR-GRH, of the Huanuco Region approving Certification of Regional Minimum Standards of Healthy Towns for implementation of Strategy for Healthy Towns.

- Regional Executive Order No. 115-2007 GRJ/PR of the Junin Region declares regional priority the promotion and culture of health, as well as the implementation of Certification of Minimum Standards of Healthy Towns for the promotion of Social Development and Well-being in the Region.

- Sensitization of local leaders and authorities with regards to the issue that result in:

  - Implementation of 52 Local Development Offices, ODL, responsible for the coordination of activities of institutions, authorities and community.
  - Implementation of 52 Local Technical Teams, ETL, as technical support for management
  - Organization and recognition of 504 Community Boards,
  - Creation of 60 social networks
  - Promulgation of 131 Municipal Public Policies for the implementation of their Local Development Plan
  - Design of 835 Community Plans
  - Design of 305 Family Plans

- Organization of Regional Encounters in Huanuco, Ucayali and Pasco for promoting experience exchange and strengthen relationship between Local Governments and Regional Governments.

- Incorporation of a Healthy Town Project design in the municipal political agenda under the framework of regional and district participative budget. For example:

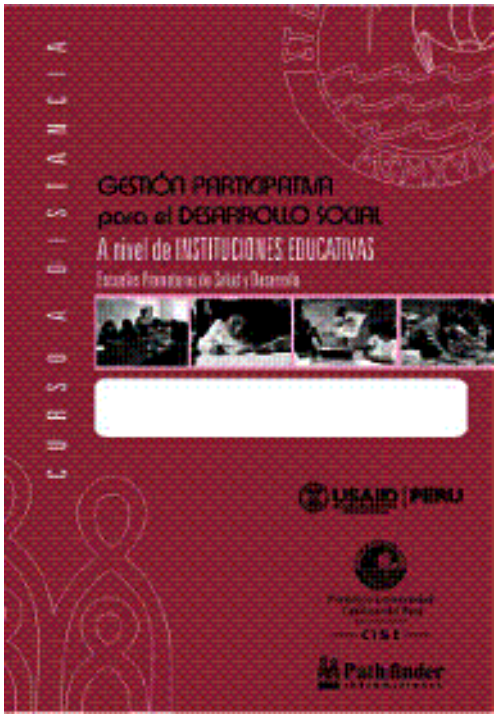
  - Junin: "Capacity Building of Local and Regional Technical Teams for Health Promotion in the Region" project approved in the Regional Participative Budget for a total amount of 337,200 nuevos soles
  - San Martin: "Promoting Participative Social Development in the Juan Guerra District" project approved for an amount of 30,000 nuevos soles.

2.3 MANAGEMENT FOR THE IMPLEMENTATION OF A HEALTHY TOWN STRATEGY

2.3.1 Training: Distance Teaching Course on Healthy Towns and Schools

The course of Participative Management for Social Development in Healthy Towns and Educational Institutions Promoters of Health and Development aimed at building local capacities for the implementation of these two health scenarios. The course was developed with the institutional support of Pontificia Universidad Catolica del Peru, sponsored by the

Social Development Management Offices and Health and Education Regional Directorates, and Local Governments.
By means of this agreement, Universidad Catolica (through its Research and Educational Services Center–CISE-), developed a Distance Teaching Training System for the Promotion of Health and Development in the 7 regions under the Project, The theoretical and practical course intended to generate abilities for the implementation of PROMSA's strategy in local scenarios. The course was addressed to members of ETLs, ODLs and educational institutions.



The different regional institutions[149] were key in disseminating the course (through the mass media, newspapers, radio stations, posters and three-leaf brochures) and its implementation

- **Characteristics of the Course**

  The course followed a group-educational feature – with 5 to 10 participants of different disciplines by group – applying a theoretical and practical modular system for the application of development plans in communities and institutions. State of the art technological tools were used for the transfer of knowledge, such as a virtual platform containing consulting material for participants. Academic monitoring to participants was permanent through a team tutor.

  Material and content preparation was entrusted to the Project Health Promotion Team.

- **Content of the course**

  The course trained participants in two contents:
  - Promotion of Social Development in Healthy Towns – SM, and
  - Promotion of Social Development in Educational Institutions Promoters of Health and Development – (IEPSyD)

  These two aspects of the course were organized in 6 modules[150] with 6-month duration as a whole.

- **Tutors**

[149] *Social Development Regional Management Offices, the Education and Health Regional Bureaus and the local governments*

[150] *The six modules were the following: Introductory Module, Participative management and organization, Health and Development policies, Promotion of healthy life styles, Generation of health environments and surroundings, Re-orientation of services (of 3-week duration each), and homework and evaluation (1-week duration each).*

Tutors are health and education professionals with experience in health promotion, residing in one of the 7 departments where the course was implemented. They were trained by the Project in tutorial work, computer science and content of the courses. They were grouped under two classifications: a) **Master Tutors**, 7 in total, who were responsible for the supervision of team tutors and of the systematization of academic performance of participants, and b) **Team tutor**, 110 in total, were responsible for academic attendance and monitoring of participants.

- **Participants**

The success of this invitation was total and is reflected by the participation of 5,160 persons of 55 provinces of the 7 regions within the project, Junin having the most participation and the least, San Martin. The levels of participation and of drop outs (which was less than 10% in average) depended on Internet access facilities. Table 24 shows the distribution of participants by province and region.

Table 24: Participants

Region	Provinces	Trained Tutors		Participants		
				Total	Course	
		Master	Team		Healthy Towns	Educational Institutions
Total	**55**	**7**	**110**	**5,160**	**2,840**	**2,320**
Ayacucho	7	1	14	1,342	791	551
Cusco	13	1	26	744	402	342
Huanuco	11	1	22	805	414	391
Ucayali	4	1	8	832	447	385
Junin	7	1	14	450	210	240
Pasco	3	1	6	645	368	277
San Martín	10	1	20	342	208	134

- **Material produced for PROMSA's strategy**

Table 25 shows a list of part of the material produced by the Health Promotion strategy for the distance teaching course for the different activities implementation phases including a household community notebook, which is an evaluation instrument of healthy habit indicators.

Table 25: Materials produced

Distance teaching course	**Manual for Healthy Towns**	Module 1: Health Promotion and Social Development. Module 2: Organization and Participative Management. Module 3: Implementation of Health Public Policies to Optimize the Local Development Plan. Module 4: Construction of Healthy Surroundings and Environments in Towns, Communities and Families. Module 5: Promotion and Communication for the achievement of Healthy Life Styles. Module 6: Reorientation of Services toward the Promotion of Health and Development.
	Manual for Educational Institutions	Module 1: Health Promotion and Social Development. Module 2: Organization and Participative Management. Module 3: Design and implementation of Healthy Policies in Educational Institutions. Module 4: Promoting Healthy Environments and Surroundings in Our Educational Institution. Module 5: Module of Health Life Styles. Module 6: Promoting Health and Education Services in Educational Institutions.
Guides for the progress of the PROMSA strategy		• Methodological Guide of Healthy Towns. • Guide for the Reorientation of the Local Development Strategic Plan (PEDL). • Diagnosis and Development Plan of my Neighborhood, Community and small village. • Building Development of our Community or Neighborhood. • Let's make Our Family one Healthy Family for Development. • Booklet: Strategy of Healthy Towns and Communities.
Videos		• Video image of Healthy Town School. • Video image of Educational Institutions Promoters of Health and Development.
Guides of Standards and Certification		• Standards of Healthy Towns. • Standards of Qualification of Healthy Communities or Neighborhoods. • Standards of Qualifications of Healthy Families. • Standards of Qualifications of Educational Institutions Promoters of Health and Development. • Guide for the Certification of Continuous Improvement Processes of Social Development in Strategy of Healthy Towns and its annexes.

2.4 HEALTH SCENARIOS

2.4.1 Healthy communities

Standards were defined by line of action for each scenario (town, neighborhood or community, schools and households) to enhance quality of life and well-being of the population, which were validated in selected districts as per the following criteria:

- Capacity of organization.

- Political commitment of authorities for development of the Local Health and Development Promotion strategy as a tool for participative management

- Willingness of grassroots organizations, public and private institutions and the mass media

- Belonging to alternative Development Program (PDA) zones and districts not under PDN zones.

At the end of the project, the strategy was developed in 72 districts, of which 32 were located in the areas of intervention of the Alternative Development Program, PDA. This part was covered by NGO PRISMA through a sub-grant together with Pathfinder International up to year 2006; later, PROMSA activities continued in the PDA zones through direct assistance to communities by MSH.

In total, the project organized the strategy in 72 districts and 689 communities. The distribution by regions and belonging or not to PDA is shown on Table 26.

Table 26. Communities intervened by the Project

REGIONS	*DISTRICTS*			*COMMUNITIES*		
	PDA	**NO PDA**	**TOTAL**	**PDA**	**NO PDA**	**TOTAL**
TOTAL	**32**	**40**	**72**	**360**	**329**	**689**
AYACUCHO	06	09	15	53	85	138
CUSCO	03	02	05	11	33	44
HUÁNUCO	08	07	15	75	49	124
JUNIN	02	11	13	20	46	66
PASCO	--	07	07	--	16	16
SAN MARTÍN	10	01	11	75	91	166
UCAYALÍ	03	03	06	126	09	135

The Healthy Communities strategy started in Huanuco through the technical assistance provided by NGO G&C in 2003 and by the end of that year, activities were extended to Ucayali. In 2004 the regions of Junin and Ayacucho were included, ending with the incorporation of San Martin, Pasco and Cusco by 2005[151]

In each intervention district, technical assistance was provided either directly or through PRISMA for the organization or strengthening of teams that would be responsible for leading the process: The Local Development Office (ODL) and the Local Technical Team (ETL). As the strategy implementation progressed, new activities were added, including the design of a participative budget that included PROMSA activities and the intervention of households and neighborhood associations for which organization is essential. Concurrently, work was done with regional and local

[151] ***Districts:***
- ***Pasco:*** *Oxapampa, Pozuso, Puerto Bermúdez, Puerto Izcozasin, Puerto Ciudad Constitución, Villa Rica and Huariaca.*
- ***Huánuco:*** *Ambo, Huacar, Pillco Marca, Aucayacu, Hermilio Valdizan, Queropalca, Llata and Puerto Inca.*
- ***Ucayali:*** *Aguaytía, Tahuanía, Callería, Irazola and Masisea.*
- ***Junin:*** *Junin, Ondores, San Luís de Shuaro, Chanchamayo, Pichanaki, Perené, Río Tambo, Sanibeni, Sincos, Llocllopampa, Acolla and Acobamba.*
- ***Ayacucho:*** *Huamanguilla, Huanta, Iguaín, Luricocha, Anco, Tambo, Chilcas, San Miguel and Luís Carranza.*
- ***San Martín:*** *Pajarillo, Huicungo, Pachiza, Campanilla, Chazuta, Tocache, Shunte, Uchiza and Nuevo Progreso,*
- ***Cusco:*** *Sicuani and Combapata.*

governments for the approval of the strategy and its lines of action, which meant the issue of municipal and regional ordinances, as seen on Table 27.

At the end of the project, in no PDA districts, the outcome of the work in healthy communities is reflected in the organization of ODLs, OTLs and other work teams.

Table 27: Lines of Action

Lines of action	Junin	Huanuco	Ayacucho	Pasco	Cusco	Ucayali	San Martin
Districts under intervention	11	7	9	7	2	3	1
Communities	46	49	85	16	33	9	91
Organization and participative budgets							
• ODL	11	6	12	12	--	6	9
• ETL	12	7	14	12	--	7	9
• CONEI	11	7	9	9	--	3	1
• Projects with participative budgets for PROMSA	24	64	90	14	--	39	72
• Family Development Plan	85	89	125	65	--	41	82
• Neighborhood Associations, organized and acknowledged	96	91	116	95	--	39	93
• Healthy Neighborhoods	45	32	13	31	01	23	14
Consensual local healthy policies							
• Regional Ordinances	1	1	--	--	--	--	1
• Municipal Ordinances	23	47	25	12	--	21	14

Once the management teams of the PROMSA strategy were constituted, the intervention in communities continued with the completion of a self-analysis (using an evaluation instrument designed by the project: Household Community Notebook) concerning the level of some healthy habit indicators:

- Malnutrition in children 6 to 9 years old
- Rate of Illiteracy
- % of households with school non-attendance (children 6 to 12 years old)
- % of inadequate housing
- % of overcrowded households (more than 3 persons per room)
- % of housing without potable water system provision
- % of households without sewerage system provision
- % of households without energy system provision

- % of households with high economic dependency
- Household per capita expenses
- % of children 0 to 12 years old
- % of households with persons 18 years old and over with incomplete primary education.

From the results of the first evaluation, a number of activities were developed in order to enhance weak indicators to attain their adequate level. A second assessment was made followed by others when needed to evaluate the progress of implemented activities.

The following are the results in the areas of intervention in the Alternative Development Project zones, PDA, developed by PRISMA through a sub-grant and in No PDA zones directly monitored by the project.

Once the project's technical assistance ended, most of the healthy habit indicators showed more than 20% increase between 2005 and 2007, exceeding the original indicator target that forecasted such an increase. With regards to children, Table 28 reports a remarkable achievement in the availability of birth certificates

Table 28. Variation of healthy habit indicators in communities that do not belong to the Alternative Development Program, PDA

Indicators	Junin		Huanuco		Pasco		San Martín	
	2005	2007	2005	2007	2005	2007	2005	2007
Children's health Indicators								
• % of children having a birth certificate	32.0	78.1	50.0	67.0	69.8	89.3	67.0	85.4
• % of children having an updated CRED card	56.7	65.6	59.0	70.0	49.0	65.0	56.3	67.1
• % of children with their immunization up dated	56.1	65.3	59.0	69.0	49.0	62.0	54.2	67.1
• % of children under 6 months under breast feeding only	90.1	92.1	93.0	98.0	93.0	95.0	91.7	95.7
Reproductive health indicators								
• % of pregnant women under prenatal control	73.0	91.0	64.0	79.3	65.0	82.0	72.0	88.0
• % of women under institutional care and/or professional child birth	46.0	65.0	45.0	57.0	56.0	78.0	60.0	67.0
• % of women in MEF who know about their fertile period	17.9	25.0	18.8	23.0	15.4	22.0	18.0	22.5

• % of MEF using contraceptives among united women
  • Modern method
  • Traditional method
	65.0
	42.0
	23.0
		68.0
		39.0
		29.0
			63.0
			40.2
			22.8
				61.6
				37.8
				23.8
					68.0
					50.0
					18.0
						70.8
						48.0
						22.8
							68.5
							48.0
							20.5
								69.1
								50.0
								19.1

Housing indicators								
• % of households drinking boiled or chlorinated water	72.5	91.0	67.0	71.6	82.0	92.7	48.2	65.0
• % of households that use a toilet connected to network or latrine	45.0	75.0	56.9	84.4	57.0	88.0	65.0	99.0

of children under three, which is a sign of the parents' awareness of providing them with identification from the time of their birth, which guarantees their rights that by law they are entitled. In fact, in all the regions, the increase was 30% in average, except for Junin where the increase was higher than 143% (it rose from 32% to 78%)

Also important was the improvement of an indicator that measures health monitoring of children 24 months old through the availability of an updated growth and development card CRED. This is even more important if one takes into account that an updated CRED card implies, as shown by the figures, that these children are also updated in their immunizations. This means that they are protected against first childhood preventable diseases that produce sequelae later in life.

As to reproductive health indicators, there is also an increase shown in all the indicators. Prenatal control and institutional childbirths have increased the most. Of the four regions under consideration, these two indicators were lower in Huanuco and higher in Junin and San Martin. However, both prenatal control by health workers and institutional childbirth registered in the communities of the area of project intervention are at times higher than in the regions when considered as a whole. According to the figures of ENDES it continues for 2006 and Table 28 shows it for the 7 regions.

In districts and communities under PDA, at the end of PRISMA's intervention, the level of some selected indicators for the measurement of healthy habits in the population are shown on Table 29.

Table 29: Indicators of healthy habits at the end of the projects under PDA

Region	Number of Districts	Communities	Indicators (%)					
			Children < 2 yrs with birth certificates	Children < 2 yrs with CRED card	MEF know FP methods	Pregnant women under prenatal control.	Children < 6 months breastfed only	Households with safe water
Ayacucho / Cusco	9	19	14.0	58.8	55.9	100.0	58.7	39.6
Ucayali	3	47	63.4	77.5	82.2	84.7	100.0	44.1
Huánuco	8	41	76.7	80.5	67.1	75.0	91.8	35.0
Junin	2	13	68.9	85.8	58.6	96.7	75.0	12.0
San Martín	10	54	70.9	88.4	76.0	86.5	100.0	21.2

Source: PRISMA: Final Project Report of Healthy Towns and Communities. July 2005-June 2006

2.4.2 Educational Institutions for Promotion and Development

The Strategy of Educational Institutions Promoters of Health and Development – (IEPSyD) promotes participative management between the educational communities (teachers, students, parents), through Institutional Educational Boards (CONEI), and their local authorities (Local Government, Health Centers, Social Organizations and others). The aim is the promotion of protective factors that will result in better learning and reduce school repetition and dropout rates

Initially, the project worked in educational institutions selected through sub-grants with NGO KALLPA in the Huanuco, Ucayali, Cusco and Pasco regions, and with NGO

TADEPA in the Ayacucho and Junin regions. Technical assistance was based on a dynamic and participative process with the educational community and the local government for the promotion and implementation of the following five lines of action:

- **Organization and participative management.**

An Institutional Educational Board (CONEI) was created and different management tools were designed: Institutional Educational Project (PEI), the Annual Work Plan (PAT) and the Educational Institutional Curricular Project (PCIE), promoting the organization of School Municipalities, Parents and Teachers Associations (APAFAs) and School Promoters or Watchers.

- **Healthy Policies**

This refers to the existence of healthy living rules (e.g.: students' safety, children non discrimination, in the case of HIV-Aids, etc) in school, according to its Institutional Educational Project (PEI) that should provide an educational environment of values, rights, responsibility, respect and trust between schoolmates, teachers and authorities.

- **Promotion of Healthy Life Styles**

These healthy styles shall be part of a curricular proposal of the educational institution where the messages are consistent with the practice, so if there are cases of stomach infections, it will not be enough to promote washing hands of children and consumption of safe water but students shall be provided with quality water, soap and towels.

- **Improvement of Healthy Environments and Surroundings**

Physical and social spaces shall be healthy, safe, free of aggression and verbal, emotional or physical violence: safe water, classrooms, patios and healthy green areas, healthy toilette rooms, adequate handling of garbage/waste, etc.

- **Reorientation and surveillance of school services.**

To adapt them to the health and development needs of the educational community, inside and outside the educational institution, for instance, cultural and recreational services, spaces for guidance and counseling, school library, school stands or cafeterias, transportation and communication.

The educational institutions (EI) in which the work was done were the following:

Huanuco: **Pillco Marca (Huánuco)** EI Juan Velasco Alvarado, EI -school Nuevo Amanecer, EI Vichaycoto, EI Huancachupa .**José Crespo y Castillo (Leoncio Prado)** EI Andres Avelino Cáceres, EI Inca Huiracocha, EI Aucayacu. **Hermilio Valdizan (Leoncio Prado)** Primary EI Sortilegio, EI Rio Azul. Higher **Llata (Huamalíes)** EI Juana Moreno de Cáceres, Primary EI 32537.

Ucayali: **Irazola (Padre Abad)** Primary-Secondary EI 64027 Juan Edison Bordoy. **Masisea (Coronel Portillo)** Primary EI 64139.

Pasco: **Oxapampa** EI San Francisco de Asis, EI Mariscal Castilla **Villa Rica (Oxapampa)** EI Rvdo Padre Egg**, Simón Bolívar de Rancas (Pasco)** EI Simón Bolívar, EI 34032, EI San Antonio de Rancas, EI Horacio Cevallos Gamez.

Junin: **San Luís de Shuaro (La Merced)** EI San Juan Santos Atahualpa.

Ayacucho: **Iguaín** EI Carlos Ch. Hiraoka.

San Martín: **Juan Guerra,** EI Belen Primary and Secondary.

Cusco: **Combapata (Quispicanchis)** EI Pre-school 578, EI Primary Nuestra Señora del Rosario, EI Primary 56044, EI Secondary Jerónimo Zavala.

STRATEGIC PRODUCT 3: PROMOTION OF HEALTH

COMPONENTS	ACHIEVEMENTS
HEALTHY TOWNS	

- Political Impact/Advocacy for the achievement of the following rules:
  - A MINSA policy on "Decentralization of the Health Function at a local level-Pilot Projects", considers Health Promotion as a key function for primary health care to be decentralized.
  - Regional Ordinance No. 002-2007-CR-GRH, of the Huanuco Region approving Certification of Regional Minimum Standards of Healthy Towns for the implementation of the Strategy of Healthy Towns
  - Regional Executive Order No. 115-2007 GRJ/PR of the Junin Region declaring the promotion and culture of health a regional priority, and the implementation of a Minimum Standard Certification of Healthy Towns for the promotion of the Social Well-being and Development in the Region.
- Sensitization of local leaders and authorities for the:
  - Implementation of 52 Local Development Offices, ODL, responsible for coordination of institutions, authorities and community.
  - Implementation of 52 Local Technical Teams, ETL, as technical support for management.
  - Organization and recognition of 504 Community Neighborhood Boards.
  - Creation of 60 social networks.
  - Promulgation of 131 Municipal Public Policies for the implementation of their Local Development Plan
  - Design of 835 Community Plans.
  - Design of 305 Family Plans.
- Regional Encounters in Huanuco, Ucayali and Pasco for the exchange of experiences and strengthening of the relationship between Local Governments and Regional Governments
- Incorporation in the municipal political agenda, Healthy Town projects under the framework of Regional (PPR) and District (PPD) Participative Budget):
  - Junin: Project, "Capacity Building of Local and Regional Technical Teams for Health Promotion in the Region" approved under Regional Participative Budget for a total amount of 337,200 nuevos soles
  - San Martin: Project, "Promoting Participative Social Development in the District of Juan Guerra" approved for an amount of 30,000 nuevos soles.

COMPONENTS	ACHIEVEMENTS
	➢ Distance Teaching Course on Healthy Town and Schools with the institutional support of the Pontificia Universidad Católica del Perú, with the sponsorship of the Social Development Management Offices, the Health and Education Regional Directorates, and Local Governments. Participating in these courses were 5,160 persons of 55 provinces of the 7 regions under the project ➢ Healthy communities: the strategy was developed in 72 districts of which 32 were located in the areas of intervention of the Alternative Development Program, PDA. In total, the project organized the strategy in 689 communities of the 72 districts. ➢ The healthy habit indicators presented an ample increase higher than the 20% proposed in the respective target.

IV. STRATEGIC PRODUCT 4: COMMUNICATIONS IN HEALTH

1. CONCEPTUALIZATION OF COMMUNICATION FOR HEALTH AND DEVELOPMENT

To inform, educate and raise awareness on various issues are necessary ingredients of communication, but not enough to change habits practiced for a long time. Strategic communication is an effective tool for habit changes and their sustainability; therefore, it is a decisive factor that connects health and social development, establishing relationships and linkages, generating actions and building collective groups and citizenship.

2. BACKGROUND INFORMATION

Communication in the health sector in Peru was born after the Cholera epidemic in the summer of 1991. That sanitary event changed health policy because of the lessons learned in all sanitary areas, among others: the significance of social communication to preserve life, the possibility of successfully facing a sanitary emergency through information; the creation of participation spaces and the transparency of political decisions on an emergency that involved the health of thousands of people.

The application of principles, methods and tools of social communication in promotional preventive health programs at an individual and collective level is in constant growth, consequently, the MINSA has designed a number of educational communication strategies of great impact in health programs and in the well-being of the people.

3. COMMUNICATION IN HEALTH IN THE FRAMEWORK OF THE PROJECT

The communication strategy in the framework of the project had different momentums and was built from lessons learned from other interventions such as the Project Change, the Consortium of Universities and the Network of Communicators in the Amazon region. It served as support for different strategies of the project: PROMSA, management of quality and the RHUS policy (basically supporting professional re-certification).

There were four coordinated cross-section strategies for communication in the health sector:

a) Strengthening of capacities for organization in the use of communication for development

b) Sensitization for the inclusion of communication in political rules
c) Creation of channels for active participation of the population in problem solution and a common view
d) Communication networks.

3.1 HEALTH COMMUNICATION MANAGEMENT

3.1.1 Institutional Communicators

The intervention requested the participation of *"institutional communicators"*[152] of the Regional Government, the Education and Health Regional Directorates, through the respective communication offices, institutional image, press and/or protocol, to which the project provided technical assistance for the preparation of a Communication Plan directly connected to the Regional Consensual Health and Education Plan.

Regional Committees of Communication or Communication Committees were prompted, without much success, in order to develop processes and communicational products in topics of health, education and development. While the idea was met with enthusiasm, their implementation is a process that has exceeded the duration of the project.

In the districts targeted by the project, support was provided to the ETL local technical teams for the conformation of their communication team and completion of activities to support the consolidation of the strategy of healthy towns and communities. The district was the ideal scenario to gather information about motivators and barriers against healthy habits, based on which communication campaigns were designed.

3.1.2 Communication in the Health Area: a NETWORK task

Communication in the health sector is based on coordinated work of all regional and local actors of the different geographic and social areas. In that sense, to give consistency, effectiveness and continuity to the activities, the project has implemented a strategy of networking, bringing together professionals and non-professionals whose activities were geared to different target audiences.

a) Network of Communicators in the Amazon Region

In 2003, there were groups of communicators formed in the regions of Ucayali (Pucallpa and Aguaytía), Ayacucho (Huamanga and in the VRAE), San Martin (Tarapoto) and Huanuco (Tingo Maria) working directly with DEVIDA (Anti-Drug Consumption Commission, "CONTRADROGAS"). The communicators that integrated the networks were empirical people (faculty, technical staff and amateurs in communication) that had not received professional training in communications. DEVIDA requested technical assistance from the project to train the networks with the purpose of making them more self-reliant and not dependent on the DEVIDA funds. The activities were focused on:

[152] *Institutional Communicators. A term designated in the project to refer to those communicators that belonged to public and private institutions, as compared to those that work in journalism.*

- strengthening the capacities of journalists, members of these networks, to generate resources for their own training, on one hand, and to develop community outreach activities aimed at social mobilization for changing habits, on the other hand

- improving the website of the network of communicators of the Amazon region and building capacities for its management.

To strengthen the capacities of communicators, the Project benefited with the services of the Consortium of Universities that developed a communication specialization program in which a total of 110 communicators participated, representing 90% of the total number of members of these networks. The website was improved with the valuable assistance of PRISMA.

b) Networks of Radio Program Correspondents

The health communication strategy selected in each region, radio stations to consolidate a radio program with social responsibility to promote habit changes based on motivators. This initiative was made possible through the coordination of a network of local social communicators. Six radio stations[153] were selected and with their communicators business strategy for the radio program was developed.

The Networks of Radio Correspondents are formed by radio communicators who were contacted by the owner of the selected radio station or the person in charge of the intervention radio program. Each selected radio team identified other allied radios that might be interested in joining these networks whose goal was the mass dissemination of health messages. Communicators elected were trained in radio production, producing radio spots, radio soap operas, radio programs and other communicational products based on motivators for promoting healthy behaviors.

Networks of correspondents were set in 7 regions of the project being more successful in the regions of Junin, Ucayali and Huanuco; in the latter, the communicator of DIRESA went from having a limited role of spreading the institutional image, to a role of integrator of a group of people within a working network to make the video "If we had only," radio and television spots for the prevention of malaria and dengue, and reorienting the health policy to suit local realities.

[153] *Huanuco: Luz y Sonido Radio Station*
Junín: Uno Radio Station of the Chanchamayo province
Ucayali: Del Progreso Radio Station in the Callería district
Cusco: Salcantay Radio Station first, and then Universal Radio Station
San Martín: PRODEMU Radio Station
Ayacucho: Atlántis Radio Station
Pasco: Universitaria Radio Station was selected, but the evaluation showed that social communication sustainability was not guaranteed

c) Communication Networks

At the end of the project, seven Communication Networks had been organized, one in each region of the area of intervention of the project, integrated by communicators, journalists, health staff, faculty members and students of the Department of Social Sciences and communications and others that operate permanently in disseminating health messages and healthy habits among different audiences. They contribute with networking between actors of the health area and mass media.

3.1.3 Training

- **Distance teaching "Communication in the Health Area"**

Under the Program framework: ***strengthening of national capacities in health communication***[154] , a training program was conducted in Health Communication with the participation of university or graduate students, professional and non-professional staff working in the areas of communication or health. The course was intended to help strengthen the capabilities of communication in the seven intervention regions of the project and was the product of a joint effort of the Consortium of Universities, with the national universities of the seven regions, State institutions, civil society, and Communicators Network for the Development of the Amazon headquartered in 7 regions.

- **Program of Specialization in Communication in the Health Area for communicators**

This has been one of the biggest tasks of the project due to its size and scope, but also by the number of participants in the program and the number of actions required to carry them out.

The program consisted of four courses, each with 15 academic hours attendance and a full month of distance course, in which participants had to work with advice from the teachers. The total hours of Agenda was 220.

The design of the specialization Program was modular. In each region four Program courses were taught with simultaneous sessions during the first three days in each module. For this, there were two teachers per course that taught similar courses in two different regions. As a result, both selected teachers were responsible for preparing the respective syllabus and the selection of teaching materials.

- **Internship experience in Radio Marañón (owners of radio stations)**

[154] *Consulting services developed from June 2005 to March 2006 in its III Stage Pathfinder assumes the coordination.*

Radio Marañón has an educational, cultural and commercial radio proposal with the participation of the population and organizations in decision-making for their development that makes and attractive model from which to draw many lessons, more so when we bear in mind that this is a strategy developed in a province that is not capital of the region. Therefore, we organized a visit to learn on site about this experience, and interact with the group of workers and employees of this radio station.

The direct contact with this successful experience motivated the internees (radio station owners and directors) of Radio "Luz y Sonido", Huanuco, radio "El Progreso", Ucayali, and radio "Uno" in Junín, and motivate them in trying a new model of radio programming that connects the commercial end with the educational end; the word with music, the information with entertainment, achieving the penetration of health messages in the population.

The experience of radio Marañón allowed selected radio stations to adjust their work to social development approach in a medium term.

"This has been an interesting experience that allowed for a new style of making radio programs, all you need is responsibility and commitment" stated Manuel Gonzáles (Programmer of Radio "Luz y Sonido"), after learning about the Marañon radio station experience. Upon his return to Huanuco, he implemented new ideas to strengthen the radio programming, specially a program named "Consultorio en la Radio".

3.1.4 Communicational Products

- **Radio Programs (radio soap-operas based on motivators)**

Prior to producing radio programs, there was an intense activity to generate local communication experiences in one radio station with social responsibility and willingness to contribute to the region's development. To that end, it was necessary to consolidate one communicational proposal aimed at changing habits based on the identification and creative address of motivators and barriers that individuals have in order to change a particular habit.

There were a number of radio programs produced, among them:

Huánuco: Program "Consultorio en la Radio/A Doctor's Office on the Radio" in Luz y Sonido radio station, is broadcasted Tuesdays and Thursdays from 10am to 12m under the name of, "In Confidence " (Between You and Me). The evaluation of the audience of this program after 3 months of having started, from an intentionally chosen sample among the persons attending the Carlos Showing HC, showed that half of the interviewees listened to the program. The sample identified topics for the radio-drama production, for example, adolescent fertility, infant- feeding and parent-child communication.

Ucayali: Program "Surcando al Progreso/In the Path of Progress" of Del Progreso Radio Station that is broadcasted from 2 to 4 pm daily. The time was chosen based on a preference study of Compañía Peruana de Estudios de Mercados y Opinión Pública CPI that placed Radio Del Progreso in 5th place of preference. A supplementary study was made to determine the times for a social communication program, and the period from 2 to 4 pm was the most indicated for all age audiences.

Junín: During the summer of 2007, a program was produced named "Together, let's rebuild Chanchamayo" to help the victims of floods. At present this program is named "The change is in each of us" and receives consultations on health from the audience and has a number of guests. After two months in the air, 400 interviews were administered in nearby districts of La Merced to identify the level of audience and preferences. This program was 5th in the rank of preference.

Cusco: Program "REDES/NETWORKS" of radio Universal, which operates with open calls from the audience on different forms of group support to face health issues. A quick study of the radio audience and preference of this program showed that 47% of interviewed adults and 30% of youngsters of the sample listened to the program. (N= 37 adults, 40 adolescents and youngsters of both genders).

- **Radio Spots**

The content of radio spots were as follows:

Medical Re-certification in the 7 regions
Maternal health and institutional childbirth deliveries in Ayacucho, Cusco and Huanuco
Healthy practices, such as hygiene, identification with students and prevention of adolescent pregnancy in Ayacucho (Iguaín), Combapata (Cusco) and San Luis de Shuaro, where prevention of child labor was added to the list

- **Televised feature reports**

In Huanuco on healthy schools, schools promoters of health, 3 feature reports,
Medical Re certification, 2 feature reports in Cusco

❖ **Communication campaign in the health sector based on motivators (Ucayali)**

In September 2006, a qualitative study was developed on motivators and barriers with regards to the use and negotiation of the condom in men that have sex with men (MSM) and sexual workers (SW), in coordination with the Communication Office of DIRESA of the Ucayali region, CERITS of the Regional Hospital of Pucallpa, the Civil Association Cayetano Heredia and the Group of Mutual Aid "Blood Brothers" GAMHESA. The enrolment of the participants was entrusted to the promoters of Universidad Cayetano Heredia and of CERITS.

The findings of the study were analyzed by the Technical Team of DIRESA and the Multi-sector Committee in November 2006, during the first meeting of preparation for the International Day against HIV-AIDS. The decision was to consider as target groups, MSM and SW and adolescents and youngsters to deal with topics of sexual diversity, exclusion and stigmatization. The suggestion was that the Education Sector should evaluate the relevance of Curricular Diversification regarding Sexual Health and Reproduction topics and the job of Counseling to parents. Finally, it was thought necessary to sensitize Human Resources to improve the quality and a warm attitude in health care services (Competence + Warm Attitude).

These decisions included coordination with different institutions interested in working the Communication Campaign with MSM and SW: Civil Assocition Cayetano Heredia and CERITS-Pucallpa, in additiona to yound promoters of APROPO, Etapa de Vida Adolescente de la DIRESA UCAYALI and Manuela Ramos.

After some days of discussions with MSM and SW promoters, the campaing products were decided. For MSM, the defined products were *a song with ambient music"* to be presented in discotheques by a choreographic show. *A key ring condom holder* to ensure the proper care of a condom and a dispenser to evaluate the use of condom in the discotheques were the ambient music is played.

For the SW the defined products were a *bar-type song* in a chicha or techno cumbia rhythm to be played in bars where they are habitués, *a calendar or poster* inviting to negotiate the use of condom with their partner and a dispenser to measure the use of condom in bars where this music theme is played.

In April 2007, the writing of the musical themes for the campaign started. Both the lyrics and the music were contributed by the MSM and SW population. While the lyrics were being written, local musicians and singers were identified to make these songs more lively. The music of both themes belongs to Anthony Guerra (Zico), and were sang by a young singer named Linda Caba.

In mid June, it was agreed with APROPO the launching of the music in discotheques and bars, together with the installation of condom dispensers.

- **Video "If we had only…"**

In the Workshop on fictional educational script writing, the communication office of DIRESA UCAYALI completed the revision of the PECE PLAN on healthy and safe pregnancy and selected the motivator fiction video production that sought to generate a change of behavior in pregnant women. The results obtained in the qualitative study served to choose the motivators. The script began to germinate with the contribution of the Workshop participants, plus the actors that would work in the video. The process included the following stages (See annex 36):

- Preparation of the Audiovisual Proposal.
- Preparation of the Video Script.
- Validation with Technical Team of DIRESA and target group.
- Preparation of the Guide for the Use and Dissemination Plan.

❖ **Bulletins**

Printed Bulletins (posters, three-leaf brochures, bulletins)

San Martín (Juan Guerra), Junín (San Luis de Shuaro), Ayacucho (Iguaín) and Cusco (Combapata) and Pasco (Oxapampa): Bulletins of Healthy Municipalities y other printed material, giant graphic murals of healthy practices on hygiene, identity, breast feeding.

Virtual Bulletins

In Ayacucho, Cusco 2, San Martín and Junín on different topics supporting the activities of the Health Regional Board, the Medical Association (on the issue of periodic certification) and the local governments

STRATEGIC PRODUCT 4: COMMUNICATIONS IN THE HEALTH AREA

COMPONENTS	ACHIEVEMENTS
COMMUNICATION IN THE HEALTH AREA	
General Achievements: • Incorporation in the political and institutional agenda of the importance of communication as a tool for change and mobilization and not only information • Strengthening of capacities of communicators in general and journalists in health for development communication • An outlook of a more holistic communication involving universities, radio stations, institutions and the community • A work proposal of health communication networking, and not disarticulated • Incorporation of communication as a strategy for motivation • The Medical Association identified communication as a tool for mobilization and participation, both for registered doctors and external stakeholders (beneficiaries of health care services). From this outlook, a web site and an exchange group (yahoo groups) were created, printed and virtual bulletins, radio spots, three-leaf brochures and banners with messages that could mobilize and attract the professionals' involvement. • The development of 7 communicators networks, one in each region	
▪ ***Network of communicators of the Amazon region, trained in Ucayali (Pucallpa and Aguaytía), Ayacucho (Humanga and in the VRAE), San Martín (Tarapoto) and in Huanuco (Tingo María) working directly with DEVIDA***	▪ Specialization in Communication: 110 communicators participated, representing 90% of the total number of members of these networks. ▪ The web site, improved with the valuable aid of PRISMA.
▪ ***Networks of Radio Program Correspondents***	▪ Networks of correspondents were established in the 7 regions of the project, being the most successful those of San Martín, Cusco and Huanuco
▪ ***Networks of communication***	▪ Seven Communication Networks formed by communicators, journalists, health personnel, faculty members, and students of the Social Sciences and Communication Departments, and others.
▪ ***Training***	▪ A Distance course "Communication in Health" ▪ A Specialization Program on Communication in Health for communicators ▪ An internship program in Radio Marañón addressed to radio

COMPONENTS	ACHIEVEMENTS
	station owners

▪ ***Communicational Products***	• Radio Programs (radio-dramas based on motivators)
	  • Huánuco: Program "Consultorio en la Radio/ A Doctor's Office on the Radio" of radio Luz y Sonido, on the air Tuesdays and Thursdays from 10am to 12m under the name of, "In Confidence ".
	  • Ucayali: Program "Surcando al Progreso/ In the Path of Progress" of radio Del Progreso.
	  • Junín: Program "The change is in each of us " under a format of conversations with women.
	  • Cusco: Program "Redes/Networks", of radio Universal
	• Radio Spots
	  • Medical Re-certification in the 7 regions.
	  • Maternal health and institutional childbirth in Ayacucho, Cusco and Huanuco.
	  • Healthy practices: hygiene, identity with students and prevention of an adolescent pregnancy in Ayacucho (Iguaín), Combapata (Cusco) and San Luis de Shuaro, where the issue of child labor was added
	• Television reports
	  ▪ Documentary reports on healthy schools in Huanuco
	  ▪ Reports on medical Re-certification, 3 in Huanuco 2 reports in Cusco
	• Campaigns of communication in health based on motivators (Ucayali) for the prevention of HIV-AIDS in MSM and SW
	• Video "If we had only..." on healthy and safe pregnancy to generate positive behavioral changes in pregnant women and the community.
	• Bulletins
	Printed Bulletins (posters, three-leaf brochures, bulletins)
	San Martín (Juan Guerra), Junín (San Luis de Shuaro), Ayacucho (Iguaín), Cusco (Combapata) and Pasco (Oxapampa): Bulletins of Healthy Municipalities and others of healthy practices in topics of hygiene, identify, infant breast feeding.
	Virtual Bulletins. In Ayacucho, Cusco 2, San Martín and Junín on different topics in support of activities of the Health Regional Board, the Medical Association (periodic certification), and local governments

V. *OTHER AGREEMENT PRODUCTS: DIVERSIFICATION OF SUPPLY SOURCES FOR BIRTH CONTROL METHODS*

1. MS-PREVEN PROJECT

In order to expand the sources of birth control methods, USAID, first through the Catalyst Project Consortium, and later through a Cooperation Agreement financially supported APROPO to develop the project "Social Marketing for the prevention of STD / HIV-AIDS and unwanted pregnancy - MS-PREVEN. This project was developed in partnership with the Universidad Peruana Cayetano Heredia (UPCH) and the PREVEN project. The purpose was to improve access for people with a relative purchasing power to goods and services from the private sector for the prevention of unwanted pregnancies through the use of modern contraceptive methods, MAC, as well as for the prevention and treatment of sexually transmitted diseases, STDs.

The primary target of the intervention was male and female young adults between 18 and 29 years of age, sexually active non-users of condoms or contraceptive methods in 10 cities nationwide [160] . The execution period was from November 2002 to October 2004, being the lines of action: Social Marketing, Communication and Training.

Among its achievements, the following are worth mentioning:

Improving access and increasing the use of contraceptives and STD treatment products in 10 cities of intervention through the growing private market of contraceptive methods. Consequently, it contributed to an increase in the number of users of methods in the target segment, highlighting its correct and consistent use. It should be noted that given the nature of the project and its comprehensive approach to sexuality in terms of prevention of STDs and unwanted pregnancies, the condom was the central point of the intervention, obtaining in this respect, clear and evident results

- Construction of a information-diagnosis-management network of STDs and MAC, the generation of knowledge and practices for preventing STDs and MAC and the development of favorable schools of thought toward sexual and reproductive health.

[160] *Tumbes, Piura, Cajamarca, Pucallpa, Huanuco, Cerro de Pasco, Juliaca, Cusco, Ica and Chincha*

- A wider supply of contraceptive and STDs treatment products (quality, price and variety) in pharmacies and drug stores of the poorest zones and the periphery of cities under intervention.

Positioning of OK condoms, re-launched as part of the project, as a condom for young adults, accessible to people with less resources. It reached 6% of the market share nationwide with more than one million sold units in 12 months since its re-launching.

- Increase by 17% of the number of condom users, and an increase of 42% of condom protected sexual intercourse.

- Development and introduction of Efectimax and Efectiplus, products for STD treatment, an unprecedented experience in Latin America.

- Development and strengthening of social networks for the prevention of unwanted pregnancies and sexually transmitted diseases. More than half a million people reached through interpersonal communication activities.

- Development of a positive climate with regards to sexual and reproductive health. A free contribution in the range of 1,160,119 American Dollars.

- Design of a franchise for a self-sustained primary health network.

- Strengthening of APROPO's management and monitoring capacity.

2. PROJECT ON ENSURED AVAILABILITY OF BIRTH CONTROL METHODS

The DAMAC project (Ensured Availability of Birth Control Methods) comprised two stages: DAMAC I (from September 2004 to August 2005) and DAMAC II (from September 2005 to May 2006), through a sub-grant from Pathfinder International under the framework of a project funded by USAID). The DAMAC I intended to increase the availability and promotion of contraceptive products at low prices in different outlets nationwide, starting in the cities under intervention of the MS-PREVEN project and including other cities of expansion.

The DAMAC I project broadened the experience of MS-PREVEN to other cities[161] with highest market development and released marketing and communication activities for habit changes. It created a Commercial Unit in APROPO, which enhanced the distribution and sales system and contributed from the side of the private commercial sector to ensure contraceptives in the country.

Among its main achievements, the following is worth mentioning:

In the distribution line of contraceptive methods, the project achieved an increase in sales of 27.7& compared to the period before DAMAC, 10.5% more than foreseen target. It broadened the commercial border, identifying indicators that signaled an increase of outlets and customers, as is the increase of pharmacies by 37% with regards the start of the project (September 2004). Also, an increase of a horizontal coverage of the MAC package in pharmacies from 16% to 50%.

- In the area of social marketing, it contributed to the growth in size of the private contraceptive market: condoms 9% and injections 13%, which represented an increase of intent to buy in the private sectors of the MAC users, who were supplied so far through the public sector. Injections 30%, pills 20%, vaginal tablets 18%, condom 4%.

- With regards to the promotion of the MAC package, projected sales were achieved through the training of pharmaceutical staff, promotional packages,

[161] *Piura, Chiclayo, Trujillo, Cajamarca, Chimbote, Arequipa, Cusco, Juliaca, Tacna, Pucallpa. Huancayo, Ica, Huanuco, Cerro de Pasco and North Lima, covering a total of 99 districts*

incorporation of co-distributors and sub-distributors, growth of local distributors, actions of own sales force, and handling of communication to customers, involvement and motivation in the outlets.

- New products were identified: a monthly injection, a non-hormone pill, and health-track products: 5 of Schering and 24 of Induquímica.

- In the communication area, there were more than 15,000 educational messages. More than one million in US$ Dollars in free contribution from mass media. Information and counseling were provided to 337,074 persons on the benefits and correct and consistent use of the MAC, and also on their fears with regards to secondary effects of the methods.

- In the line of training, there were 2, 318 training sessions: 1,074 in pharmacies, 109 to spokesmen and 1,135 to the public in general (volunteers, journalists, promoters and owners of internet businesses). There are 244 volunteers that are currently performing dissemination and promotion actions in a sustainable fashion. There were alliances/agreements entered into with 77 organizations and private companies for the promotion of sexual and reproductive health.

The DAMAC II project aimed at improving the overall availability of contraceptives in pharmacies of the commercial sector and the quality of information on sexual and reproductive health. The strategies used included the strengthening of the distribution system, the broadening of the commercial border, the design of trade policies based in a market segmentation. Also, activities were planned in the pharmacy sector with the intention of achieving customer loyalty.

The DAMAC II project focused on distribution in the pharmacy network and continued with a database and monitoring systems to improve strategies. It also sought to improve the quality of information in sexual and reproductive health and incorporated health-track products in the network of local distributors. Through this network created by APROPO, the trading border was expanded, reaching populations not served by the commercial distribution system.

The results of distribution and sales, and the information and management systems have been positive and have facilitated that APROPO continue with social marketing in sexual and reproductive health. Among the most significant results, the following are worth mentioning:

- **Outlets**. The list of pharmacies of APROPO increased to 7,742 outlets nationwide, of which 59% are located in central places and 41% in the periphery. Of this, 7% represent chains and 93% are horizontal outlets. The list increased by 20% between DAMAC I and DAMAC II. This increase shows the effort to expand the trading border and the incorporation of new territories.

- **Coverage**. At the end of DAMAC I the MAC package had 50.44% coverage. At the end of DAMAC II, coverage was 44.47%. This was due to the fact that one of products of the MAC package was out of stock due to a new product under this brand.

- **Sales per units and values**. Total sales were 3.719 million Soles, the same that represented 101.2% of the sales target. The impact of DAMAC II versus DAMAC I represents a monthly average increase of 22.18%. These sales refer to the MAC package (contraceptives) that differentiates and sells APROPO.

- Quality of information in sexual and reproductive health in private pharmacies. We identified specific training needs of the sales force of the different distributors that cater pharmacies. Also, the SER system trained 453 pharmacy workers, strengthening the management capacity of the outlet through merchandising and customer loyalty techniques, providing them with referrals to health professionals for medical care in places were the PREVEN project is intervening.

  Additionally, communication activities reached 314,000 persons providing information on sexual and reproductive health. With the participation in various activities in which information was disseminated, there was an in-kind contribution of US$ 693 thousand dollars.

3. REDPLAN SALUD

RedPlan Salud (RPS) is a network of professionals for improving community access to services and quality products in sexual and reproductive health. It began in 2000, organized by INPPARES, with the technical and financial support of USAID, (first through Catalyst, and later through the Cooperation Agreement), Schering, and Pharmacia.

RedPlan Salud represents an alternative to the public sector that is not sufficient to fully meet the growing demand for services and products.

Initially the goal was to organize the network in 5 districts: Comas, San Juan de Lurigancho, Vitarte, Los Olivos and Villa María del Triunfo, starting with the participation of 50 health professionals. After six years of development, RPS is now a network of affiliated health professionals working under a prestigious umbrella brand, INPPARES, a well known NGO that provides technical assistance; provides quality products and services at low prices, provides

marketing tools, promotes the network and monitors the quality of services and products. INPPARES makes sure that consultation, sales and income for its members increase.

The RPS affiliates are health professionals with private practice that use the distinctive logo that identifies them as affiliates of the RedPlan Salud and receive training in various health topics, products at competitive prices, promotional material and other support for campaign and promotional activities.

As of June 2007, there are 6 supervisory midwives who visit the district segments B, C and D of Lima, distributing contraceptives and other products related to the obstetric gynecological consultation (pregnancy, HIV forecasting, antifungal, anti-inflammatory, etc.)

The program was extended to: Piura, Chiclayo, Chimbote, Arequipa, Tacna, Trujillo (agreements) and in August 2007: Huancayo (agreement); with 1 supervisor for each city. There are a total of 6 in Lima and 7 in the provinces.

The distribution of the professionals affiliated to the RPS by city is presented on Table 30.
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Table 30: Affiliated to the Red Plan Salud

City	2007
TOTAL	**1127**
Lima - Callao	620
Chiclayo	154
Chimbote	88
Arequipa	26
Tacna	25
Piura	161
Trujillo	53

The achievements to be noted are:

The affiliated professionals provide the full range of contraceptive methods and other quality products at accessible and affordable prices.
The pharmacies affiliated to the Network provide support ensuring availability and sales of brand contraceptives at preferential prices, as well as support in IEC, training and others.

INPPARES manages the organization of the network and provides confidence and security in users being an NGO with more than 30 years working the SSR issue.

Table 31: Care Services provided nationwide by the Red Plan Salud

Year	Total	Family Planning and EC	Care in Sexual and Reproductive Health	HIV diagnosis	Others
2003	51,650	15,739	18,610	12,385	4,916
2004	159,981	48,019	62,873	43,842	5,247
2005	339,817	107,126	133,631	89,064	9,996
2006	649,233	248,922	287,921	98,684	13,706
2007	452,401	144,077	236,919	64,710	6,695

Next steps:

- Extend the network to other cities in the country, where INPPARES has presence and in other cities by means of agreements.
- Develop loyalty programs with customers.
- Initiate a plan for training in primary care.

VI. CONCLUSIONS / CONTRIBUTIONS

Quality management and health human resource management (RHUS) are in the practice, integrated into the final product provided by the health facility in the delivery of services. This is determined by the background of knowledge, skills and attitudes of the provider and quality elements, attributes and dimensions shown in supplies, equipment, materials and others. Therefore, the selection of providers is very important, as their competences should coincide with the functions they will carry out at the facility and the resolving capacity of such. These competences can be broadened and improved with an adequate RHUS policy that takes into account previous training, supervision and work compensation. In addition, it should also take into account the context in which the delivery is provided; that is, the system that allows providers to make decisions, instruments, team, persons with which they interact and the relationship of the facility with the community and its authorities, among other factors. In this sense, the proposal of Competence Development Centers (CDC) at a regional and micro-network level has enabled quality and RHUS policy integration, training of human resources and development of MCC projects, based on measurement of standards and indicators that in turn become new competences.

There is the risk that not enough resources are allotted for improving care quality at health facilities, and therefore, there is no compliance with one of the objectives in the entire health system which is to meet the legitimate needs of users. Fortunately, at present, health staff's perception is changing in the light of equal opportunities and rights approach that includes the empowerment of users, which makes possible a more horizontal relationship. This has been possible thanks to the contribution of quality management processes described and to the new approach on MINSA's Health Promotion; shown in experiences such as Healthy Towns and their different scenarios: Families, neighborhoods and educational institutions, supported and developed by Pathfinder International in its intervention sphere since 2003.

On the other hand, processes such as decentralization and the transfer of the health function to regional and local governments have contributed to expedite and improve interaction between health facilities and the population through Management Agreements. Officials are more aware of their co-responsibility in the sanitation issue. During the last two years of the project, there has been a growing interest on the part of mayors and other officials in the population's health problems.

Achievements and progress made up to now are undoubtedly very important. However, challenges and perspectives ahead are still great. It is now the regions' turn to continue in this endeavor and in coordination with local actors, apply and recreate the various models, tools and processes developed up to now.

Below, we present the conclusions of the most significant results or contributions achieved through the implementation of the project:

- Regulatory Mechanisms
- Health Quality
- Human Resources (RHUS)
- Health Promotion (PROMSA)
- Competence Development Centers at Micro-networks (CDC-MN)
- Interventions Integrated into the Micro-network (Quality, RHUS, PROMSA)
- Management Agreements (Regional Government – Local Government)

Regulatory Mechanisms:

- The project helped put the need to implement systems on the professional associations' agenda in order to safeguard quality of health professionals through the development of periodic certification processes. We also achieved for these organizations to envision the implementation of this process based on competences, that is, making sure professionals not only have the necessary knowledge to properly perform but also to show the necessary skills and attitudes to do it with quality.
- With regards to Faculty Associations, the project's contribution was towards the need for designing quality standards to improve health professionals' education and to decide on the development of standardized curricula nationwide, with the necessary inclusions for adapting it to the reality of each Region.
- An important contribution of the project has been to promote the creation of an instance in civil society in charge of the necessary political advocacy to make efforts for quality improvement in education a permanent concern of national authorities. Proof of this was the enactment of the Law on the creation of the SINEACE.

Health Quality

- Activities carried out by the project have contributed to strengthen mechanisms to apply the quality management system in seven regions of the country, in the framework of current regulations proposed by MINSA. Therefore, we provided support in the design and preparation of maternal perinatal quality accreditation standards and its respective data-processing application, as well as in the preparation of maternal perinatal and infant quality standards. These are used at health facilities for self-evaluation. Based on the identified gap, health staff starts continuous improvement processes. In this sense, DIRESAs, Networks and Micro-networks count with human resources that have strengthened skills to analyze quality standards information and planning continuous improvement projects.
- To achieve quality in health services also implies generating changes in educational entities and professional associations. In this framework, the project has helped the Medicine, Obstetrics and Nursing Faculty Associations develop their accreditation processes, design the basic or nuclear curricula and implement National Exams. Likewise, in order to sustain these changes in the professional exercise, work has been carried out with the Medicine, Nursing and Obstetrics Associations to promote periodic certification (professional re-certification) as a process that enables updating

- On the other hand, in the framework of the approval of the General Law on Education in 2003, which included the creation of the National Educational Quality Evaluation, Accreditation and Certification System (SINEACE), the project facilitated summoning member institutions to consolidate what is established in the Law in relation to the SINEACE. This gave way to the conformation of Initiative Groups for Quality in Higher Education – GICES – that succeeded in having the regulation of the National Educational Quality Evaluation, Accreditation and Certification System approved. At present, GICES, which was enacted on July 10th, 2007, stands as the only institution specialized in actions addressed at informing and motivating the population on quality-related issues in higher education in Peru.

Human Resources (RHUS):

- Strengthening the capacities of teams in charge of human resources in the Regions enabled to see human resource major issues as a strategy to achieve desired changes in health services.
- The implementation of RHUS policies resulted in the execution of concrete actions with the participation of authorities and workers at all levels and should mainly contribute to the development of human resources taking into account that health service quality is basically determined by competences in health service providers, in addition to supplies, procurement and other materials.
- Sensitized local governments are committed to RHUS management and participate in motivation and incentives, training and planning, etc. Such is the case of the Villa Rica district, where a best-worker award system was developed with the direct participation of the local government, and institutionalized by District Ordinance.
- Through the project's intermediation, the competence approach became part of DIRESAs management teams' lifestyles in the intervention regions. They understood the importance of identifying and regulating competences to later train and evaluate based on these competences, and that at the end, counting with competent and well-motivated workers is a key part in achieving quality care.
- RHUS managers in the regions, properly sensitized and motivated on competence management and continuous improvement are capable of implementing RHUS policies from a regional to a local level, showing tangible products as work competence norms, competence evaluation instruments, etc. Huánuco DIRESA approved its work competences for first care level through a Director's Order.
- DIRESA's management team's commitment with the implementation of RHUS policies is shown through constant participation and prioritization of implementation actions and the decision to allot resources for their institutional operative plans to comply with these actions. DIRESAs in Huánuco, Junín and Pasco allotted resources for the implementation of their RHUS regional policies during the second semester of 2007 with the idea of increasing them for 2008.
- The decentralization process enables regions to make progress in their RHUS regional policy implementation processes, regardless of but aligned with the national level. This

- Technical teams generated in the regions of Huánuco, Pasco and Junín have developed competences to maintain and promote RHUS management based on competences and continuous improvement in each region and they are even capable of providing technical assistance to other regions of the country.
- With the project's intervention, progress was made in the identification and regulation of work competences prioritized for first care level category I-2 in intervention regions. In addition, evaluation instruments were designed for prioritized competences in relation to children, pregnant women care and the training management component. Still pending is the identification and regulation of work competences of the other first level categories and other care levels. Likewise, still pending is the development of the evaluation and training processes based on established competences. This work should be carried out by another project's technical assistance.

Health Promotion (PROMSA)

- Taking as reference progress made by other institutions in Healthy Neighborhoods and Schools, the project wagered on work from the local government for the implementation of Healthy Municipalities. Organization proposals were made to local authorities (Local Development Office) for the institutionalization of spaces in the community linked to the local government (Local Technical Team), and together they would be in charge of promoting the development of healthy scenarios in the district.
- Firstly, the institutionalization of Healthy Districts was placed on the regional agenda as an important strategy for achieving healthy behaviors, improving living conditions of the population and reach local development.

Competence Development Center in the Micro-network (CDC-MR)

- CDC-MN represents a local integration strategy for actions and processes related to quality improvement, improvement of competence-based performance, organization of services and local health management. This is part of a greater process related to the development of competences in the health system.
- The localities of Margos and Amarilis (Huanuco), Villa Rica (Pasco) and Pichanaki (Junín), are first experiences that show new evidence on the decentralization of the training system through the development of tutorial skills aimed at the improvement of competence-based performance of municipal workers and health services in micro-networks.
- In the Huanuco region, the CDC-MN has enabled micro-networks to develop local capacities in coordination with the local government and the community, which are useful to close the gap in capacities for the improvement of local sanitary indicators. These are very important for a successful projection of management agreements between the regional government and the local government.
- The National University of Central Peru and the Hermilio Valdizán National University, together with DIRESA and NETWORKS quality and human resource technical management teams have played a critical role in technical assistance and

Integrated Interventions in the Micro-network (Quality, RHUS, PROMSA)

- This coordination process is not easy. It requires a lot of political will from decision-makers so they can be present at key times as well as count with a technical group identified with their territory and committed to change. Another important aspect is to be able to count with methodologies and instruments developed with them, such as the work competence norm, the continuous improvement project and contents for developing workshops.
- We have to take care that regional or local actors are the ones that are actively involved and facilitate their joint mobilization. This bond represents the proof of coordinated work among the health sector, regional government and local government for the benefit of the community.
- Finally, financial sustainability is still a challenge as it is influenced by poorly coordinated sector and territory budget planning models. It also calls for advocacy work for generating financial resource scheduling re-directed at quality standard achievements, competence-based training management, existence of healthy families, development of citizen surveillance, etc.
- Likewise, coordinated work calls for the generation of changes in the supervision, monitoring and evaluation models. In this framework, the development of a monitoring and evaluation system at a sector and inter-government level in which there is communication involved is an issue still to be explored. This implies having an information system to help show with specific data, whether there are changes or not in the implementation of quality standards, competence-based evaluations and others.
- Joint intervention requires focusing on territorial space. It is impossible to start this process simultaneously in different territories, because it is necessary to develop and consolidate phases, moments or stages. To empower the Micro-network and Local Government technical teams and community leaders are part of a previous step to achieve action interaction. Next, is the commitment of institutional representatives to summon and organize prioritized actions and achieve the approved participation of their teams, generate good rapport and the identification of their roles in the implementation of quality, human resource and health promotion actions, all of which requires great efforts.
- To achieve coordination of thematic components, it is necessary to identify inter-dependent actions that show results at a territorial level. This needs everyone's involvement; therefore, it is important to prepare territorial quality standards for public services, human resources and health.
- This process should go hand in hand with a strategy for developing capacities in strategic actors and operators in order to manage technical and methodological contents. We should not forget that quality standards, work competence norms and continuous improvement projects are only means to achieve results in strengthening institutions and the population.

- Permanent coaching is necessary, especially at all local government levels to institutionalize the health issue, generate and keep communication spaces among the local government, Health Micro-network and the community. This is important in decision-making and sharing information among these actors.

Management Agreements (Regional Government– Local Government)

- Management Agreement is understood as the establishment of a written and signed relationship between two or more parties with the purpose of establishing commitments and results in face of the vision, mission and objectives of the Region; it is agreed for a specific period of time and includes the definition of indicators through which such is evaluated.
- Experience obtained through Management Agreements in Huanuco helped find the way to coherently align objectives, strategies and goals of the Regional Government and Local Governments: Provincial Municipality and District Municipality in the compliance of goals and obtainment of results, which accounted for the effort of each institution.
- An important aspect was the consolidation of the local Municipality involvement in health issues of its population, in full coordination with the health facility staff within its jurisdiction.
- Direct involvement of the population in community surveillance of quality indicators proposed in the management agreement constitutes the link between the population, and the health facility.
- The implementation of Management Agreements in regional and local spaces constitutes a first experience in the country. Therefore, each one of the activities and processes developed has been and is still a learning process for the different actors involved. Notwithstanding its first experience nature, the balance is highly favorable regarding the following aspects.
- Coordinated work between the Regional Government and District Municipalities to achieve better health levels and quality of life in the population is perhaps the most important aspect observed in the implementation of Management Agreements. It has been observed that little by little, management teams of local governments have assumed that sanitary results in the population is also their responsibility and that the sanitary work is not limited to health facilities but that also the family and the community are spaces in which the health of the population is determined on a daily basis.
- Based on this commitment as well as that of health facilities, it was possible to include informed community representatives in this experience. The involvement of community agents in applying the survey for measuring indicator baselines was crucial. It helped gather primary information in selected homes with greater accessibility and with knowledge of the specific reality of the areas and families interviewed.
- Consequently, as stated, the work developed up to date has constituted an interesting and necessary strengthening experience, especially due to the coordinated involvement and work of Regional Government instances – through the Social Development Management and the Regional Health Directorate -, Local Governments – through District Municipalities – and the community in general.

- On the other hand, it was important to obtain information of indicators linked to chronic malnutrition and maternal health, considered as priority health issues in specific spaces such as the Districts of Amarilis and San Francisco de Cayrán. Generally, aggregated figures are managed that do not allow visualizing reality in specific spaces such as districts. In this sense, results observed required specific interventions, also scheduled for the entire 2008, with the purpose of closing gaps and always with the involvement of local governments and communities.
- In short, up to now, the implementation of the Management Agreement between the Huanuco Regional Government and the District Municipalities of Amarilis and San Francisco de Cayrán has enabled to mobilize all actors involved in the different spaces, including the organized community. Nevertheless, the experience should continue during 2008 with the implementation of intervention plans to achieve goals in each indicator and based on them, improve sanitary results of the population in both districts. The implementation of this experience constitutes the final objective. In this sense, instances such as the Management Committee, the Monitoring Technical Team and the Areas in charge of each indicator should continue with their joint and permanent work to achieve expected results.

VII. *LESSONS LEARNED / RECOMMENDATIONS*

General Aspects.-

The work carried out during those years in the 7 Regions of the scope of the project and especially in 4 of them where efforts were concentrated with the purpose of showing the integration of project components, leaves us with lessons not only in relation to results per se, but also in the global management of the project.

To help improve maternal, perinatal and infant health, it is essential to include quality improvement processes in health services, such as improvement of staff's work competence and policies to encourage good performance. In addition, the achievement of impacts in population's health is not only carried out with changes in health services but also with the conscientious participation of local authorities and the organized community. This is because the health system not only requires changes in the provider's behavior but mainly changes in users' behaviors.

On the other hand, in order to make results achieved in health services sustainable, it is necessary for efforts carried out by health workers to have the technical and political support of authorities from the different government levels (national, regional and local).

After analyzing what worked out and what we consider can be improved, we present the following list of lessons learned as recommendations that we hope can contribute to the implementation of other projects in the health field:

a) Technical assistance teams in the Regions should be made up by professionals experts in the project's expected results but also highly committed in the transfer of conceptual frameworks, methodologies and instruments so regional teams can conduct the different processes in the Region.

b) It is important for all those who make up the project's technical assistance team to share the same vision of what is expected as concrete health results in the population and of the strategies to be followed to achieve them.

c) Proposing project management with a continuous improvement approach helps in permanent self-evaluation and to the implementation of the necessary changes, especially in a scenario with very dynamic political and social settings, such as the one we have lived through.

d) Management by results helps guide the work of all teams. That is why we are focused on making quality services and the promotion of healthy habits and behaviors more accessible in order to reduce maternal, perinatal and infant mortality.

e) Any intervention carried out at health facilities should be technically coached by DIRESA or their network staff. Therefore, technical assistance provided by the project should be aimed at strengthening capabilities at these levels. This strategy enables politically and technically empowering management levels in face of health facilities, brings them closer to the reality they face each day, allows them to jointly design change strategies and helps

f) Project monitoring should include monitoring of the perception on technical assistance by those receiving it. This allows adjusting the composition of teams or improving working strategies.

g) A periodic and comparative analysis of progress made in the Regions included in the project sphere, helps focus efforts where there are conditions for achieving results sooner, so these results can serve as motivators for progress in other Regions.

h) Coordinated and permanent work with regional and local authorities helps them commit themselves to a series of activities, which is made evident by their financing or co-financing.

Specific Aspects.-

Regulatory Mechanisms:

a) Even though the project significantly contributed to the sensitization and commitment of Professional Associations and Faculty Associations for improving quality in education and professional exercise, institutionally, it is necessary for these organizations to work in coordination with each other.
b) To improve performance of health professionals in the first care level, organizations, such as Professional Associations and Faculty Associations should necessarily work following a team "logic." Competences identified should help the health team as a whole achieve health results in the population.
c) In order to improve the performance of health professionals, we should close the gap between working competences, necessary to take care of priorities in the work areas and professional competences, which are the result of university education and which do not always respond to health priorities in the different regions of the country.
d) Re-certification processes of professionals carried out by Professional Associations should be based on competences.

Health Quality

a) The quality of health services, that includes a coherent policy of health human resources, a Health Quality Management System and diverse involvement activities by authorities - at all levels - and from civil society, is a key factor for the improvement of living conditions and health level of the population.

b) This vision of quality is not sufficiently incorporated in the perception of high level officials who do not feel quality management is a necessary tool in achieving successful results in sanitary management – but this occurs among medium level officials, and this is shown in the limited political support, human resources and materials.
c) At an operative level, knowledge has been spread among health staff and a growing number of workers have skills in the use of continuous quality improvement approach and methodology. At this level, we find the main achievement obtained by the project through the measurement and improvement of quality standards that gave rise to a quality culture at health facilities and created new tools for a better and more productive relationship with their local and community authorities.
d) The following are some relevant lessons by areas of the Quality Management System:

- Planning:

    - The progressive incorporation of activities and goals related to the measurement and improvement of quality standards (maternal, infant and accreditation) to the Annual Operative Plan's planning process and budget of each DIRESA, have turned into a true management tool.
    - DIRESA´s officials are convinced of the benefits of promoting health Facility Accreditation in their regions, as a mean to ensure care quality and the achievement of sanitary goals.
    - The maternal and accreditation quality standards, that found a space for their formulation and validation in the project regions, have become national mandatory laws nationwide.

- Organization:

    - In spite of the fact that the quality management teams at managerial and operative levels could not be consolidated and last in time, nevertheless, a minimum quality structure was strengthened based on work and the conviction of the staff in charge of the quality and sexual health strategy and the child component.
    - The staff in charge of DIRESA's quality and sexual and reproductive health strategy acquired better technical and political management, which empowers them and gives them the capacity to influence over other officials of the region and over the operative staff of networks and micro-networks.

- Assurance and Improvement:

    - Many health workers assume that quality cannot and should not be developed only in just one service, but globally in the entire facility; in this sense, they acknowledge the comprehensive vision as an advancement and opportunity provided by accreditation in achieving the quality improvement in a more unified way.
    - The work strategy designed by the Project for coaching and training of health staff made possible the massive dissemination and expansion of the approach and

- Health staff has created awareness that quality standards and indicators can turn into management tools to negotiate and reach agreements with local and community authorities on certain sanitary results. In many districts and provinces discussions are currently carried out about the reduction of certain sanitary indicators, through coordinated work between the health sector and the authorities, using quality standards as a tool for verifying its compliance. Nationwide, they are becoming part of the Agreements by Results.

- Quality Information

  - Quality information systems in the maternal and neonatal area have helped identify gaps between health procedures and what should be done according to care regulations and protocols, aspects that directly influence sanitary results.
  - Also, it has allowed measuring the changes produced in time by improvement projects, so the staff can internalize care quality in a practical way; identifying critical points on which timely interventions are required to obtain sanitary results.

Health Human Resources

a) Improving staff performance is an important aspect in health service management, but it is also important to take into account the need to improve human resource planning and distribution. This is related to political decisions aimed at improving working conditions in the most excluded regions, or creating differentiated payments or incentives to allow assigning professional resources to the most deprived populations.

b) The participation of RHUS managers from the regional level to the local level, as part of work teams, is important in order for the implementation of RHUS policies in the regions to be successful. The implementation organization may differ from one region to another according to their particularities, but the most important thing is to ensure team inter-relationship, by promoting participation and coordination.

c) Introducing the competence approach in the management of health human resources has allowed mobilizing and expanding RHUS managers' perspectives at DIRESAS, Networks and Micro-networks. This was very significant among the members of staff or human resource offices of the intervened regions, which have started to pay more attention and more importance to development actions instead of the purely administrative tasks.

d) It is important for the teams in the regions to carry out meetings to share their progress in RHUS policy implementation at the end of each sub-process inviting field actors in charge of health training as well as health providers. Maybe it is not advisable to divide the work, because each region has its particularities which will be translated into products with different nuances.

e) The processes for identification and standardization of work competences should be fully completed and executed by different teams. If this is not the case, there is a risk of

f) Both in competence identification and standardization processes, operative staff should be included in the discussion, as they have previously received training on the methodology used.

g) For the design of work competence evaluation instruments, it is necessary to count with the participation of experts on this matter. People in charge of the methodology who head work group should not be experts on the subject to avoid biased opinions.

h) Work team at a local level shall necessarily include representatives from the local government and the organized community. It is the best way to make them involved and to assume their responsibility.

i) Regional technical teams have internalized the identification methodologies and competence standardization and the performance evaluation based on competences because they have seen their usefulness in fulfilling their functions.

Health Promotion and Health Communication

a) The Cooperation Agreement have allowed to create awareness on the importance of living in healthy scenarios and to put the development of activities in the regional and local agenda aimed at improving people's quality of life. The application scope of the PROMSA strategy is getting larger. Altogether, (PI and MSH) extends to almost 600 communities of 72 districts in connection to 417 health facilities and 53 health micro-networks expanding to other 61 districts.

b) The contribution to the decentralization of health functions is huge. Precisely, within the framework of this process, the Project has set up the basis for continuing with PROMSA actions from another perspective through Management Agreements. In point of fact, taking as a basis the regional ordinance and the political will, a specific intergovernmental ruling has been achieved which gives sense to the local governments' work and coordinates it with the regional work and that of the community, in order to jointly fight chronic malnutrition and maternal-neonatal mortality in different contexts as for example communities, families and schools.

c) Health information and communication is a key instrument for health promotion and change of attitudes because they contribute to socializing messages addressed towards a new attitude in individuals and families. Communicators were trained in the 7 regions using a curriculum developed by Universities Consortium in the Catalyst project jointly with PRISMA. These networks developed a new experience inserting health promotion contents in private broadcasting radios in a sustainable way showing that an inter-institutional alliance is possible in dealing with social issues.

d) When key and committed people are contacted, there is a paradigm change in the promotion of health from a sector approach to a territory approach where the main actor is the local actor. It is not the sector (MINSA) but the territory jurisdiction (mayors, neighbors' association, mothers, teachers, individuals, private companies). The concept of citizens involved in health is developed in this way, according to which people have

Competence Development Center at the Micro-network (CDC-MR)

a) There are health centers and urban and rural district town councils that identified under certain criteria, have a valuable potential consisting in health professionals and local and community government leaders. They represent an important opportunity for tutorial skill training and for developing teaching learning activities for staff at health centers and community agents that contribute to training and maintenance of work competences adapted to local sanitary care needs of micro-networks.
b) It has been observed that under certain criteria established at the CDC-MN pilot experience carried out, it is possible to develop a CDC-MN an escalation proposal, for a larger number of MN in each region keeping in mind that not all micro-networks can be CDC-MN due to the fact that they do not count with professional staff, municipal managers and community leaders with successful experience in community development that are capable of changing local health work into work competence training spaces.
c) Nevertheless, it is possible that the few CDC-MN (approximately 14-18 by region) by improving their training production capacity can be enough for all micro-networks in the regions to have access to a permanent training program, accessible at local level, adapted to local sanitary needs and priorities and of low cost for the institution and local governments.
d) Regarding technical assistance and sustainability of the CDC-MN experience, two aspects are important that should be kept in mind for a CDC-MN implementation:
    a. On one hand, technical assistance from DIRESA and NETWORKS for improving service organization within the frame of categorization and availability of FON resolving capacity, care quality through the compliance of quality standards and quality improvement plans, the use of SIP information. HIS and SISMED and referrals and counter-referrals in operation including the waiting house and the 24-hour ambulance and emergency service are decisive for the availability of application fields in work competence training in clinical preventive aspects. Also, healthy environment models, such as the classroom, the successful JVC and successful healthy family-house, are application fields that should be available in MN for the work competence training in health promotion at local levels.
    b. On the other hand, the technical assistance from regional Universities is essential because university teachers of health related careers have ensured a permanent education process in health. This includes methodological training aspects, use of teaching methods and techniques for the transfer of knowledge and skills during the service. More time and participation of this actor is needed for a flexible modular and curricular design adapted to local needs and available time limits of health workers, community agents and others in micro-networks.

e) Due to the fact that the training demand of community agents is approximately 10 times higher compared to the staff number at health facilities to be trained at MN, it is suggested that CDC-MN could count with training points in healthy environments, in health posts and other sanitary spaces, according to the availability of promotion models, in each

f) Regarding the economic and financial sustainability, we can say that the success in CDC-MN implementation is less possible in health facilities and towns that lack management capacity of local resources. In the case of micro-networks whose central core is CLAS, it is much more feasible to finance improvements in the organization and availability of environments for in-service training. In these cases, the SIS reimbursement has allowed to cover the transfer, food and supplies and teaching material expenses of interns. In the case of community agents training on healthy environments, the co-management of resources at educational centers, community neighbor associations and specially in towns is essential to pay for operative costs of field internships.

g) Regarding the experience of Management Agreements, in the specific case of Huánuco region, the implementation of CDC-MR as part of the agreement is a key strategy of local operative support to train the staff and community agents in the improvement of quality care and contribute to the achievement of goals and expected results established in the indicators of management agreements.

Integrated Participations at the Micro-network (Quality, RHUS, PROMSA)

a) The technical assistance faced a strong management paradigm and a not so well coordinated service delivery at DIRESA, NETWORK and Micro-network levels, that is, the processes and achievements in each component of the Project not necessarily were in synergy to obtain certain results or related indicators. In view of this, planning of strategic activities in human resource management, quality management and health promotion was redirected and sought from a regional and local level through a joint participation plan.

b) This planning at DIRESA level enabled the alignment of their actions and resources at least in quality, human resources and health promotion. In this framework, the preparation and approval of Work Competence Regulations became a mobilization axis for achieving the meeting point between quality and human resources: for quality would not be possible without competent human resources. A lesson learned in this planning process is that this planning opens and engages the participation at DIRESA level; thus the importance of inserting coordination actions into their own management tools such as the operative plan and the management agreement.

c) At a local level, joint planning was established with the participation of the Health Network, Micro-network and Local Government, the binding mechanism in this space were maternal perinatal and infant quality standards. Measuring, analyzing and communicating the results of quality standards reinforced the need to coordinate human resource actions (competent based evaluation and incentives), as well as for aligning, focusing and mobilizing technical and financial resources from the community and government to close the gaps in quality standards. These commitments implied:

    a. Attracting the interest of the town toward management by results.

b. for communities to generate and sustain attitude changes toward maternal and infant health care.
c. fostering in micro-networks, the need to carry out team work internally, among the people in charge of the different programs or areas; as well as to establish a relationship with the community and the local government to achieve sustainable changes of continuous improvement not only in health services, but also in the demand.

d) These qualitative changes observed from outside and from inside show the leadership quality and acknowledgement among their peers and society in general, establishing trust bonds among the micro-network, local government, community organization leaders and users.

e) Another lesson learned from this coordination process is the need to create an active and motivating technical political speech based on key inputs existing in the region such as regional health policies, priorities and objectives of the coordinated regional health plan and the local development plan; present the alignment and common interest in achieving quality health among the population, generate greater involvement and commitment in actors. In this framework, the decentralization process was favorable because it allowed the creation of a political and sanitary speech.

f) Maybe a lesson is also how this coordination process of quality components, human resources and health promotion forces us to consider the importance of bringing together RHUS, Quality and PROMSA policies to the local governor, to the Micro-network team and to the community to empower them in their understanding, adaptation, implementation, assessment and supervision. That is to say, it is not enough to approve policies, rules and regulations, but rather how these get to be understood and defended by citizens. In this process, a key factor is how to implement them.

Management Agreements (Regional Government – Local Government)

a) In order to achieve a common interest in activities based on health results, it was essential to have political will, coordination of common goals and active participation of management teams of local and regional governments.

b) Sensitization of local governments for improving maternal – infant health in their localities through indicators was critical for mobilizing decisions to allocate logistics, financial and community agent resources in order to disseminate the scope of health problems (baseline) and participation activities and tasks for solving them.

c) The participation and commitment assumed during the entire process by the regional and local authorities is a central aspect that allows to successfully build the experience. In this case, the participation of employees and technical teams of the Social Development Management, Regional Health Directorate and District Municipalities has been permanent and engaged and is probably the only alternative to institutionalize and give continuity to the experience to pursue the improvement of sanitary outcomes.

d) The involvement of social actors of greater financial importance (SIS, JUNTOS, MEF) is not very feasible because the adaptation decisions are centrally determined and their expenditure allocation structure lacks flexibility for local needs. Nevertheless, it is necessary to develop the necessary strategies and mechanisms to include such financial actors in the Agreement in the understanding that the indicators to be measured are critical in populations with low resources.

e) To strengthen the Management Agreement, links among indicators should be developed with financing allocation in the districts with poor families (demand) and SIS (supply).

f) To carry out a logic cause analysis based on evidences of each indicator in the Management Agreement will help develop a platform of underlying indicators showing results in the short term (lessons), with the purpose that their use be validated among the actors and give signs of the tangibility of improvements achieved as a result of the fulfillment of activities and tasks planned in the participation plan.

g) The proposed indicators that have exceeded 80% in the baseline should be extrapolated towards another stricter indicator consistent with the service delivery system, with access to services in the locality. For example, finding 90% of children with an updated CRED card, suggests the revision and adjustment of this indicator towards a more demanding one, as for example, the decrease in the percentage of children with a nutritional risk.

h) Management agreements between the regional government and district governments are a more flexible experience that adapts to the needs and scarce local resources, and has turned micro-networks into a local operator for the local government. This proposal is a valuable alternative in view of MINSA´s national decentralization proposal, which is somewhat different due to the absence of a national subscribing counterpart. Nevertheless, it ensures the framework for a national social policy (CRECER) and health sector policy.

i) One aspect that this experience has shown is the difficulty to count with timely and reliable information in institutional information systems. In this line, the development of the experience has helped improve and update the Perinatal Information System and SISMED software at health facilities of the Amarilis Micro-network. Nevertheless, this is a pending task that the Regional Health Directorate and District Municipalities should immediately and co-coordinately develop with the purpose of obtaining quality and timely information at least about the sanitary issues considered a priority in their fields.

TECHNICAL TEAM

Project: "IMPROVING THE HEALTH OF PERUVIANS"

STAFF ASSIGNED TO THE COOPERATION AGREEMENT
USAID PERU CA - 527-A-00-04-00109-00

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ANNEX

See attached documents.

- Annex I
- Annex II
- Annex III
- Annex IV
- Annex V