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PDQ – "Puentes" in Peru:
"Mobilizing Communities to Bridge the Quality of Care Gap"

In 1998-2000, the PDQ approach was applied in the 'Building Bridges for Quality' project in 3 pilot areas in Puno Sub-region, Peru. The project was a joint initiative by the Ministry of Public Health in Peru, JHU/PCS4 and Save the Children to pilot a community mobilization strategy to improve the quality of health services. The PDQ approach invites community members and service providers to enter into an ongoing, respectful dialogue about what constitutes quality services and how they can improve their health and health services. The pilot project also complemented the Peru MOH Quality Improvement initiatives, and the local project, "ReproSalud".

Objectives

Project Goal

Develop and strengthen shared responsibility between health service providers and communities for the quality of health care in order to improve the population's reproductive health and health in general.

Objectives

- Increase utilization of public health services in selected project areas.
- Improve interaction and communication between clients and health service providers.
- Establish mechanisms and systems to improve coordination and collaboration between health services and community organizations.

Description

In 1998, the Peru MOH was implementing several quality improvement initiatives, which had limited success and have not increased utilization significantly in many parts of the country. At the same time, a national project, "ReproSalud" was working with communities to improve maternal and neonatal health but had little contact with public sector health services. Related to this, a rapid study of communication needs conducted in 1997 found that the barriers to utilization of health services (especially by the indigenous people) were predominantly "intangible" (psychosocial) rather than "tangible" (cost, distance, hours, etc.).

During 1998-2000, JHU/PCS4 in partnership with Save the Children, provided assistance to the Ministry of Public Health Puno Sub-Region in three selected pilot areas for the PDQ application, namely: Huancané, Moho, and

Ayaviri. The pilot areas included 2 Hospitals, 2 Health centers and 1 Health post, and three communities. The pilot areas were mainly composed of indigenous people, most of whom are poor, speaks only Aymara or Quechua, only had Primary education while many are illiterate, and mostly belong to the lower class.

The PDQ pilot aimed to bridge the gap and differences in Health service providers' and community members' socio-economic, cultural and organizational realities and experiences, with a special emphasis on gender. This gap presented barriers to clients and service providers from establishing and maintaining a mutually respectful relationship that will help improve the clients' health and the quality of health services.

The project coordinated with the directors of the Puno Sub-regional level to set-up a local MOH sub-regional team that is responsible for planning, implementing and monitoring the project with technical assistance from the JHU/PCS4 project. SC and PCS/JHU staff trained this local team, as well as, worked with them to develop a facilitation guide to use with the Health workers and Community members through sociodramas, group discussion, and testimonials, aimed to elicit the two groups' definitions and perceptions of quality health care. Later on, the team developed and produced participatory videos with the two groups separately. The videos then, served as a catalyst to initiate dialogue between the two groups on their perception of "quality health care." During the Bridging the Gap phase, the local team and JHU/PCS met with both groups over two days to develop a definition of "quality" and a joint action plan aimed at improving quality. Participatory exercises were used throughout the process, and the videos were shown as a stimulus for discussion. In addition, all participants visited the community and the health facility as a process of "getting to know each other". While viewing the videos, participants' reactions were processed where common

themes, barriers and resources were identified, while strategies were also negotiated. This helped them to develop a draft action plan based on strategies.

The participants reviewed the draft action plans where suggested changes were noted and incorporated, then it was distributed to all formal representatives of the community and to participating health service providers for finalization and formal agreement. The local MINSA team and PCS provided technical assistance while the QI team implemented the activities. To monitor their progress together, all the partners established monitoring mechanisms and indicators that reflect the agreed upon definition of quality. It was also planned that after 1 year, a participatory evaluation of the project will be conducted.

Results

- Community-provider relations have improved. There is Better treatment of clients and better communication.
- The MOH has reported increase in utilization of family planning and child survival services
- Observable changes in facilities including posting public signs on prices, staff schedules, more complete drug stock at more affordable prices, greater privacy
- Providers are more attentive and friendly with the community, and they make a greater effort to respond to community complaints. The community also believes that providers have improved health care according to what the community wants.
- There is more active community participation, as seen by the ongoing planning, monitoring and coordination meetings between communities and providers.
- Community members are interested in health, and they go to the health facilities with greater confidence.
- Community members have more trust in health workers, as they feel there is greater respect for their customs/ beliefs. They also know that they need to pay for services
- The community knows more about health service programs, and there is increased community demand for and attendance at health education sessions

Products / Outputs produced in the process

- Trainer's manual, facilitation guides, brochure, video, article published in IDS Bulletin, 1/2000: Howard-Grabman, L. *Bridging the Gap Between Communities and Service Providers: Developing Accountability Through Community Mobilization Approaches*
- Videos of the definitions of Quality by the Community, and by the Health Workers.
- Video made to document the process and to assist in building consensus to "scale up" the initiative.

Challenges and Lessons Learned

- The local MOH project team members transformed their roles to facilitators. They are now acting as change agents within the MOH, although they face huge challenges. While you may have a third party facilitate (e.g. NGO), the power of this process was that MOH staff are leading the change. This appears to result in greater commitment from them.
- Building relationships is KEY to initiating work between communities and service providers (especially in this setting). This is part of the intervention, not preparatory work.
- Participatory video was a valuable tool to enable groups initially to express themselves freely without fear of direct confrontation/conflict and reflect upon their own attitudes and behaviors.
- Service providers and communities felt stronger when they worked together. Their alliance helped to renew commitment and energy to push through the perceived and real barriers that kept them from acting alone.

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* This monograph is a product of a Save the Children/CORE Group's joint Technical Advisory Group on Partnership Defined Quality.