527-0219

PD-AAB-041 (2)

DEPARTMENT OF STATE
AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D.C. 20523

PERU

PROJECT PAPER

EXTENSION OF INTEGRATED PRIMARY HEALTH

AID/LAC/P-030

Project Number :527-0219

PROJECT AUTHORIZATION

Name of Country/Entity: PERU

Name of Project: Extension of Integrated Primary Health

Number of Project: 527-0219

Number of Loan: 527-4-072

1. Pursuant to Section 104 of the Foreign Assistance of 1961, as amended, I hereby authorize the execution of a loan ("Loan") and a grant ("Grant") to the Republic of Peru ("Peru") for Extension of Integrated Primary Health involving planned obligations of not to exceed $5.8 million in loan funds and $1.35 million in grant funds over a four year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project.

2. The project consists of the creation and implementation of a system of integrated primary health care extension including the following elements: (1) provision of basic rural health services utilizing health auxiliaries, community promoters and nurse-midwives; (2) community education and support to basic sanitation activities; (3) training and supervision of health workers; (4) establishment of a basic health care information system and (5) studies and evaluation and technical assistance ("Project").

3. The Project shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

a. Interest Rate and Terms of Repayment

Peru shall repay the Loan to A.I.D. in U.S. Dollars within twenty-five years from the date of first disbursement of the Loan, including a grace period of not to exceed ten (10) years. Peru shall pay to A.I.D. in U.S. Dollars interest from the date of first disbursement of the Loan at the rate of (a) two percent (2%) per annum during the first ten (10) years, and (b) three percent (3%) per annum thereafter, on the outstanding disbursed balance of the Loan and on any due and unpaid interest accrued thereon.

b. Source and Origin of Goods and Services (Grant)

Goods and services financed by A.I.D. under the Grant shall have their source and origin in Peru or in the United States except

as A.I.D. may otherwise agree in writing.

c. Source and Origin of Goods and Services (Loan)

Goods and services, except for ocean shipping, financed by A.I.D. under the Grant shall have their source and origin in Peru or in countries included in A.I.D. Geographic Code 941, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Loan shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States or Peru.

d. Condition Precedent to Initial Commodity Procurement

Prior to disbursement for commodity procurement, the MOH will furnish to A.I.D. a copy of agreement in form and substance satisfactory to A.I.D. among MOH Central level staff, the Regional Directors, and USAID on a commodity procurement plan for the first twelve months of implementation.

e. Conditions Precedent to Disbursement for any Purpose other than Initial Commodity Procurement or Technical Assistance

Prior to any disbursement of Loan or Grant funds or the issuance of any commitment documents under this Project Agreement for Loan or Grant funds for any purpose other than commodity procurement, or technical assistance, Peru shall furnish in form and substance satisfactory to A.I.D.

(1) Time-phased Regional Operational Plans, detailing each activity by months and financial requirements (MOH and A.I.D.) to accomplish Project activities. These will include a detailed Financial Plan showing proposed expenditures, a general training plan, a staffing plan, information and evaluation system, and a plan to carry out the baseline survey and health studies.

(2) A statement of MOH objectives agreed upon with UNFPA and PAHO in utilizing the resources available from USAID and UNFPA in a complementary fashion. The statement should identify the geographic or programmatic areas where the two programs will be focussed and should provide for coordination of effort and for reporting to both parties the progress in all areas of activities being supported.

(3) An action plan which outlines the arrangements between the MOH and appropriate regional authorities which articulates the regional plans and programming goals, identifies the responsibilities of the MOH and Regional Office, outlines the method of community and financial supply, assures the appropriate availability of vehicles and personnel for training and supervision at all levels, and establishes appropriate reporting requirements.

f. Condition Precedent to Distribution of Pharmaceuticals and Equipment

Prior to any distribution of pharmaceuticals and equipment, the MOH will submit to A.I.D. a plan for the procurement, storage and distribution of commodities to the health posts; such plan will also describe maintenance requirements and procedures at both Central and Regional levels.

g. Peru shall covenant, except as A.I.D. may otherwise agree in writing:

(1) To carry out jointly with A.I.D. a formative evaluation after the initial six months of Project activities and two in-depth evaluations of the Project - one at the end of the first year and the second at the end of the third year.

(2) That it will continue to provide sufficient annual budget allocations following completion of the Project so as to assure continuity of the Project activities.

(3) That project activities will be implemented at the regional level through regional administrators designated in accordance with the terms of the Project Agreement; and that funding provided for the Project will be utilized directly to support activities at the regional level

h. The following waivers to A.I.D. regulations are hereby approved:

U.S. and local procurement is authorized under the Grant portion of the Project.

9/12/79

Leonard Yaeger, Director
USAID/Peru

Clearances: HEN:JBallantyne: ____
CD:GWachtenheim: ____
FHO:HKaufman: ____
PROG:LSmucker: ____

RLA:JKessler:css 9/6/79

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

TRANSACTION CODE: A (A = ADD, C = CHANGE, D = DELETE)

PP

2. DOCUMENT CODE: 3

3. COUNTRY ENTITY: PERU

4. DOCUMENT REVISION NUMBER:

5. PROJECT NUMBER (7 digits): 527-0219

6. BUREAU OFFICE: A. SYMBOL: LA; B. CODE: 05

7. PROJECT TITLE (Maximum 40 characters): Extension of Integrated Primary Health

8. ESTIMATED FY OF PROJECT COMPLETION: FY 81

9. ESTIMATED DATE OF OBLIGATION: A. INITIAL FY 79; B. QUARTER 4 (Enter 1, 2, 3, or 4); C. FINAL FY 81

10. ESTIMATED COSTS ($000 OR EQUIVALENT $1)

A. FUNDING SOURCE	FIRST FY B. FX	FIRST FY C. L/C	FIRST FY D. TOTAL	LIFE OF PROJECT E. FX	LIFE OF PROJECT F. L/C	LIFE OF PROJECT G. TOTAL
AID APPROPRIATED TOTAL	3,980	3,170	7,150			7,150
GRANT: PN HE	130/50 (180)	420/750 (1170)	550/800			1,350
LOAN: HE	3,800	2,000				5,800
OTHER U.S. 1						
OTHER U.S. 2						
HOST COUNTRY		2,400			2,400	2,400
OTHER DONORS		5,570	2,400			
TOTALS	3,980	3,170	9,550		2,400	9,550

11. PROPOSED BUDGET APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE C. GRANT	PRIMARY TECH. CODE D. LOAN	E. 1ST FY 79 F. GRANT	E. 1ST FY 79 G. LOAN	H. 2ND FY ___ GRANT	H. 2ND FY ___ I. LOAN	K. 3RD FY ___ L. GRANT	K. 3RD FY ___ M. LOAN
1. HE	530	510	510	800	5,800				
2. PN	440	440		550	-				
3.									
4.									
TOTALS				1,350	5,800				

A. APPROPRIATION	N. 4TH FY ___ O. GRANT	N. 4TH FY ___ P. LOAN	Q. 5TH FY ___ R. GRANT	Q. 5TH FY ___ S. LOAN	LIFE OF PROJECT T. GRANT	LIFE OF PROJECT U. LOAN
1. HE					800	5,800
2. PN					550	-
3.						
4.						
TOTALS					1,350	5,800

12. IN-DEPTH EVALUATION SCHEDULED: MM 9, YY 80

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA BLOCK 21? (IF YES, ATTACH CHANGED PID FACESHEET.)

1 (1 = NO, 2 = YES)

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE: Leonard Yaeger 9/12/79

TITLE: Mission Director, USAID/Peru

DATE SIGNED: MM DD YY

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

AID 1330-4 (3-78)

(TM 3:19)

AGU 3A CN 3 HB

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS PART I

TRANSACTION CODE: A ADD / C CHANGE / D DELETE

PAF

2. DOCUMENT CODE: 5

3. COUNTRY ENTITY: PERU

4. DOCUMENT REVISION NUMBER:

5. PROJECT NUMBER (Digits): 527-0214

6. BUREAU SYM: A. SYMBOL: LA B. CODE: 05

7. PROJECT TITLE (Maximum 40 Characters): Extension of Integrated Primary Health

8. PROJECT APPROVAL DECISION: ACTION TAKEN: A A. APPROVED / C. DISAPPROVED / DE DEAUTHORIZED

9. EST. PERIOD OF IMPLEMENTATION: YRS. 3 QTRS.

10. APPROVED BUDGET AID APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE C. GRANT	D. LOAN	E. 1ST FY 79 F. GRANT	G. LOAN	H. 2ND FY G. GRANT	J. LOAN	K. 3RD FY L. GRANT	M. LOAN
1. DE	530	510	510	800	5,800				
2. PN	440	440		550					
3.									
4.									
TOTALS				1,350	5,800				

A. APPROPRIATION	N. 4TH FY O. GRANT	P. LOAN	Q. 5TH FY R. GRANT	S. LOAN	LIFE OF PROJECT T. GRANT	U. LOAN
1. DE					800	5,80
2. PN					550	
3.						
4.						
TOTAL					1,350	5,800

11. PROJECT FUNDING AUTHORIZED — ENTER APPROPRIATE CODES: 1 LIFE OF PROJECT / 2 INCREMENTAL LIFE OF PROJECT

	A. GRANT	B. LOAN
	1	1

C. PROJECT FUNDING AUTHORIZED THRU FY 79

12. NET AID PROJECT FUNDING ALLOTMENT REQUESTED ($000)

B. ALLOTMENT REQUEST NO.

A. APPROPRIATION	C. GRANT	D. LOAN
1. DE	800	5,800
2. PN	550	-
3.		
4.		
TOTALS	1,350	5,800

13. FUNDS RESERVED FOR ALLOTMENT

TYPED NAME (Chief, SER/FM/FSD)

SIGNATURE

DATE

14. SOURCE ORIGIN OF GOODS AND SERVICES: 000 / 941 / LOCAL / OTHER

15. FOR AMENDMENTS NATURE OF CHANGE PROPOSED

FOR PPC, PIAS USE ONLY	16. AUTHORIZING OFFICE SYMBOL	17. ACTION DATE MM DD YY	18. ACTION REFERENCE (Optional)	ACTION REFERENCE DATE MM DD YY

AID (330-6 7-78)

PROJECT PAPER

EXTENSION OF INTEGRATED PRIMARY HEALTH

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PART I. PROJECT SUMMARY AND RECOMMENDATIONS

A. Recommendations

It is recommended that a loan of $5,800,000 and a grant of $1,350,000 be authorized to the Government of Peru to assist in the development of a project for the Extension of Integrated Primary Health covering a period of three years' disbursement. The Project Loan and Grant will begin in FY 79 and terminate disbursements in FY 81.

B. Introduction and Summary Description

1. The Problem

The severe health problems confronting a large portion of Peru's population are primarily the product of income maldistribution which has complex economic, social and political origins. Though the Government of Peru (GOP) has repeatedly signalled its intention to improve the health situation of its population, the serious economic and fiscal constraints of recent years have not permitted the Ministry of Health (MOH) to build an institutional capability to address major health issues. Increased population, what the Minister of Health has labeled as "the Peruvian demographic explosion", has made the job of providing improved access to minimal health services even more difficult. Emphasis on curative health services, especially high-cost, low-yield inpatient hospital services, have further reduced the MOH's impact on the major health problems of the country. Frequent reorganization within the MOH has also impeded long-range health planning and rational allocation of scarce resources.

The serious health problems affecting the rural and marginal urban populations are intensified by maldistribution of public sector health services and the economic crisis confronting Peru. In rural areas approximately 50% of the general mortality rate is made up of those under five years. Infant mortality is estimated at 120 per 1000 with maternal mortality estimated at 40 per 10,000 live births per year. The principal causes of death are infections and parasitic diseases, all of which are susceptible to control through vaccinations and sanitary measures. Enteritis and respiratory diseases are the major causes of illness and death in the entire population. All of these are complicated by malnutrition which is associated with the basic cause of approximately 60% of the total deaths of children under five. This total mortality pattern is strongly related to high risk pregnancies, a condition which can be dealt with practically in a low cost extension of integrated maternal and child health programs. Geographic factors greatly influence health status as well as other socio-economic factors. Of Peru's total population of approximately 1[illegible],300,000 (1979), about 33 percent live in rural areas, many in remote mountainous or jungle regions, which provide little access to health facilities.

The MOH is responsible for providing health care to the majority of the population. Social Security provides preventive and curative services to its insured workers and the

Armed Forces similarly covers its members. Both of these systems, like that of the MOH, are concentrated in urban areas, leaving minimal or non-existent services for approximately 6,000,000 people. The MOH basic infrastructure consists of 107 hospitals, 403 health centers and about 1200 health posts. Staffing levels, equipment, and supplies for these facilities varies greatly. As in most countries physicians do not generally live and work in rural areas. Recently graduated medical students perform obligatory one-year service, usually in the rural area hospitals or in some of the health centers.

The problem centers on the necessity of extending the existing health care structure into the rural and marginal areas in order to reach the unserved and underserved population. To accomplish this objective with limited resources, the GOP has developed a plan of primary health care assistance. The definition of primary care in the Peruvian context includes the combination of (a) development activities required to satisfy basic health necessities, i.e., simple curative services, e.g., tuberculosis control, antihelmintics, preventive services, e.g., vaccinations, family planning, prenatal services, and (b) community development activities such as environmental sanitation, which are supported by and developed in the community with the assistance of MOH personnel.

The existing MOH infrastructure has severe limitations in reaching the underserved and unserved population. The first problem is one of human resources and trained personnel. The lack of resources at all levels affects the health services system, especially at the Regional and local level. The few resources which are available are concentrated in urban areas, further diminishing the quality of services offered to the rural poor. (See table 1) In 1977 there were 3,408 inhabitants per medical doctor in Peru with even higher ratios in areas outside Lima.

Medical equipment is scarce, often obsolete and poorly maintained. Financial resources are not available to purchase basic medicines and equipment. Fewer resources exist for adequate training, information collection, health planning and environmental sanitation.

Moreover, those resources which do exist (trained personnel, equipment, and medicine) are centered in the hospitals and health clinics of the large cities. Thus, over the years an infrastructure has been developed which includes:

TABLE 1

PHYSICIANS PER DEPARTMENT - 1979

Departments	Total Physicians	Number of Inhabitants per Physician	Rate of Physicians x 10,000 Inhabitants
	10,246 (1)	1,687	5.9
Amazonas	19	15,347	0.65
Ancash	178	4,962	2.00
Apurímac	21	15,984	0.62
Arequipa	526	1,320	7.58
Ayacucho	42	12,577	0.79
Cajamarca	81	13,476	0.74
Callao	312	1,354	7.38
Cuzco	149	5,662	1.76
Huancavelica	24	15,434	0.64
Huánuco	73	6,802	1.47
Ica	255	1,830	5.46
Junín	196	4,457	2.24
La Libertad	498	1,958	5.11
Lambayeque	272	2,532	3.95
Lima (Provincia)	216	1,530	6.53
Lima Metropolitana	6,588	693	14.42
Loreto	131	5,015	1.99
Madre de Dios	5	5,025	1.98
Moquegua	68	1,473	6.79
Pasco	37	5,660	1.77
Piura	286	3,639	2.74
Puno	87	10,210	0.97
San Martin	45	6,440	1.55
Tacna	94	1,345	7.44
Tumbes	43	2,235	4.47
Not Located	861	- -	- -

(*) Source: Medical College of Peru

(1) Includes 861 not designated by location

Regional Office (Operational Level)

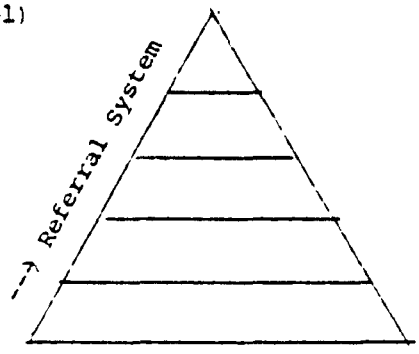
Regional Hospital

Large Area Hospital

Small Area Hospital

Health Clinic

Health Post



However, the infrastructure concentrates existing resources in the larger facilities of urban hospitals and clinics. Health services for the rural poor are focussed at the small community level, which relies heavily on traditional healers and empirical midwives; the formal infrastructure at the health post level is usually woefully inadequate. The health post is staffed by a health auxiliary, usually a man with six months training, who often has neither the training, equipment, or medicine to provide rudimentary health care.

Therefore, the objective of the project is to extend the current infrastructure to the community level, by: 1) reinforcing the role of the health auxiliary and health post by providing adequate training, equipment and basic medicines for this fundamental entry into the health system; 2) selecting and training community agents and empirical health worker and providing simple equipment and medicines; 3) introducing community development activities in environmental sanitation including protection of water sources and waste disposal; and 4) providing the support for a community level information system for health management and evaluation and undertaking studies, including a baseline household survey, to examine health problems and further improve the capacity of the MOH to extend services to the poor.

2. Background

The design of this Project reflects the conscious effort by USAID to respond rapidly to positive policy changes instituted by the MOH in recent months. These changes focus upon three major considerations: 1) the GOP's commitment to primary health care which conforms in both process and content to AID's mission to serve the poor, particularly those in rural areas; 2) the MOH has elaborated a plan for extension of primary health care services which provides a sound basis for project development

and offers the opportunity for full governmental support and efficient and cost effective implementation throughout the country; 3) the GOP has ordered the MOH to operationalize its population policy thereby providing a unique opportunity to include family planning information and training for the community within the context of their integrated primary health care plan.

For these reasons, the Mission has developed this Project incorporating the major elements of the Government's Primary Health Care planning document and including the family planning component as an integral part of the overall plan. Moreover the Project has the unanimous support of the MOH, the National Institute of Planning (INP) and the President of Peru, thereby assuring rapid approval and priority focus within the MOH in relation to implementation.

As recently as early 1978, the MOH was reluctant to request USAID assistance in the health sector, and other donors were also having difficulty moving programs through the Ministry, e.g., United Nations/PAHO was facing serious problems of bureacratic and policy constraints on project implementation. However, USAID found some receptivity within the Ministry for a small health planning project which would offer an initial opportunity to collaborate with the Health Information and Planning Sectors of the MOH in preparation for a larger loan/grant program in the Centro Medio Region at some future time. A PID was developed and sent to AID/W for approval on this basis.

In September, 1978, changes at the highest levels of the Ministry altered the potential role of USAID in the Health Sector. New leadership entered the Ministry, and the Ministry itself was reorganized with the creation of a new Directorate of Maternal Child Health and Population. This new organization was formalized and manifested a much stronger service orientation than had previous administrative directorates.

Thus, by the beginning of 1979 the Mission was in a position to work with the Ministry in developing community-based service programs including provision of family planning services. The first request for assistance came from the Sur Medio Health Region. Utilizing the assistance of AID/W and Columbia University, the Mission and persons from the Sur Medio Health Region developed a large scale Maternal Child Health and Population Project which will go into the implementation phase in FY '79. The Sur Medio project provides a unique opportunity to respond quickly to MOH initiatives which support AID health and population policy goals.

Given this background, it became clear by early 1979 that the health planning PID required modification. In response to MOH requests, the Project design was modified to include a service delivery component in the Centro Medio Region similar to that developed for Sur Medio. However, it soon became evident that the MOH favored the development of a national program, refusing for both political and conceptual reasons to support any more internationally funded programs on a regional or pilot basis. Thus the Mission considered the potential political and programmatic advantages of collaborating with the MOH to support its national project of primary health care. Moreover, USAID realized the advantage of becoming the first international donor to support the plan which would maximize our involvement in planning and initiating this significant government impetus to improve primary health care services.

Events moved rapidly and the MOH secured the approval of the Ministry of Economics and Finance for a health loan component. An MOH Commission was established to work with USAID and AID/W team to develop the PID and Project Paper. As anticipated, the MOH has responded rapidly to all requests for additional information and procedural clarification and has solved many of the critical operational and implementation issues so as to expedite project execution.

Thus, within the time frame of one year, USAID has created a dynamic collaborative relationship with the GOP, and especially the MOH, in the development of a national health care program based upon the principles and directives of both the MOH and AID to extend integrated primary health care services, including family planning information to the rural poor.

3. Summary Description

USAID through the proposed Project, will assist the MOH in its effort to develop a primary health care system and begin implementation of its five-year national plan. The Peruvian national primary health care plan proposes to provide basic health services to the six million people currently estimated as having no access to health care services, according to MOH planners.

In accordance with the national policy, the executing agency for the project will be the General Directorate of Health Programs located in the central level of the MOH. The Implementation of Project activities will be the responsibility of each Health Region under the guidance and coordination of the Central Ministry. In this manner the Ministry will maintain compliance with the standards

and goals of the Project while at the same time it assures that the decentralized, more efficient, regional administrative units will be directly responsible for day-to-day management and implementation.

The Project summary description includes five major components: 1) Rural Health Services, 2) Community Education and support for Sanitation Activities, 3) Training and Supervision, 4) Information System, Studies and Evaluation and 5) Technical Assistance.

a. Project Components

(1) Rural Health Services

This Project component provides the major focus for the program in assuring that the basic health services designated under the national primary health care plan are extended to an additional 4,284,000 million persons currently underserved in the existing health infrastructure. Utilizing health auxiliaries, community promoters, and empirical nurse-midwives, the MOH will extend critically needed preventive services, e.g., immunizations, family planning information and prenatal care, simple curative services especially focused upon mothers and children, e.g., oral rehydration, tuberculosis control and health and nutrition educational services to isolated rural communities.

This component incorporates the medicines, basic medical equipment and transportation including bicycles and mules.

(2) Community Education and Support to Sanitation Activities

This Project component will support environmental sanitation and community health education activities under the MOH National Plan. Rather than focus upon sophisticated technology and systems, this component will provide basic appropriate materials and equipment needed to assist in the development of simple health education actions at the community level, e.g., basic hygiene, nutrition education, family planning, and improved extension and protection of water services and waste disposal. These activities complement the rural health services component by supporting community self-help actions designed to upgrade the environment and stimulate community awareness regarding simple preventive health principles.

(3) Training and Supervision

The Project will support training activities

for three levels of health workers. Initial training will focus on health auxiliaries, MOH employees who currently staff the rural health posts. These para-professionals, who have received up to six months training by the MOH, will receive a brief refresher course with emphasis on supervision and family planning information. The second cadre of personnel to be trained will be the community health promoters. Approximately 4,100 promoters will receive four weeks of intensive training including: vaccination techniques, identification and treatment of respiratory diseases, helminthic infestation and family planning. In the third series of training courses approximately 4,100 traditional midwives will participate in a fifteen day program designed to improve maternal and child health. Prenatal, postnatal, including infant care and family planning information and childbirth services will be emphasized.

Supervision activities will center upon onsite continuing education and assistance for community level para-professionals. Since training activities are limited in scope, content and duration, supervision becomes a vital component of the monitoring system and will assure adequate practical technical support for the often isolated community agent in the field.

(4) Information System, Studies and Evaluation

This component is designed to strengthen the MOH capability: (a) to collect and process data required for management and analysis of the primary health care system including the introduction of community level data forms; (b) to investigate and assess major health and nutrition issues and problems at the national and regional levels including baseline studies of priority disease indices and contraceptive prevalence in the target population; and (c) to monitor and evaluate the Project components on a routine basis, culminating in a final indepth end of Project evaluation by a joint GOP/AID team.

(5) Technical Assistance

This Project component will support a resident nutrition advisor and short term consultant services (28 working months) in public health, logistic systems, health care management, evaluation, health, nutrition and family planning training for para-professionals, and information systems. This external technical assistance will help assure that Project planners and administrators have at their disposal the full range of experience and practice of other Latin American countries in implementing similar health programs.

4. Summary Project Strategy

This Project initiates USAID involvement in the health sector. The main objective of the Project is to institutionalize the concept of extension of integrated primary health by providing USAID financial assistance to establish a community based delivery capability.

Therefore, the first phase of the AID strategy includes the institutionalization of the Government's Plan for extension of coverage of Integrated Health Services by equipping 1040 of the 1200 existing health posts, training and supervision for health auxiliaries, promoters and midwives (over 9500 persons), community education in health, nutrition and family planning, and technical assistance. In effect this represents almost 100% of the potential universe. Certain health posts were not considered because of isolation and low population densities (e.g., jungle areas), whereas other health posts are already functioning well (e.g., urban pueblos jovenes) and do not require the type of assistance which the Project will provide. Under the Project, critical inputs will also be provided to improve the central-level MCH outreach capacity. The total planned investment will help insure that the necessary infrastructure for carrying out the longer-range objectives of the National Plan is in place and thereby develop a firm basis for further AID and other donor inputs over the long term. In addition to providing a basis for the institutionalization of the MOH's Plan, the Project will also be assisting the MOH attend to the critical health needs of Peru's economically and socially marginal population in a time of severe economic crisis.

The Mission has determined that major impact in the health sector requires a significant allocation of resources. Moreover, as the first and principal international donor, AID can be assured more involvement in policy decisions regarding equipment, training, logistic system, information system development and execution and family planning guidelines within the primary health care system.

C. Summary Financial Plan

	AID	GOP	TOTAL
I. Rural Health Service			
1. Medicines	1,600	200	1,800
2. Medical equipment	1,800	760	2,560
3. Transportation	220	100	320
	3,620	1,060	4,680
II. Community Education and Support to Sanitation Activities			
1. Community Education	410	170	580
2. Sanitation Activities	240	130	370
	650	300	950
III. Training and Supervision			
1. Training	1,150	400	1,550
2. Supervision	720	400	1,120
	1,870	800	2,670
IV. Technical Assistance	210	-	210
V. Information System, Evaluation and Research			
1. Information	130	140	270
2. Evaluation and Research	670	100	770
	800	240	1,040
Grand Total	7,150	2,400	9,550

Note: Contingency and inflation have been factored into the various investment categories.

D. Summary Findings

The Project development committee has concluded that the Project is technically, economically and administratively feasible. The GOP is formally committed to the objectives of the Project, which

conform to priority policies of the GOP, i.e., cost effective primary health care, maternal and child health, extension of services to the rural poor and the population norms and guidelines.

II. PROJECT BACKGROUND AND DETAILED DESCRIPTION

A. Background

1. Introduction

Peru is the third largest country in South America; nevertheless, it is among the countries with the least arable area per inhabitant--its population density per arable square kilometer is 476.2. The Andean mountains cross the country from south to north separating it into three different regions which differ from each other in flora, fauna, climate and socio-cultural characteristics: coast, mountain and jungle. The coast represents 11.54% of the total area, with approximately 46% of the population. The mountain and jungle represent 26.83% and 61.63% of the area, and 44.1% and 9.9% of the population respectively.

Peru's demographic growth shows an increasingly centralized trend. There is a tendency for the population to concentrate in certain regions, particularly the Lima metropolitan area and a handful of other urban areas. The result has been a growing dichotomy between rural and urban, as well as coast vs. sierra.

Rural Areas - Characteristics

33% of Peru's population lives in rural areas, which are dependent upon subsistence agriculture. The rural population is scattered in valleys which are separated by deserts on the coast, mountains in the sierra and rich vegetation in the jungle, so that distribution of goods and services is very difficult and costly due to the scarcity and inadequacy of the roads. For this reason, beasts of burden are frequently used for both communications and transportation. Some rural localities are completely isolated from the rest of the country during the rainy season, since roads are washed out.

The rural population is mostly young, with 48.7% under 15 years and 4.2% over 65. Annual average rural growth rate is very low 0.6%) due to wide-scale migration to the cities. (Migration rate is estimated at 2.5%) See Tables II-1 and II-2.

Health problems in rural areas are very serious. The general mortality rate is very high (17.0 per 1,000) and the rate of infant mortality is 139.1 per 1,000 born alive. Death of children under five years old is approximately 50% of total deaths (See Table II-3). The main causes of mortality are infectious and parasitic diseases, susceptible to control by vaccination and environmental sanitation. Nutritional deficiencies are related to the basic causes of death in approximately 60% of total deaths of children under five years old. Likewise, 33% of pregnant women show nutritional anemias. In this way, malnutrition exacerbates disease and diseases contribute to malnutrition.

TABLE II-1

PROJECTED RURAL POPULATION BY GROUPS (1979-83)

	1979		1980		1981		1982		1983	
Total Population	5'762.8		5'800.0		5'836.2		5'871.5		5'905.7	
Infants (less than one year)	285.2	(4.95%)	270.3	(4.66%)	272.0	(4.66%)	273.6	(4.66%)	275.2	(4.66%)
Children under school age (1 to 4 years old)	856.6	(14.86%)	879.0	(15.16%)	877.8	(15.04%)	876.9	(14.94%)	875.6	(14.83%)
Students (5 to 14 years old)	1662.2	(28.85%)	1679.1	(28.95%)	1698.6	(29.10%)	1716.3	(29.23%)	1735.5	(29.38%)
Adults (15 to 64 years old)	2717.9	(47.16%)	2728.0	(47.03%)	2741.2	(46.98%)	2755.2	(46.92%)	2767.5	(46.86)
People over 65	240.9	(4.18%)	243.6	(4.20%)	246.6	(4.22%)	249.5	(4.25%)	251.9	(4.27%)
Fertile age women (15 to 49 years old)	1127.8	(19.57%)	1131.1	(19.50%)	1136.4	(19.47%)	1142.2	(19.45%)	1147.2	(19.40%)
Pregnant women *	335.5	(5.82%)	317.9	(5.48%)	319.9	(5.48%)	321.9	(5.48%)	323.8	(5.48%)

* based on birth rate with 15% increase
(estimating some pregnancies are not completed).

TABLE I-2

Projected Demographic Index Rural and Urban Areas (1975-85)

INDEX	RURAL AREA		URBAN AREAS		NATIONAL AVERAGE	
	1975 - 1980	1980-1985	1975-1980	1980-1985	1975-1980	1980-1985
Natural growth rate annual average ‰	32.5	31.7	26.1	26.0	28.2	27.9
Actual growth rate annual average ‰	6.8	5.8	39.7	37.9	28.2	27.9
Gross birth rate annual average ‰	49.5	46.6	35.0	34.2	40.0	38.2
Total fertility rate	8.51	8.13	4.52	4.28	5.71	5.27
Gross reproduction rate	4.15	3.96	2.20	2.09	2.79	2.57
Net reproduction rate	3.14	3.13	1.81	1.75	2.27	2.18
Gross death rate annual average ‰	17.0	14.9	8.9	8.2	11.8	10.3
Child death rate annual average ‰	139.1	121.4	80.2	70.2	100.7	86.2
Life expectancy at birth - years	52.4	54.8	59.8	61.8	57.2	59.6
Emigration (rural) and immigration (urban) rate annual average ‰	25.8	25.8	13.7	11.7		
Dependency relation ‰	1,100.2	1,131.1	780.2	739.3	882.5	845.3
Proportion of children under 15 years	48.5	48.8	40.8	39.4	43.4	42.4

TABLE II-3

Percentage Distribution of

Total Death Rate By Age Groups. Perú 1972

AGE GROUPS	PERCENTAGE		
Infants (1 year)	30.9	48.4	53.1
Children under school age (1 to 4 years)	17.5		
Students (5 to 14 years)	4.7	4.7	
15 to 19 years	2.0	25.6	25.6
20 to 64 years	23.6		
more than 65 years	21.3	21.3	21.3
	100.0	100.0	100.0

Diagnosis of Health Condition
1975 - P.A.H.O. - M.O.H.

Health levels in rural areas depend upon many factors, which vary in different geographic areas. These factors do not depend exclusively on the health sector, but also on other socio-economic sectors (See Table II-4).

Housing and Basic Sanitation

Housing and basic sanitary conditions are poor. Almost all houses in rural areas lack domestic water and sanitary systems. On the other hand, accelerated urban growth, increasing use of insecticides, growing exploitation of mineral resources, etc. create contaminating agents, such as residual waters which pollute the environment.

Nutrition

Nutritional levels in rural areas are poor due to combined effects of inadequate food consumption and frequent infection, especially gastrointestinal diseases. In the last years, due to the economic crisis affecting the country, these levels have deteriorated even more in the total population, but especially in the lower income strata. Average caloric consumption per day is under 2,000 calories per capita (ENCA projection for 1977). Food consumption in rural areas is mainly (69%) potatoes plus cereals and by-products. (ENCA - 1970-72). Consumption of animal products is very low. The dominant nutritional problem is that of children below three years of age, who are seldom reached by existing programs.

2. Current Policies

The GOP has instituted a series of governmental decrees, policies, guidelines and plans which provide the legal, political and administrative basis for the implementation of this Project. These include, but are not limited to: the Population Policy of 1976, Supreme Decree 625-77-SA, which provides for the implementation of integrated health services, including family planning, under the direction of the MOH; The Tupac Amaru Government Plan, Supreme Decree 20-77-PM, which provides for integrated primary health services including community participation, basic medicines system, environmental sanitation and increased priority coverage for health services to mothers and children; The Global Plan for Development 1979-80 which supports free access to the public for information and services for responsible parenthood and sex education; and the Plan for Support for Primary Health which forms the basis for the development of the service system for extending coverage for integrated primary health care to underserved rural communities.

TABLE II-4

An Index of Conditioning Factors in Health Condition

Rural and Urban Areas

Peru 1972

INDEX	RURAL	URBAN	NATIONAL AVERAGE
Number of inhabitants per house	4.7	5.1	4.9
Percentage of houses without water supply	98.7	40.7	70.1
Percentage of houses without sanitary systems	98.4	53.4	72.9
Percentage of illiterate people over 15 years old	51.4	12.5	27.5

1972 Census

These government documents create the legal and organizational framework for the design and implementation of this project. USAID and AID/W staff participated with MOH representatives as part of a Joint Commission of AID and the MOH to design the Project documents. The Project has had the full support of the MOH in all stages of project development.

3. Project Strategy

The strategy of the proposed Project is to reinforce the GOP's first initiatives to implement, test and expand upon a national program of integrated* primary health care to extend basic health preventive and curative services to rural communities which currently have little or no access to health services. If successful, this program will establish the infrastructure, both human and physical, required to institutionalize a community based health services delivery system as a part of the formal health structure. On the basis of an incremental phased implementation plan, each of Peru's health regions will offer basic preventive and curative services through extension of the formal system into the community via traditional empirical midwives and community agents.

Major emphasis will be placed upon preventive health actions, e.g., prenatal and postnatal services including family planning information; low cost curative services (e.g., tuberculosis control, oral rehydration, parasite control); environmental sanitation, (e.g., latrines, waste disposal and protection of water sources); community education and self-help community action in health (e.g., basic preventive health and sanitation, family planning and responsible parenthood information); and studies designed to provide baseline, diagnostic and fiscal analyses regarding health conditions and community and government resources.

Recent USAID support for health sector activities has been minimal and includes: maternal and child health training and research, private grants to various university, hospital and clinical units for family planning training and services and research and information projects with private institutions.

The Mission feels strongly that it is time to move into new initiatives in the health field, which are designed to support and test the GOP's apparent commitment to move resources into a field which responds to A.I.D.'s own concerns in the provision of basic human rights. The USAID strategy supported by the present Project, therefore, is designed to support the GOP's National Plan for Extending Primary Health Services to unserved and underserved rural and marginal urban areas. (See Annex L for a description of the Plan's Goals and Objectives). This National Plan was developed by a group of health experts from the MOH and approved by an Inter-Governmental Commission composed of repre-

* Integrated is defined as the range of health services which includes health, nutrition, environmental sanitation and family planning information provided as a coordinated delivery system at the community level.

sentatives of the various key ministries and institutes of the Government including INP and the Ministries of Labor, Food and Agriculture.

The Plan includes preliminary documentation for twenty years (long term plan), five years (intermediary plan) and one year (short term implementation plan). These official plans document the needs for health services in treatment and prevention including: medicines, equipment, training and supervision, environmental health, nutritional and community education including family planning information. The Plan has full support at all levels of the Government.

This Project initiates USAID involvement in the health sector. The main objective of the Project is to institutionalize the concept of extension of integrated primary health by providing USAID financial assistance to establish a community based delivery capability.

Therefore, the first phase of the AID strategy includes the institutionalization of the Government's Plan for extension of coverage of Integrated Health Services by equipping 1040 of the 1200 existing health posts, training and supervision for health auxiliaries, promoters and midwives (over 9500 persons), community education in health, nutrition and family planning, and technical assistance. In effect this represents almost 100% of the potential universe. Certain health posts were not considered because of isolation and low population densities (e.g., jungle areas), whereas other health posts are already functioning well (e.g., urban pueblos jovenes) and do not require the type of assistance which the Project will provide. Under the Project, critical inputs will also be provided to improve the central-level MOH outreach capacity. The total planned investment will help insure that the necessary infrastructure for carrying out the longer-range objectives of the National Plan is in place and thereby develop a firm basis for further AID and other donor inputs over the long term. In addition to providing a basis for the institutionalization of the MOH's Plan, the Project will also be assisting the MOH attend to the critical health needs of Peru's economically and socially marginal population in a time of severe economic crisis.

USAID has initiated the present Project recognizing that the Project plan responds to both AID and GOP program initiatives including: 1) preventive health focus; 2) low cost basic health curative services especially for mothers and children; 3) integrated service delivery, including family planning information as one of the range of activities provided; 4) focus upon rural areas where health services are currently unavailable; 5) community education and community development emphasizing local support and involvement in self-help activities to upgrade health and sanitation conditions; and 6) utilization of indigenous para-professionals to extend health resources to areas which cannot support technical specialists and medical professionals.

The Mission has determined that major impact in the health sector requires a significant allocation of resources, especially during a period of economic crisis. Moreover, as the first and principal international donor, AID can be assured more involvement in policy decisions regarding equipment, training, logistic system, information system development and execution and family planning guidelines within the primary health care system.

At the same time, USAID is currently implementing a major demonstration project in the Sur Medio Region. This project, already in the implementation phase, will provide the indepth evaluation, monitoring and testing ground for experimentation in service innovation, training, family planning policy application, baseline survey and information system.

Future Plans

USAID recognizes that a $7 million program cannot meet national level requirements for a primary health program. Three program areas of vital importance are addressed in only a limited form in this Project: (1) the level of support is insufficient in the area of environmental sanitation; (2) a rural health program does not meet the demand for family planning information which is greatest in urban and especially marginal urban areas; and (3) the extreme malnutrition which has accompanied the present economic crisis in Peru, cannot be effectively dealt with under the Project.

The Project does, however, include two important pilot programs which will serve as the basis for future AID financing in the health sector. One component of the strategy includes a marginal urban area program which will be developed under the present Project for a Lima hospital area population to test the feasibility of service delivery in marginal urban areas focusing on maternal child health and family planning information (See Detailed Project Description).

In addition, the Project proposes a pilot component to initiate environmental sanitation activities on a modest scale, initiating the development of environmental sanitation infrastructure at the Hospital Area level in twenty five areas. This pilot activity will provide for basic sanitation activities in water source protection and waste disposal in selected sites. This component will serve two purposes: (1) it will test the feasibility of low-cost methods of alleviating a critical health problem; and (2) it will establish norms for the medium term goal of nationwide replication.

In order to determine the most feasible and cost - effective methods of addressing problems of malnutrition, the Mission is

preparing a PID for FY'81 grant financing of a national nutrition improvement program addressing the program areas mentioned above in future follow-on AID programming is important, since all three are required in order to maximize achievement in AID's overall program of support to the health sector. Malnutrition could seriously undermine both curative and preventive health service objectives, especially over the next two to five years of economic crisis in the country. Environmental sanitation is critical to prevent major diseases associated with mortality, particularly gastro-intestinal and parasitic diseases related to current high infant mortality rates in Peru. Finally, family planning services are a vital integrated health component of any health program in the country. While the Government at present is facing some opposition in the implementation of its population policy, i.e., distribution of contraceptive as part of integrated primary health, efforts will continue to encourage government support for widespread family planning service availability.

The components being financed by this Project were selected by the MOH and the USAID as the priorities under the existing Plan and supported by USAID as its first phase plan for institutionalizing the concepts of primary health care for rural areas utilizing para-professionals at the community level. A phased USAID strategy for financial support was required due to: 1) limited AID financial resources, 2) limited MOH absorptive capacity due primarily to the lack of trained community level personnel and infrastructure support for other activities, e.g., environmental sanitation and nutrition and 3) priority requirements for basic health medicines and equipment needed in these times of severe economic crisis.

In order to assure that the beneficial effects of this first phase financial investment on the part of the GOP and USAID are maximized, the USAID strategy envisions a second follow-on program possibly as early as FY 80) including further support for: 1) a full scale program in environmental sanitation including potable water systems, 2) nutrition activities as a complement to community education, 3) continue efforts to encourage GOP support for widespread availability of family planning services, 4) institutional support for a full-fledged information system in the health sector, and 5) services for rural and marginal urban areas not covered under the project, but included in the Government's Plan.

4. AID Financed Projects in Related Areas

Other AID financed projects in agriculture, education, family planning and housing are addressing important indirect causes of malnutrition and poor health in Peru. AID agricultural project are designed to make available credit to small landholders, improve crop production, finance feeder road construction and small irrigation systems, strengthen agriculture cooperative and federations of cooperatives. The overall goal of these projects is improved productivity and increased farm family incomes in the high jungle and sierra. In addition the Mission has provided grant financing for an experimental project for the use of effluent for irrigation purposes, on the coast, as well as a pilot project in fresh water fisheries in the sierra. A closely-related project is a pilot effort to extend village potable water systems, carried out under an OPG with CARE. Initial evaluation results indicated strong community support for the project and a substantial potential for improved health. This project could become the basis for a potable water component of health sector assistance in the Centro Medio Region and elsewhere in the sierra.

General education development projects receiving AID assistance seek to improve the economic opportunities of low-income Peruvians; these projects include a pre-school education pilot project which will incorporate nutritional education of parents.

AID assistance to GOP family planning is designed to alleviate population pressure, which is recognized as a major obstacle to the achievement of general development goals and, most immediately, to nutrition goals.

P.L. 480 Title II

The principle AID activity in nutrition has been the P.L. 480 Title II Program, functioning since 1962. This program is currently conducting school feeding operations on a government to government basis and is coordinated through the joint efforts of MOH, MOE and ONAA (National Food Support Office) of Ministry of Agriculture

and Food. It is now reaching 500,000 students nationwide, providing a balanced supplemental daily diet. Food for Work, Maternal-Child Health and other child feeding programs, conducted by three private voluntary agencies (CRS-Caritas, SAWS-OFASA, and CWS-SEPAS) are currently reaching a total of 525,000 beneficiaries annually.

The Title II Program is meant to provide all beneficiaries with supportive nutrition as well as health education. At present, however, only a small percentage of the beneficiaries are receiving health education, because of lack of staff and budgetary resources in all of the participating agencies. Recently AID began providing assistance to the PVOs through OPG funding which will help resolve the lack of financial support and facilitate nutrition and health education.

A strong AID involvement in health and nutrition will complement the Title II effort and make it more effective. Improved health/nutrition/family planning programs on the part of the GOP will hasten the time when AID Title II inputs can be phased down and out.

5. Other Donors

The major international donor agency involved in the health sector is PAHO; Lima is its regional center and the site of the PAHO Center for Environmental Sanitation. While PAHO's assistance is not massive in terms of financial resources ($678,000 in 1978), the great number of projects (28), each with its accompanying long and short-term advisors, exerts a considerable impact upon the Ministry. The largest projects are concentrated primarily in the Southern Region each focusing on the development of health auxiliaries and the provision of basic services. Thus, AID's emphasis on low-cost rural care is being reinforced by PAHO within the MOH.

The Inter-American Development Bank (IDB) has concentrated its efforts on sewerage programs. In the fifteen year period from 1960 to 1975, loans totaling $14.2 million have been dispersed for rural water projects which involve communities of over 2000 inhabitants. The IDB is also participating in a parallel effort, providing urban water and sewerage systems. Three loans totaling $85.5 million have been channeled to this program.

The UN Fund for Population Activities (UNFPA) has a project in Maternal Child Health/Family Planning, for which PAHO will provide technical assistance. This program will provide $5.3 million in assistance over the next four years. The project has some of the same objectives as this one, namely to place strong emphasis on maternal child care and family planning as priority elements of a basic health program. However, there are several important distinctions

such as the UNFPA relation to the Directorate of MCH and Population while this project will work through the Directorate of Health Programs. The UNFPA project has some elements of decentralization but presently its primary focus is at the centralized Ministry of Health level for planning and implementation. This proposed project, while providing for some coordination and planning at the central level, is primarily focussed on the regional level for implementation.

The UNFPA project generally deals with activities from the Ministry level down to the health centers while the primary focus of the AID Project will be extend services beyond the health center into the community. While there are differences, it is clear there are sufficient similarities that care must be taken to assure these two projects will be complementary in their provision of assistance. This requires at least the type of informal coordination presently carried out in frequent discussion between Mission personnel, representatives of UNFPA and PAHO, and Ministry of Health officials. Further sharing of reports and joint planning will be necessary. The Project Agreement will include a condition precedent requiring further articulation by the MOH of how it plan to use these resources in a complementary fashion. However, there is enough difference in the planning/negotiation/implementing style of USAID and UNFPA/PAHO that the Mission does not believe it prudent to lock itself into a joint effort for which sucess or progress in one project is dependent upon the other. Rather the strategy has been to seek discrete actions that are complementary but not interdependent.

There is one World Bank (IBRD) financed water supply project, the goal of which is to extend water services to urban slums. The project totals $8,800,000 and is concentrated in Lima.

The Governments of West Germany, Holland and the U.S.S.R. have provided bilateral support for the health sector. The Government of Holland has been involved since 1962, primarily in the development of rural potable water systems. Other agencies such as Church World Service, and Catholic Relief Service-Caritas, have funded small projects related to food distribution and health care, and small community development projects. The World Food Program has been involved in food distribution through the local office of PAMI (Programa Alimentacion de Materno Infantil).

Table II-5 shows all on-going international donor programs in the health area.

B. Detailed Description

1. Project Goal/Purposes

This project contributes to achievement of the sector goal of improving the health and well-being of the rural and marginal urban population. The purpose is to strengthen and extend basic health services to rural and marginal urban population with emphasis on community participation including environmental sanitation and community education.

2. Project Elements

There are five project elements in the detailed program and financial plan: a) Rural Health Services, b) Community Education and Support for Sanitation Activities, c) Training and Supervision, d) Information System, Studies and Evaluation and e) Technical Assistance.

The Project is designed to provide financial assistance to the MOH in support of its efforts to extend primary health care to a portion of the population currently underserved. (See Annex L, MOH Primary Health Care Assistance Plan: Goals and Objectives). Primary care is defined by the MOH as the combination of actions taken by the community itself with the support of the formal health infrastructure in order to fulfill the basic health needs of the population.

This approach was selected to foster community self-help and self sufficiency, to utilize the experience of indigenous traditional health workers and to function within the severe economic constraint facing the GOP.

TABLE [illegible]

INTERNATIONAL [illegible] IN THE HEALTH SECTOR

FINANCIAL AGENCY	NAME OF PROJECT	PLACE	DURATION	TOTAL AMOUNT
UNFPA	Maternal-Child Health Population	PERU	4 years	$ 5'331,110
AID	Project for Maternal and Child Health and Population	SUR MEDIO REGION	3 years	1'800,000
HOLLAND	Extension of Health Services Program	ORDESO	2.1 2 years	521,500
UNDP	Dev. & Ext.Health Ser.Prog.	ORDELORETO	2 years	176,501
UNICEF	Development & Extension Health Service Program	ORDE PUNO	2 years	179,805
POPULATION COUNCIL	Project Support for Health Professionals in Maternal Health, Family Planning & Responsible Parenthood	ASPEFAM	2 years	100,000
POPULATION COUNCIL	Project Support for Informatica-Information System	INFORMATICA	2 years	27,000
WORLD FOOD PROGRAM	Food Assistance Program for Mothers and Infants	PERU	3 years	
A.I.D.	School Feeding Program (PAE)	PERU		
GENERAL FEDERAL REPUBLIC	Lupinos Project	INS(NATIONAL HEALTH INSTI-TUTIONS)		
GERMAN FEDERAL REPUBLIC	Applied Nutrition	ORDEPUNO		
DENMARK	Medical Care Extension	ORDE LORETO		
SWEDISH ASSOCIATION FOR DEVELOPMENT TRAINING	Survey on Family Partipa-tion in Multiple Problems	RSLM (Lima)		
SWISS EVANGELIC MISSION	Voluntary Services	ORDESO ORDEPUNO		
SWISS TECHNICAL COOPERATION	Extension of Medical Services	ORDEPUNO		
TERRE DES HOMES	Voluntary Services	ORDEPUNO		
AMAZONIC MEDICAL SOCIAL FOUNDATION	Yarinacocha Hospital	ORDEPUNO		
HOSPICE INTER-NATIONAL	Small Hospitals' Construction	R.S.C. MEDIO		
INTERNATIONAL FOSTER PLAN	Protection & Medical Care	R.S.C.CENTRO MEDIO		
INTERNATIONAL PHYSICIAN	Developme (Health Serv-ices in Central Huallaga	R.S.C. ORIENTAL		
EYE INTERNATIONAL FOUNDATION	Opatalmological Training	ORDESO		
UN FUNDS FOR DRUG ABUSE CONTROL	Epidemiology Studies on Drug Abuse	PERU		
PAHO	Special Health Projects Chagas disease, environ-mental health, vaccines, etc., more than 100 projects; technical assistance	PERU- Ongoing ±		$1,000,000

a. Rural Health Services

This Project element provides the basic health medicines, equipment and transportation for extension of preventive health services to an estimated 4,284,000 persons currently either unserved or underserved in rural areas. Through community agents promoters) and empirical midwives, the Project will offer preventive services, e.g., immunizations and prenatal, postpartum services, including responsible parenthood education and simple curative services, e.g., oral rehydration, parasite control treatment.

In addition, the health auxiliaries working in the health posts will offer supervision for community workers and preventive and simple curative services to those residents able to visit the health posts.

Norms have been established for the required services and evaluation of the project will be based upon completion of these objectives see input - output chart).

In addition referrals will be made to health posts for residents needing the services of the health auxiliary and from the health post to the health centers and hospitals when indicated.

1) Medicines

Medicines will be provided at the level of the health post for use by health auxiliaries, midwives and promoters. A medicine list, including criteria for estimating yearly quantities of medicines is found in Annex M. The total cost is estimated at $1,700,000.

2) Equipment

The equipment to be financed by the Project will reinforce the current capacity of the health posts and provide minimal equipment for the traditional midwives and health promoters so as to contribute to the extension of primary health care services to the community level.

Three levels are considered for equipment:

(a) Equipment for Sanitary Posts (See Annex J)

The purpose of the project is not to equip new centers but to complement existing ones. Complete equipment for 100 health posts will be financed each year 1979-80-81). However, equipment will be distributed in accordance with the Regional requirements since all health posts already have some equipment owned by the Ministry: Unit Costs US$2,600.

No. of Units 300
Cost for equipment per post $2,600
Total Yearly Cost (thousands) $780,000

(b) Equipment for Community Use

This equipment will be utilized to extend services to the community level through the midwives and promoters.

-Equipment for Midwives (See Annex J)

At the end of each training course, the following will be furnished:

	1979	1980	1981
Number of health supply kits/year	1500	1392	1284
Total cost	$135,000	$125,300	$95,200

-Equipment for Promoters (See Annex J)

At the end of each training course, the following will be furnished:

	1979	1980	1981
Number of health supplies kits/year	1500	1392	1284
Total cost	$225,000	$208,800	$192,600

(c) Equipment for Hospital Areas

Audio-visual equipment to be used during the training courses will be considered.

Number of sets	50
Unit cost	$1,000
Total cost	$50,000

The proposed equipment will be purchased from local and foreign sources, and will be utilized at centers and posts for continuing education for staff and health education in the community.

3) Transportation

An easy and inexpensive form of transportation will be provided. This will provide travel from the health posts to the community in order to facilitate community activities, vaccinations, etc. Two types of transportation are considered:

(a) Bicycles

Unit Cost US$155.00

	1979	1980	1981
No. of bicycles	375	348	318
Total cost	$58,125	$53,940	$49,290

Bicycles will be provided to the health post for use by the health auxiliary and/or promoter and/or midwife, whichever is required.

(b) Mules

Unit Cost US$270.00

No. of mules	186
Total cost	$50,220

Mules will provide transportation to and from the health post for the auxiliary, promoter and/or midwife to enable them to reach

rural communities where no other means of transportation can be used.

b. Community Education and Support for Sanitation Activities

This project element includes two community level components: community education and sanitation activities. Both are critical to improving the general health of the community by encouraging community activities to foster improved awareness of health conditions and community education and action to upgrade environmental and family health.

1) Community Education

This component includes two important educational objectives: one is to provide basic educational supplies and printed materials so that the community level personnel can work with the residents to design and/or print and distribute their own educational materials and a private sector subcontract (USAID) to update and expand the existing health and family planning education distribution system of films, slides, books, pamphlets and monographs for both the MOH and other Peruvian academic and service institutions. The subcontract will provide support for a private institution to purchase additional materials, update the inventory of materials, expand the list of institutional and individual participants and distribute educational materials throughout the country.

The content of the indigenous community level educational program includes health, nutrition, sanitation, and maternal child health and responsible parenthood. Regional and hospital level professionals will assist the health auxiliaries, promoters and midwives in the design and distribution of materials in coordination with community sponsored activities to promote health education.

The subcontract materials will include a variety of posters,pamphlets and small books for community personnel and health, nutrition and family planning films, slides, books and articles for professionals and para-professionals.

At this time, the Mission has a contract to improve the current inventory and distribution system including: a procedures manual, index system, inventory control, evaluation and utilization system. Under this project subcontract, the existing system will be transferred to a Peruvian institution for management.

Technical assistance will be provided under the project to assist in the design, content and utilization of all educational materials. Because of the similar nature of this project to many other country health projects already underway, we can utilize outside expertize in education and profit from the wealth of experience available from other countries, particularly in Latin America.

2) Environmental Sanitation

The Project will contribute some equipment and basic materials required to protect water sources, e.g. springs, provide latrines and make minimal housing improvements. This equipment will be provided at the hospital area level for rural communities and will be utilized by health auxiliaries and promoters under the supervision of the area environmental health technicians. The following equipment is considered: manual pumps, latrine molds and equipment, cement and other materials and tool kits. Miscellaneous materials to build wells and to install latrines is also considered. Included in this line item is an amount for transportation costs of the materials and per diem (food and lodging) for the environmental health technicians. This equipment will service the hospital areas:

Cost per area	US$10,000
Total cost	US$250,000

The area environmental health technicians are usually men, with secondary school education and certificates for training in environmental health. They are capable technicians and can effectively supervise auxiliaries in the use of the equipment. It is clearly evident that this project component is sufficient to cover only a small portion of the total need for environmental sanitation activities.

c. Training and Supervision

This element includes the training and supervision of personnel at every level of the health system in the basic objectives in health services and education which are included in the Project. The ultimate success of the Project depends upon the effectiveness of these two components in both the delineation of the specific curriculum content and the methodology employed to assure Project objectives are met. Often, projects of this type fail to achieve program objectives by attempting to resolve all health and development problems and failing to focus both the training and supervision on simple health interventions within the capability of

community para-professionals to implement.

1) Training

Utilizing the experience in course design by both PAHO and the Sur Medio Regional training team, the MOH will design the final model documents to be utilized in the training of staff at all levels. These include: a) MOH Central level training teams composed of doctors, nurse-midwives and nurses; b) Regional level personnel responsible for operational plans and implementation; and c) Area hospital level staff who will form the critical team of trainers for health auxiliaries, promoters and empirical midwives.

2) Curriculum

The primary focus in course content will be the information and skills required to implement the primary objectives: a) vaccinations; b) pre, postnatal and childbirth services, c) tuberculosis diagnosis and treatment; d) community education including family planning; e) nutrition education and f) improvements in environmental sanitation including water source protection and waste disposal.

Additional course content includes the collection of data for the information system, simple skills in community involvement in educational and health activities and referral instructions so as to assure that para-professionals limit their medical actions to simple health treatment and prevention.

3) Supervision

This component consists of the essential continuing education, monitoring of logistics supplies of equipment and medicine, face-to-face assistance in resolving community level work problems including health treatment and prevention skills, data collection, and community education activities. The supervisory levels are: a) Central level health professionals will supervise Regional planning and implementation; b) Regional level teams will supervise area hospital level staff in training, logistics and information; c) Area hospital staff will supervise the health centers and posts; d) health center staff will supervise the posts and the e) health post health auxiliaries will supervise community level promoters and midwives.

The continuing education program will be designed in conjunction with the training courses, thus assuring both the continuity and practicality of the two activities. Supervisors will be

required to identify functional areas where skills are lacking as a result of insufficient training, i.e., "refresher courses" to renew skills already acquired at a minimal level during previous training and new activities to be considered, e.g., revisions in referral procedures, modifications in data system, community education actions in health and family planning based upon community specific concerns and realities.

Health auxiliaries will be responsible for monitoring the utilization of medicines, maintenance of equipment, design and use of educational materials at the community level and replacement of indigenous personnel.

Financial support will be provided for training of health auxiliaries, promoters and traditional midwives.

Basic Training Courses:

These are provided for the traditional community resources (midwives and promoters) and the health post resources (health auxiliaries). The basic training courses do not include courses for replacements for midwives and promoters, but these are included in the refresher courses. Two types of training are considered in this group: basic training and refresher courses.

Basic Training Courses for Traditional Midwives:

The purpose of the basic training courses for traditional midwives is to provide information and training for traditional community personnel so as to improve prenatal and postpartum care, upgrade first aid skills and foster community education in family planning.

Place: Health Center nearest the midwives' place of origin.

Number of Participants per Course: 15

Number of Instructors per Course: 2 (Area Hospital nursemidwives and/or nurses)

Duration: 15 days

Budget:		
	Per Diem (food and lodging)	$ 800
	Transportation	100
	Supplies	100
	Cost for one course	$1,000

	1979 1/	1980 1/	1981 1/
Number of Courses per Year	100	93	85
Total Yearly Cost	$100,000	$93,000	$85,000

Basic Training Courses for Health Promoters

The purpose of the basic training courses for health promoters is to provide basic health skills to contribute to the control of communicable and infectious diseases, to administer first aid, and to offer health and family planning education.

Place: Health Center located nearest to the promoters' place of origi

Number of Participants per Course: 15

Number of Instructors per Course: 2 (Area Hospital nursemidwives and/or nurses).

Duration: 30 days

Budget:

Per Diem (food and lodging)	$1,600
Transportation	100
Supplies	100
Cost for one course	$1,800

	1979	1980	1981
Number of Courses per Year	100	93	85
Total Yearly Cost	$180,000	$167,400	$153,000

Basic Training Course on Integrated Maternal Child Health and Family Planning Education for Health Auxiliaries

The purpose of these courses is to train health auxiliaries in maternal child health and family planning education and provide continuing education in supervisory skills to assist community level personnel.

1/ Each year indicated refers to twelve months of project activities beginning upon completion of project conditions.

Place: Health Center located nearest to the health post.

Number of Participants: 20

Number of Instructors per Course: 2 (Area Hospital nursemidwives and/or nurses)

Duration: 10 days

Budget:		
	Per Diem (food and lodging)	$600
	Transportation	200
	Supplies	100
	Cost for one course	$900

	1979	1980	1981
Number of Courses per Year	19	17	15
Total Yearly Cost	$17,000	$15,300	$13,500

Refresher Courses for Midwives and Promoters

The purpose of these courses is to up-date the information provided to midwives and promoters during the training courses. Calculations for participants have been made based on the total number of trained midwives and promoters, without considering the percentage of retirees so as to utilize those funds in training new replacements for midwives and promoters.

Refresher Courses for Promoters

The purpose of these courses is to up-date the information provided during the training courses.

Place: Health Center nearest to the promoters' place of origin

Duration: 7 days

Number of Participants per Course: 15

Number of Instructors per Course: 2 (Area Hospital nursemidwives and/or nurses)

Budget:		
	Per Diem (food and lodging)	$375
	Transportation	100
	Supplies	50
	Total Cost per Course	$525

	1980	1981
Number of Courses per Year	100	193
Total Yearly Cost	$52,500	$101,000

Each year the refresher courses will be conducted for the promoters trained the prior year. The number of courses will increase each year as the number of trained promoters increases.

Refresher Courses for Midwives

The purpose of these courses is to up-date the information provided to the midwives during the training courses.

Place: Health center located nearest to the promoters' place of origin.

Duration: 7 days

Number of Participants per course: 15

Number of Instructors per course: 2 (same as above)

Budget:		
	Per Diem (food and lodging)	$375
	Transportation	100
	Supplies	50
	Total Cost per Course	$525

	1980	1981
Number of Courses per Year	100	193
Total Yearly Cost	$52,500	$101,000

The refresher courses will be conducted once a year for each midwive. Therefore, the number of courses will increase each year as the number of trained midwives increases.

Supervision, a critical factor in project success, includes costs for per diem (food and lodging) and transportation of supervisory personnel.

Supervision will be considered at five levels.

1. From Health Posts to Midwives and promoters with an annual frequency of approximately 12 supervisory visits for midwives and promoters.

Duration: 1 day

Cost per visit: $5.00

	1979	1980	1981
No. of midwives/promoters	1,500	2,892	4,284
No. of visits, No. of midwives/promoters by 6	9,000	17,352	25,704
Total Cost (No. of visits by 5)	$45,000	$86,760	$128,520

The number of visits is figured by six taking into consideration that midwives and promoters are trained progressively during the year and not simultaneously.

2. From Health Center to Health Post with a yearly frequency of twelve (12) supervisory visits per health post.

Duration: 1 day

No. of Persons: 2

Cost per Visit: US$10.

	1979	1980	1981
No. of health posts	375	723	1,041
No. of Visits (No. of health posts by 12)	3,000	8,676	12,492
Total Cost (No. of visits by 10)	$30,000	$86,760	120,492

* The first year is estimated on the basis of eight months since during the first months' equipment and medicines will be ordered and training initiated.

3. From Hospital to Health Center with yearly frequency of six (6) supervisory visits for each Health Center.

Duration: 1 day

No. of persons: 2

Cost per visit: US$20.00

	1979	1980	1981
No. of Health Centers	188	362	521
No. of Visits (No. of health centers by 6)	1,128	2,896	3,126
Total Cost (No. of visits by 20)	$22,560	$57,920	$62,530

4. From the Health Regions to Area Hospitals with a yearly frequency of four visits to each hospital area.

Duration: 2 days

Number of persons: 2

Cost per visit US$40.00

	1979	1980	1981
No. of Hospital Areas	50	50	50
No. of visits (No. of Areas by 4)	200	200	200
Total Cost (No. of Areas by 40)	$8,000	$8,000	$8,000

5. From the Central level to the Regions with a yearly frequency of two visits to each region.

Duration: 10 days

No. of persons: 1 person

Cost per visit: US$164.

	1979	1980	1981
Number of Regions	14	14	14
No. of visits (No. of regions by 2)	28	28	28
Total Cost (No. of visits by 164)	$4,592	$4,592	$4,592

d. Information System, Studies and Evaluation

1. Information System

This component of the project element includes financial support for the design, testing and implementation of a nationwide information system for primary health care. The information system, for the first time, will include a community level registration form to collect relevant and simple user data for project management and evaluation.

Forms have been developed (including detailed instructions) which have been officially designated as the preliminary documents to be used in the Project. They will be pre-tested in the Sur Medio Region. The information system will be used by community promoters, nurse-midwives, health auxiliaries and other health

professionals and paraprofessionals for both direct services and referrals to posts, centers and hospitals.

In addition, the project includes simple calculators for data collection, printing and publication of forms and reports on community level activities in the health sector, writing materials for data collection and courses, and data processing equipment including two computer terminals to be utilized at the regional level in one designated region and central level in Informatica - the Directorate of Information in the MOH. After careful study, a final decision will be made regarding future data equipment needs.

The Informatica System element will assure that utilization of the new forms will form a critical part of the training courses for the health post staff and community level personnel. The forms to be utilized will be as simple as possible in order to assure rapid and accurate collection, processing, retrieval and analysis. Technical assistance will be provided to assist in design, testing and implementation of the system.

2. Health Studies

The Health Studies include three components: a) a household survey for health, nutrition and contraceptive prevalence in order to establish a baseline for project evaluation; b) a logistics study to examine the existing medicine and equipment distribution, maintenance, inventory and control system and make recommendations for effective utilization of materials to be provided under the project; and c) a model program for a marginal urban area (Hospital Area No. 7 of the Lima Health Region) to test the relative cost effectiveness of service delivery in primary health in these populated underserved areas.

a) Household Survey

The baseline survey is designed to collect data in selected areas of the coast, mountain and jungle regions to assess health status. This information is critical for both project evaluation and regional program operational planning. Utilizing a model baseline survey questionnaire already developed for the Sur Medio Region, the MOH project planners, with technical assistance provided in the Project, will design, test and implement a similar modified baseline survey prior to Project implementation and again three years after initiation of Project activities.

The survey includes simple questions designed to assess and diagnose health status including: environmental sanitation, maternal and child health, contraceptive prevalence, nutritional status, attitudes of the community regarding health priorities and disease concepts and prevalence of tuberculosis and parasites. A project condition is included to assist in assuring that the baseline survey is initiated in a timely and effective manner.

b) Logistics Study

The logistics study will be utilized to initiate an indepth review and assessment of existing inventory, distribution, maintenance and control systems for basic medicines and equipment and make recommendations regarding effective logistics support for community distribution of commodities.

The study will be undertaken by a joint AID/MOH team composed of logistics experts who will collaborate in the assessment of all levels of commodities procurement and supply. The team will also make recommendations regarding the feasibility of various alternatives which might be effective in fortering community payment systems to assure medicines are available after project support terminates.

c) Integrated Primary Health in a Marginal-Urban Area

The extension of Integrated Primary Health must reach marginal-urban populations, in order to achieve the actual goal of providing health care to the poor. In order to compare and understand various strategies for serving these marginal urban areas an operations research project will be implemented in one marginal urban area so as to compare rural and urban delivery systems within the total project. Health promoters and traditional midwives will be selected by the community, trained to give elemental health assistance focusing especially on mothers and children and medicines and equipment provided to extend service delivery to the community. In order to assure the effectiveness of this Program, the referral system must be carefully developed, and supervision has to be reinforced at all levels. Health promoters and traditional midwives will execute very simple activities such as: vaccinations, first aid , T.B. control, prenatal and childbirth services, postpartum care for mothers and infants and community education in health and responsible parenthood.

The main areas of investigation will include: 1) cost effectiveness per user in marginal urban versus rural areas; 2) efficacy of utilization of empirical midwives and community agents in marginal urban areas, particularly "pueblos jovenes", 3) redirection of costly hospital based, service delivery to community focused primary care utilizing paraprofessionals, 4) receptivity of this target population to community education, especially in responsible parenthood, and 5) investigation of various interventions designed to reduce maternal morbi-mortality due to illegal abortion, and high risk pregnancy within the urban area health system.

e. Technical Assistance

The service of technical experts will be provided to assist in project design and implementation. These include:

- fiscal management	- 3 months
- logistics and commodities' management	- 2 months
- health and family planning training and supervision	- 5 months
- evaluation and studies	- 6 months
- nutrition planning	-12 months
	28 months

Total - 28 months at $7,000

Per month $196,000

Additional support in this component includes $14,000 for seminars for regional health directors and their designated representatives to coordinate project operational planning.

Total - $210,000

3. Project Input-Output Chart (3 years)

Inputs		Outputs	
DOSE anti-polio vaccine...	1,532.6	Vaccinated Infants	408.7
" DPT vaccine	1,532.6	Vaccinated 10-year old children wit' TBC reinforcement	305.9
" anti-measles vaccine.	510.9	Prenatal Services for Pregnant Women	192.2
" BCG vaccine	893.2	Childbirth Services	124.9
Medicines		Postpartum Women receiving services	124.9
Number of Training and refresher courses for midwives and promoters....	571	Infants receiving services	163.5
Training courses for health auxiliaries	52	Services for Pre-School Children	391.7
Equipment		Treatments for Tubercubsis	43.4
Midwife	4,284	First aid to Patients	4,338.0
Promoter	4,284	Trained and equipped midwives	4,284
Health Post	300	Trained and equipped promoters	4,284
Audio-visual sets for areas	50	Trained health auxiliaries	1,041
Supervisory Visits - 12 per level		Complete and Reinforced Health Posts	1,041
Equipment and materials for environmental sanitation	25	Areas with complementary audio-visual equipment ...	50
		Supervised midwives	4,284
		Supervised promoters	4,284
		Health Posts-Supervised ..	1,041
		Health Centers-Supervised	520
		Hospital Areas - Supervised	50
		Hospital Regions - Supervised	14
		Protected Wells	1,800
		Installed Latrines	3,600
		Improved Housing	1,800

PART III. PROJECT ANALYSIS

A. Technical Analysis

Severe economic crisis and rapidly expanding population have both contributed to the serious health and nutrition conditions prevalent in Peru. The already inadquate infrastructure of services is further undermined as an increased number of persons require services of both a curative and preventive nature, while GOP resources for health have decreased relative to the increasing demand and high rates of inflation. Chart III-1 graphically portrays Peru's population pyramid, both urban and rural, and demonstrates the large proportion of young adults and children.

Clearly, the strategy for any health project in Peru must consider the following factors, if it is to impact upon health status:

1. The cost for services must be minimal, yet effective in reducing major health problems. Since there is little expectation of a major shift in GOP resources for health, the project must be of low cost and high yield in order to be considered for replication at the national level.

2. Maternal and Child Health including Family Planning information must be considered as priorities since population growth and infant mortality are two of the major health problems of the country.

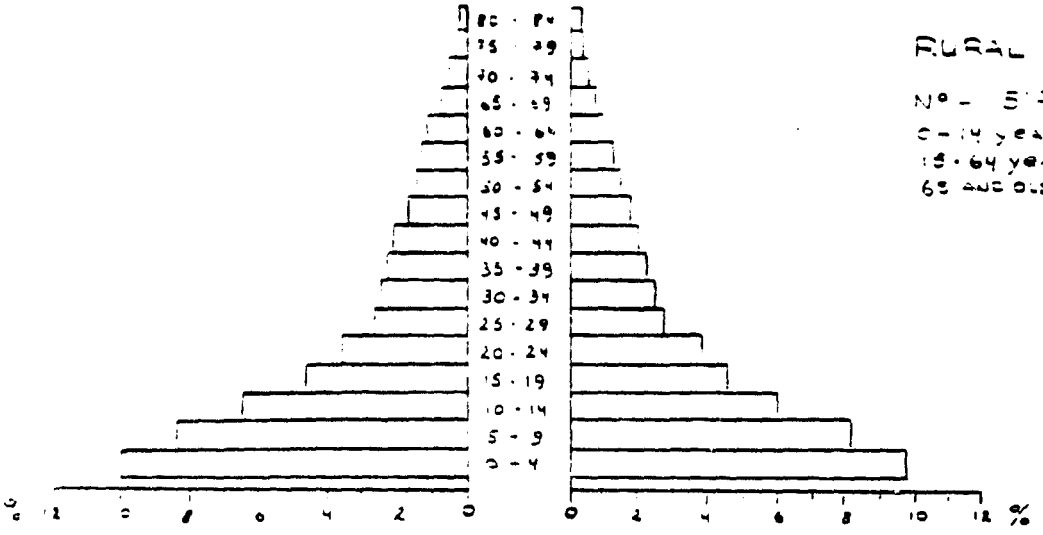
3. Paraprofessional service delivery must be the mainstay of any health program designed for rural areas in Peru. The critical shortages of professional health personnel and their lack of availability especially in rural areas, requires a health strategy focused upon primary care and extension of the existing health service into the community via health auxiliaries and indigenous community agents. This approach is in keeping with the MOH stated policy priority.

4. Preventive services must be given priority since cost and effectiveness of preventive rather than curative services provides the only rational approach given high demand and scarce resources. Environmental health is a vital component of such an approach.

5. Major emphasis must be placed on training, supervision and continuing education of new and existing personnel especially paraprofessionals. This training must include not only health program content, e.g., family planning information, oral rehydration, health education, but also management and administrative skills to maximize program success.

CHART [illegible]

POPULATION OF PERU - 1979



RURAL POPULATION

Nº - 5'362.8

0 - 14 years — [illegible] %

15 - 64 years — [illegible] %

65 and older — 3.9 %

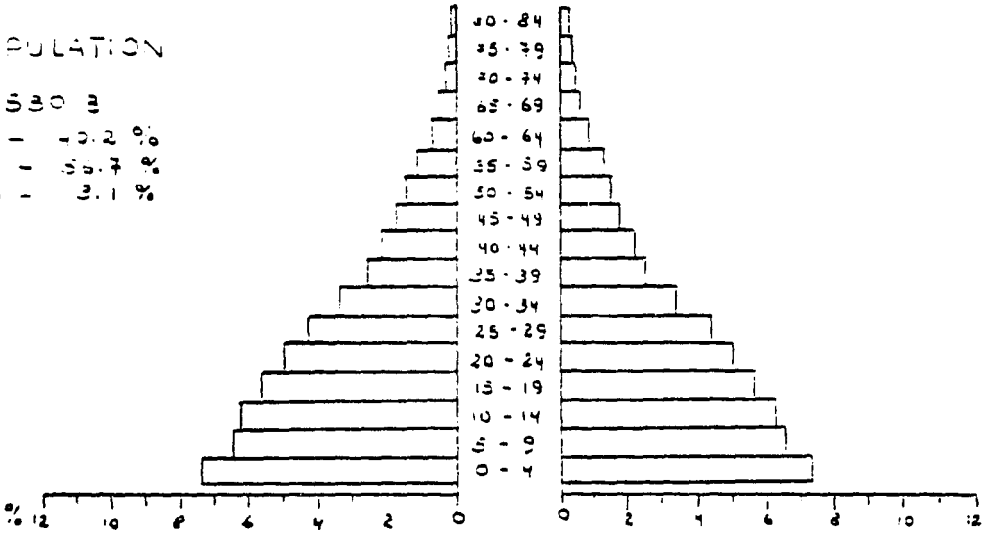
URBAN POPULATION

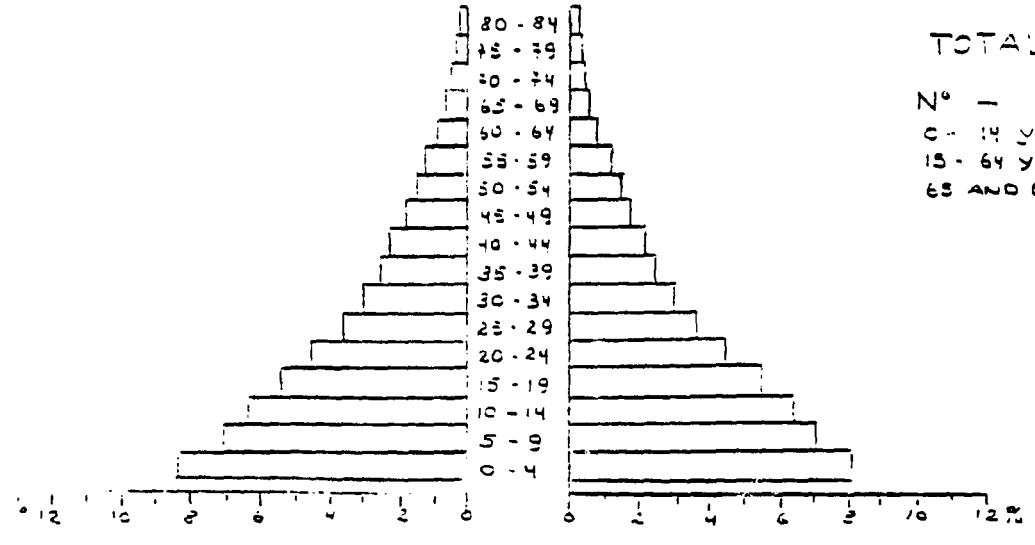
Nº — 11'530.3

0 - 14 years — 40.2 %

15 - 64 years — 56.7 %

65 and older — 3.1 %





TOTAL POPULATION

Nº — 17'293.1

0 - 14 years - 43.3 %

15 - 64 years - 53.3 %

65 and older 3.4 %

6. Data collection and improved data management must be included to facilitate project evaluation, measure impact of the MOH health services upon health status and provide management with the information feedback to modify and improve program performance.

It is for all of these reasons that the strategy for the Project includes the implementation of a primary care health delivery system focused upon preventive services, with special attention to mothers and children and utilizes a major portion of the funds for training, supervision, evaluation and data collection. In addition, the Project will strengthen and reinforce national level information collection, analysis and planning and management capabilities of the MOH central, regional and local staff. Finally, the Project provides for the implementation of fiscal, programmatic and diagnostic studies to assist the GOP in the development of future health programs.

B. Financial Plan

1. Total Project Financial Requirements

The total financial investment envisioned by the proposed AID Loan and Grant and the GOP contribution is equivalent to $9,550,000 as follows:

	US Dollars	Local Currency	Total
AID Loan and Grant	3,980,000	3,170,000	$7,150,000
GOP		2,400,000	2,400,000
		TOTAL$	9,550.000

Loan funds will be utilized for: medicine, medical equipment, environmental sanitation, transportation for community level personnel (mules and bicycles), training equipment and inflation and contingencies. Grant funds will support: community education, supervision travel and per diem, technical assistance, training seminars, materials and per diem, evaluation and studies, including baseline survey and a small portion of inflation costs, if required.

2. Host Country Financial Capability

The GOP contribution, amounting to approximately $2,400,000; during the life of the Project, is primarily in the form of MOH contributions in the following areas: 1) Rural Health Services - $1,060,000; 2) Community Education and Support to Sanitation Activities - $ 300,000; 3) Training and Supervision - $ 800,000; 4) Information System, Evaluation and Research - $240,000; Inflation and Contingencies have been factored into the various investment categories (see financial table).

C. Administrative Feasibility

1. Structure and Organization of the MOH

TABLE

PROJECT FINANCIAL PLAN - SOURCE AND APPLICATION OF FUNDS
(In thousands of U.S. Dollars)

Investment Category[1]	A. I. D. Total (1)	A. I. D. Loan	A. I. D. Grant	GOP Total (2)	Grand Total (1)+(2)
I. Rural Health Services					
1. Medicines	1,600	1,600	-	200	1,800
2. Medical Equipment	1,800	1,800	-	760	2,560
3. Transportation	220	220	-	100	320
II. Community Education & Support to Sanitation Activities					
1. Community Education	410	210	200	170	580
2. Sanitation Activities	240	90	150	130	370
III. Training and Supervision					
1. Training	1,150	830	320	400	1,550
2. Supervision	720	720	-	400	1,120
IV. Technical Assistance	210	-	210	-	210
V. Information System, Evaluation and Research					
1. Information	130	130	-	140	270
2. Evaluation & Research	670	200	470	100	770
Total	7,150	5,800	1,350	2,400	9,550
	75%			25%	100%

1/ The contingency and inflation have been factored into the various investment categories.

TABLE II

PROJECT FINANCIAL PLAN - REQUIREMENT OF FOREIGN EXCHANGE AND LOCAL CURRENCY
(In thousands of U.S. Dollars)

Investment Category 1/	A. I. D. Total FX + LC (1)	A. I. D. FX	A. I. D. LC	GOP Total LC (2)	Grand Total (1)+(2)
I. Rural Health Services					
1. Medicines	1,600	1,600	-	200	1,800
2. Medical Equipment	1,800	1,800	-	760	2,560
3. Transportation	220	170	50	100	320
II. Community Education & Support to Sanitation Activity					
1. Community Education	410	150	260	170	580
2. Sanitation Activities	240	-	240	130	370
III. Training and Supervision					
1. Training	1,150	-	1,150	400	1,550
2. Supervision	720	-	720	400	1,120
IV. Technical Assistance	210	180	30	-	210
V. Information System, Evaluation & Research					
1. Information	130	80	50	140	270
2. Evaluation & Research	670	-	670	100	770
	7,150	3,980	3,170	2,400	9,550

1/ The contigency and inflation have been factored into the various investment categories.

TABLE III

GOVERNMENT OF PERU - COUNTERPART
(In thousands of U.S. Dollars)

INVESTMENT CATEGORIES*	
I. RURAL HEALTH SERVICES	
1. Medicines	200.0
2. Medical Equipment	760.0
2.1 Health Post Equipment	
-Office Materials and Equipment	100.0
-Medical Equipment	560.0
2.2 Audio-Visual Equipment	100.0
3. Transportation	100.0
-Chauffer Salaries	70.0
-Gasoline and Lubricants	20.0
-Parts and Repairs	10.0
II. COMMUNITY EDUCATION AND SUPPORT TO SANITATION ACTIVITIES	
1. Salaries	210.0
-Sanitation Inspector Salaries	80.0
-Health Educator Salaries	130.0
2. Goods and Services	90.0
-Tools and Sanitation Materials	50.0
-Office Materials	40.0
III. TRAINING AND SUPERVISION	
1. Training	400.0
-Salaries (Instructors, Health auxiliaries)	350.0
-Goods and Services	50.0
2. Supervision	400.0
-Salaries	400.0
IV. TECHNICAL ASSISTANCE	
V. INFORMATION SYSTEM, EVALUATION AND RESEARCH	
1. Information	140.0
-Salaries	70.0
-Office Equipment	50.0
-Office Materials	20.0
2. Evaluation and Research	100.0
-Salaries	100.0
TOTAL	2,400.0

* The contingency and inflation have been factored into the various investment categories.

The MOH is composed of central (i.e.Lima) level management support, advisory and lineal or executive organizations.

The Central level administration designs the health policies and is composed of the offices of the Minister and Director Superior who received advice and counsel from the General Inspector of Health, the Executive Advisory Board and the Advisory Committee of the MOH (CCAMSA) as well as from the Public Relations and Information Office. The National Council of Health is a consulting organization of the Ministery of Health and is composed of delegates from the MOH, Social Security of Peru, Sanitary Division of the Armed Forces and Department of Interior, Private Sector, Universities, Confederation of University Professional Institutions and the Medical Association of Peru.

Central level technical offices coordinate the development of health programs and activities. These are the General Offices of Health Programs, Maternal Child Health and Population and Special Health Programs. Health Regions are decentralized operational entities responsible for developing and implementing health programs in their respective geographical regions.

Regional officesare comprised of a Regional Director and Sub-Director with advisory and support units among which are Programming, Information, and Integral Medical Attention.

The Regions are further subdivided into hospital zones which constitute the core of programming and the institutions directly responsible for the execution and compliance of the health programs within their target area. Each hospital zone has four levels of services, each level having its own type offacility to provide health services to the community. These levels are: health posts, health centers, general hospitals and the regional hospital base of the hospital zone.

Resources available

The lack of resources at all levels affects the health service system, especially at the Regional level. The few resources which are available are concentrated in the large urban areas further diminishing the quality of services offered to the rural poor.

Technical staff comprise four percent of the total health manpower available within the MOH. The core personnel is mainly paraprofessional and auxiliary level employees. In 1979 there were 1,687 inhabitants per medical doctor in Peru, however, most physicians are concentrated in Lima. Regional resources are even further restricted For example, in one of the most important regions outside of Lima, the Centro Medio Region, in 1976, the rates of medical personnel in

relation to the population were: 0.62 doctors, 0.16 dentist, 0.76 nurses, and 0.19 midwives per each ten thousand inhabitants respectively.

2. Project Administration

The project will be coordinated from the Office of the Director General of Program in the MCH. The major project components of rural health services, community education and sanitation activities, training and supervision will be implemented under the direction of the Health Region with coordination by the Central Level of the MCH.

The information system will be designed with technical assistance and implemented by the Regions. Training in data collection and use of the integrated system of registration forms will be coordinated by Informática ,MCH.

The baseline study which is a household survey in health, nutrition and contraceptive usage will be coordinated by the Office of Program in collaboration with the universities selected to undertake the survey. Trial questionaries will be tested and then instituted at the community level so as to obtain national and regional level data of statistical significance. The other studies will be coordinated by the Office of Program and implemented with the approval of the Central level by the Regional Office involved.

Technical assistance will be provided by short term and resident advisors in cooperation with the Family Health Office. Short term assistance will be utilized for activities at the Central and Regional levels. Technical assistance will also be provided by a Peruvian national health expert in planning, research and public health under contract with USAID.

At the Regional level project administration will be formally instituted in a pyramid structure of health service delivery and referral. In brief, the project will extend service coverage from the present infrastructure of Health Region, Area Hospital, health clinic and health post to the newly instituted community level system of indigenous community health workers in the"base health unit" in the rural communities designated.

Chart III-4 outlines the structure for administration within the health region.

CHART III- 4

THE HEALTH REGION SERVICE SYSTEM

LEVEL III -	Regional Hospital	- Diagnosis and Integral Assistance - Hospitalization - Especialization Services - Auxiliary Services - Preventive - Promotional
	General Hospital	- Diagnosis and Integral Assistance - Hospitalization - Auxiliary Services - All those services related to the Health Center - Preventive - Promotional
LEVEL II -	Health Center	- Diagnosis and Treatment - All those services related to the Health Center - Nutrition - Treatment - Medical examination and notification
	Health Post	- Preventive and Promotional - Medical examination and notification - Mother, Child, Adult services - Medical examination - Sample Collection

Sanitary Education
Community Work
First Aid
Case Detection
Follow-Up Treatment
Case Reports

Primary Health Post
Promotor, Empirical Midwife

Community
Committee

D. Economic Analysis

1. Benefits

Health care is a basic human need, Good health is desired by all, and is one of the fruits of development. Experiences in developing countries has shown that the relationship between economic development and increased health is highly variable. Some countries have improved their health status despite limited economic development. Others have shown only limited improvements in health status despite rapid overall economic growth. A substantial body of evidence has been compiled which indicates that specific measures to improve health care for the vast majority of a population can have a major development impact. 1/However, the lack of good baseline data on morbidity, mortality, and productivity in rural areas precludes detailed calculations of the benefits from improved health that can be expected from this Project. In addition, the relationship between several Project elements (such as house visits by community health agents) and improvement in health status of the beneficiary population is by no means direct.

Thus, it is difficult to predict in advance the amount of suffering that will be avoided from improved health status, or the increased person years of work that will become available as a result of this Project. Even if this could be done, conceptual difficulties in putting a dollar value on suffering preclude calculation of benefits that could be compared with costs. In turn, the economic benefits from an increased supply of healthy labor will depend on the macroeconomic development of areas.

In spite of the difficulties in estimating the benefits to accrue from this Project, the nature and some indication of the magnitude of benefits expected can be given for illustrative disease conditions:

a. Tuberculosis: Vaccination with BCG and treatment of active cases by auxiliary nurses under instructions from health centers should greatly reduce the current level of active cases (See outputs-inputs chart).

b. Tetanus: Vaccination against tetanus of potential mothers, and innoculation of children with DPT, may reduce this frequent cause of death in new-borns to near zero levels.

c. Gastro-enteritis (diarrheas): These are major killers of the very young, and cause much lost time among workers. These illnesses are easily controlled with simple medication. It will also be interesting to note the relationship between reduced gastro-intestinal illness and improved nutritional status, particularly in young children.

1/ See comparative data on per capita income, infant mortality and life expentancy for all developing countries published by the Overseas Development Council in The U.S. World Development Agenda 1977.

d. Intestinal parasites: These are common at all ages, killing the young, sapping the energy of workers, and worsening malnutrition among people of all ages. Reduced incidence of intestinal parasites should be equivalent to a larger supply of food (perhaps several million dollars worth of grain) for people who previously could not absorb all the calories they were eating.

The nature of benefits expected from the Project is, of course, well defined: among other things, decreased morbidity and mortality for infants, mothers and the rural population as a whole (leading to decreasing crude death rate and increasing life expectancy), better nutrition habits, increased nutrient absorptive capacity and decreasing crude birth rates. Our ability to quantify changes in these indicators will depend in large measure on the availability of nation-wide rural health baseline data. Such data will be gathered and analyzed with assistance provided under this project. Pending such data, it is not feasible to quantify the specific benefits.

2. Financial Replicability

Tables III-5, III-6, and III-7 provide the economic documentation for estimates of GOP recurring costs (medicine, equipment, etc.) for project continuation after completion of AID disbursements at an estimated annual cost of $1,330,000. A covenant has been included in the Project agreement which requires the GOP to continue budgetary support for the Project upon completion of AID financed investments. A financial analysis will be undertaken as part of the project studies (AID/W funding) to assist the GOP in analyzing its health sector costs and the relative benefits of various approaches to health sector financing.

The GOP should have no difficulties in absorbing the additional costs following the completion of Project activities. $1.3 million per year represents approximately 1.2% of the MOH budget for the year 1979 (approximately $102.7 million). In addition, the GOP's financial contribution to the Project has been phased so that in year three of activities, the MOH will be financing some $1.2 million, nearly the amount which will be required in year four when A.I.D. assistance will end.

E. Social Analysis

1. The Problems

The social consequences of Peru's ill-defined general health policy, combined with inadequate and sporadic geographic coverage, have led to a generally deteriorating quality of life in recent years. The demographic explosion (current population growth rate is estimated at 2.9% annually) has not been paralleled by an expansion of the GOP's ability to deliver health, population, and nutrition services, especially in areas outside the Lima-Callao metropolitan area. As a result, the target population to be addressed under the present Project has the

TABLE III-5

Total Budget AID and GOP Contributions (per year)
(in thousands of U.S. Dollars)

Investment Category	Project AID/GOP Total (1+2+3)	Year 1 (1)	Year 2 (2)	Year 3 (3)	Year 4* (GOP only)
I. Rural Health Services					
1. Medicines	1800	560	600	640	100
2. Medical equipment	2560	1310	470	780	560
3. Transportation	320	130	90	100	50
	4680	2000	1160	1520	710
II. Community Education and Support to Sanitation Activities					
1. Community education	580	450	60	70	70
2. Sanitation activities	370	270	40	60	60
	950	720	100	130	130
III. Training and Supervision					
1. Training	1550	360	530	660	200
2. Supervision	1120	220	390	510	200
	2670	580	920	1170	400
IV. Technical Assistance	210	100	60	50	—
V. Information System Studies and Evaluation					
1. Information	270	160	50	60	60
2. Evaluation and studies	770	710	30	30	30
	1040	870	80	90	90
	9550	4270	2320	2960	1'330

* Maintenance beyond Life of Project

TABLE III-8

Total Budget - AID Contribution (per year)
(in thousands of U.S. Dollars)

Investment Category	Total 1+2+3	Year 1 (1)	Year 2 (2)	Year 3 (3)
I. Rural Health Services				
1. Medicines	1600	500	530	570
2. Medical equipment	1800	1200	330	270
3. Transportation	220	110	60	50
	3620	1810	920	890
II. Community Education and Support to Sanitation Activities				
1. Community education	410	410	—	—
2. Sanitation activities	240	240	—	—
	650	650	—	—
III. Training and Supervision				
1. Training	1150	300	390	460
2. Supervision	720	120	250	350
	1870	420	640	810
IV. Technical Assistance	210	100	60	50
V. Information System Studies and Evaluation				
1. Information	130	130	—	—
	670	670	—	—
	800	800	—	—
	7150	3780	1'620	1750

TABLE III-7

Total Budget - GOP Contribution (per year)
(in thousands of U.S. Dollars)

Investment Category	Project Total (1+2+3)	Year 1 (1)	Year 2 (2)	Year 3 (3)	Year 4*
I. Rural Health Services					
1. Medicines	200	60	70	70	100
2. Medical equipment	760	110	140	510	560
3. Transportation	100	20	30	50	50
	1060	190	240	630	710
II. Community Education and Support to Sanitation Activities					
1. Community education	170	40	60	70	70
2. Sanitation activities	130	30	40	60	60
	300	70	100	130	130
III. Training and Supervision					
1. Training	400	60	140	200	200
2. Supervision	400	100	140	160	200
	800	160	280	360	400
IV. Technical Assistance					
V. Information System Studies and Evaluation					
1. Information	140	30	50	60	60
2. Studies and evaluation	100	40	30	30	30
	240	70	80	90	90
	2400	490	700	1210	1'330

Maintenance beyond Life of Project

following characteristics:

- High incidence of disease, occasioned by both inadequate preventive medicine as well as a shortage of trained personnel in fields of curative medicine;

- Increasingly lowered nutritional levels, especially among children under the age of five;

- Generally low levels of knowledge concerning even the most basic of health and hygienic procedures; and

- Inadequate access to basic health services, as well as insufficient infrastructure such as potable water, sewerage, etc.

The baseline data to be collected during the life of the Project will assist the Mission in identifying specific remedial action which the GOP and international donor community can undertake. In the absence of quantifiable data at the present time, however, it is not possible to give a clear indication of all the social benefits.

2. Socio-Economic Profile of Beneficiaries

a. Identification of Beneficiaries

The primary beneficiaries of the Project will be aproximately 4,000,000 rural inhabitants, who will receive the benefits of increased access to medically trained personnel, information on ways and means to protect their health, and improved preventive and curative services.

Women (pregnant or of child bearing age) and children will receive the most direct benefits of the Project through immunization, family planning information and maternal-child health care. Benefits to the rural poor at large also will occur through access to referral and treatment services and instruction in nutrition and environmental sanitation.

Secondary beneficiaries will be health agents and other personnel delivering health services. The health agents (whose background most nearly approximately those of their rural clients)will receive one month of training in maternal-child health care,nutrition, family planning, environmental sanitation, diagnosis, primary health care and community development.Whether they continue working as health agents or not, the information will be beneficial to them for improving the health quality of their own lives.

b. Social Organization

The community agents and empirical midwives will work in their particular community within the existing community organization. Many of the communities which are most accessible to the health centers already have existing committees formed for health, sanitation and/or community development, e.g.,the Ayni, local community social organization of leadership and community decision making. Others, the majority,will development new organizations for health service, education and environmental sanitation working with local leaders, mothers clubs, agricultural groups and school committees.

The training for both auxiliaries and community agents will include basic skills in identification of community needs,working with existing groups and formation of census maps and information collection regarding family composition and simple medical history. Health auxiliaries will supervise and assist in faciliting joint community actions in health education, promotion of health services and environmental sanitation.

c. High Risk Families

Although familial ties are relatively stable in these rural areas, emphasis will be placed upon identifying families of high risk

in relation to health and social problems. Community agents will work with pregnant mothers in special programs in care and feeding of infants and children, improvement of hygienic conditions and water supplies, family planning and other preventive health services.

d. Socio-Economic Benefit

Improved health is likely to have a beneficial impact on farm labor both of the women and men. Efforts will be made to assist women in their marketing activities through the formation of shared child care services during extended visits away from the community.

e. Quality of Life Indicators

Education, housing and environmental sanitation are poor and seriously affect the health of the community. Basic health education will be stressed not only in the training of the community level participants, but also in formal and nonformal community actions It is anticipated that the project will markedly improve community awareness of preventive health measures, particularly as they relate to maternal and child health.

3. Traditional Medical System

The traditional medical system is outside the current infrastructure of formal health services of the MOH. The two critical healers in the community are the "curandero " or herbal doctor and the empirical midwive. The first utilizes many effective traditional herbal preparation for a variety of illnesses, diseases, and accidents, e.g., compresses, salves, herbal teas and baths. Through ignorance, the traditional healer often delays health actions by the auxiliary or doctor which might help the sick individual and effect a cure. Moreover, many of the preparations are worthless or actually harmful (See " Donde No Hay Doctor "), David Werner, Pax-Mexico).

The empirical midwife delivers most of the babies in rural communities. She is usually an experienced older woman, herself a mother of a large family and has received training in childbirth problems through an empirical process as an assistant to a former midwive. Normal deliveries cause few problems even in situations of poor sanitation and lack of sterilized equipment. However, effective technique in complicated births, preventive prenatal control, and postpartum services are rarely provided since the empirical midwife has little or no formal training and little equipment or medicine to assist the mother or child.

Depending upon the source of the illness, traditional "priests" and faith healers are utilized by the community as a means to exercise the root causes of illness perceived as supernaturally inspired. Thus, mental illness and psychological distress are often successfully "treated" through the power of suggestion and sympathic support from community leaders in spiritual concerns. However, severe physical illness is often confused with spiritual malaise thus thwarting effective immediate treatment of disease by the formal health system.

4. Suggested Approaches to Project Implementation

Selection and Training of Personnel.

The rural population's perception of modern health practitioners is likely to depend on the quality and dependability of service, and on the ability of the modern practitioner to adopt the rural manner of delivering health service. Health practitioners trained in modern concepts--especially doctors--may frighten rural clients away. Reports are that rural doctors advise medical treatment only and do not provide the sympathetic feedback and psycho-therapeutic consultation which is the key to the traditional practitioner's appeal. Auxiliaries in public dispensaries also are reported to be unsympathetic and often denigrating.

Since most healers or midwives are adults respected for their knowledge and their success in healing or treating, a similar respect must be obtained at the outset for health agents. The selection criteria that agents be adults and highly motivated to promote and to heal (with previous experience in community development if possible) should assure greater success. Moreover, since teaching and treating are highly personalized, careful evaluation of inter-personal communication skills will be made of health agent and auxiliary candidates prior to selection.

The question whether female or male health agents will be more accepted by rural clients is not resolved. Each has different skills, and in the traditional system provides different kinds of services. Preliminary experience indicates that the females tend to stress maternal/child care and family planning, environmental sanitation and potable water. Males tend to be concerned about environmental sanitation, also family planning and treatment of illnesses. Females seem to view their employment more as a full time job.

Whether the candidate is male or female may not be important to delivery of health services. Success will depend mostly on whether agents are properly motivated, skilled in interpersonal relations;

and able to learn both abstract and concrete aspects of basic treatment and preventive measures. Selection of candidates may, in fact, be the most important variable affecting success of the Project. Nonetheless, health agent activities should be monitored over time to determine whether male/female roles have a long-term impact on effectiveness of services delivery.

5. Traditional Beliefs and Disease Etiology

There are potential cultural conflicts and constraints to adoption of modern health beliefs and practices by rural people. Traditional belief views life as a state of delicate equilibrium between forces of nature, fellow humans, and the spirits. For example, the auxiliaries, community agents and midwives may prove a source of conflict for the community if they: (1) do not provide service acceptable to referred clients; (2) perceive themselves as purveyors of modern health care only; (3) view health agents and traditional practitioners as inferiors; or (4) do not perform their own diagnostic, treatment and supervisory duties competently. A lot will depend on the quality of auxiliary training (as well as selecting persons who are apt to be receptive) and on the supervisory support auxiliaries themselves receive.

Acceptance of modern medicine will, in part, depend on the traditional definition of disease etiology, rather than the correct biological definition in the modern belief system, On the other hand, modern practitioners have " oversold " their product. For example, there is widespread belief that one injection can provide immediate cure.

To minimize such potential contraints to effective delivery of services, field health personnel will need to be thoroughly sensitized to traditional beliefs in their areas of assignment. Trainers should present these beliefs objectively, and draw parallels to the scientific explanation of the same phenomena. Client stress levels can be reduced (and acceptance of services increased) if health agents and auxiliaries provide praise for consumption of modern medicines, use of dispensaries, and practice of preventive measures, rather than berate clients for use of traditional healers and slowness in seeking modern assistance. In short, health personnel will be most effective if they allow their rural clients to receive social support from both the traditional and modern systems with a minimum of negative sanctions.

6. Benefit Incidence/Spread Effect

Since the Project aims to delivery of health sevices to approximately 4'000,000 rural inhabitants, benefit incidence

and spread effects should be looked at qualitatively, as well as quantitatively. In addition to helping to bring about improved nutrition, environmental sanitation, personal hygiene, maternal and child health in the rural areas, the Project may have some additional effect on family patterns, since recent research has indicated that women want to limit their family size. (See World Fertility Survey, Peru 1979). There is ample proof from other countries that, should family planning methods be adopted, the spacing and limitation of offspring can result in improved life-style and increased opportunities for the fewer children who are born.

Spread effects may be attained through formal and informal channels of communication. The existence, activities and " successes") of the health agents may be publicized through community meetings, PVO and other personnel working in the area and health programs on the radio. Word-of-mouth communication may be used consciously and extensively to promote the program. In rural areas, an individual's health problem is a public matter. News is quickly transmitted to neighbors and acquaintances. Good health service by a n agent will be promptly recognized and discussed extensively. Hence, the health agent must be given careful guidance and supervision-- especially in the early months of the program---to assure the transmission of a positive image.

7. Participation of and Impact on Women

At least one-half of the rural persons potentially affected by the project will be females.

The overwhelming majority of these women will be from peasant backgrounds. The Project will provide them an avenue for better health, as well as possible entrance into salaried employment as auxiliaries. Improvement in women's health should facilitate their responsiveness to community development activities and ability to engage in economic activities. Ideally, the project will help women raise their status as productive contributors to rural life by inducing receptivity to early treatment of illnesses through modern care (for themselves and others), and an attitudinal change toward healing from one of functional healing of illness to one of combined preventive and functional care. From these activities, women will contribute to development in rural areas by reinforcing the health of their children and improving the productive capacity of the labor supply.

IV. IMPLEMENTATION PLANNING

A. Administrative Arrangements

1. Implementing Agency

The principal implementing agency responsible for the overall Project will be the MOH, Office of Director General for Program. Implementation of the health services component will be the responsibility of the Director of each of the Health Regions. Implementation of the information system will also be the Health Regions with the cooperation and support of the Information Office, MOH.

The Office of the Director General of Programs of the MOH will coordinate all central level activities in cooperation with the Office of Coordination of International Programs, Information, Planning and Maternal Child Health and Population. These include: a baseline household distribution survey in health, nutrition and population to be contracted under existing collaborative efforts between the MOH, the Health Regions and the universities, and a Cost Analysis Study (AID/W funding) to determine comparative health costs and financing of primary care and other environmental and preventive health services in the MOH.

The Health Regions will be responsible for the execution of the project service components, training in cooperation with the central level MOH Directorates, information system in cooperation with Informatica, MOH and environmental sanitation and community education in cooperation with the community level organizations of health and development. Table IV-1 outlines the infrastructure for administration within the health region.

Under the Project, each of the Health Regions will submit to the MOH a time-phased Plan of Operations; once initial conditions precedent have been met, Project funded technical assistance may be used to assist the regions in the preparation of their individual Plans. These will then be reviewed by USAID, in conjunction with the MOH, and once a Regional Plan is approved by both of these entities, Project operations will begin in that region. Regional Plans of Operation will include the following:

- -- proposed activities by month;
- -- detailed financial plan, showing projected expenditures;
- -- plan for supervision of Project activities; and
- -- actual staffing patterns at both the regional and community levels, with projected requirements.

TABLE IV-1

HEALTH INFRASTRUCTURE - February 1979

Administrative Scope	Place	Territorial Responsibility	Areas	Hosp.	H.C.	S.P.
ORDE-NORTE	Piura	Tumbes and Piura Departments	Piura	2	15	42
			Sullana	1	9	35
			Tumbes	1	5	9
			TOTAL	4	29	86
ORDE-NOR CENTRO	Huaraz	Ancash Department Marañon Province (Huanuco)	Santa	3	8	15
			Huaraz	7	16	33
			TOTAL	10	24	48
ORDE-TAM	Tacna	Tacna and Moquegua Departments	Tacna	1	7	12
			Moquegua	2	4	15
			TOTAL	3	11	27
ORESO	Cuzco	Cusco, Madre de Dios and Apurimac Departments	Cusco H Regional	1	6	23
			Cusco H Lorena	1	8	25
			Canchis	1	4	23
			La Convención	1	-	27
			Madre de Dios	2	1	9
			Abancay	2	6	47
			TOTAL	8	25	154
ORDE-PUNO	Puno	Puno Department	Puno	1	6	37
			Azangaro-Sandia	1	4	12
			Juliaca	2	3	21
			Melgar-Carabaya	1	2	22
			TOTAL	5	15	92
ORDE LORETO	Iquitos	Loreto Department Pinoria district and Puerto Inca	Iquitos	1	7	31
			Yurimaguas	1	2	15
			Pucallpa	2	2	31
			TOTAL	4	11	77
ORDE-AREQUIPA	Arequipa	Arequipa Department	Arequipa	2	11	32
			Islay	1	2	8
			Camana	2	7	33
			TOTAL	5	20	73
ORDE-LIBERTAD	Trujillo	La Libertad Department	Pacasmayo	3	3	3
			Trujillo	5	19	19
			Huamachuco	1	2	15
			TOTAL	9	24	37
ORDE-ICA	Ica	Ica Department Lucanas Province and Parinacochas (Ayacucho) Castrovirreyna Province (Huancavelica)	Ica-Palpa	4	14	17
			Chincha-Pisco	2	6	14
			Lucanas-Parinacochas	2	1	27
			TOTAL	8	21	58
CENTRO-MEDIO REGION	Huancayo	Junin Department Huancavelica (Castrovirreyna) Ayacucho (Lucanas-Parinacochas)	Huancayo	1	14	30
			Jauja	1	3	21
			Tarma	1	3	10
			Chanchamayo	3	7	35
			Ayacucho	3	12	23
			Huancavelica	1	4	23
			TOTAL	10	43	142
CENTRO-ORIENTAL REGION	Huanuco	Pasco Department/ Huanuco Honoria district and Puerto Inca	Huanuco	1	2	19
			Tingo Maria	1	2	14
			La Union	1	2	42
			Cerro de Pasco	-	8	25
			TOTAL	3	14	100
LIMA METROPOLITANA REGION	Lima	Lima Department	Rimac	2	20	1
			Barrios Altos	2	10	-
			La Victoria	1	7	3
			Breña	1	3	-
			Magdalena	1	4	-
			Callao	2	10	6
			Collique	1	4	7
			Cono Sur	2	28	-
			Chosica	1	13	12
			Cañete-Yauyos	4	-	11
			Chancay-Caratambo	4	7	12
			TOTAL	30	109	52
LAMBAYEQUE CAJAMARCA AREAS	Chiclayo	Cajamarca and Lambayeque Departments	Chota	1	3	21
			Cajamarca	2	12	35
			Lambayeque	1	17	25
			TOTAL	4	32	81
SAN MARTIN-AMAZONAS AREAS	Tarapoto	San Martin and Amazonas Departments	Tarapoto	1	5	53
			Moyobamba	2	-	13
			Huallaga	1	5	32
			Amazonas	3	8	65
			TOTAL	7	18	163
				110	396	1,192

Upon approval of the plans, the MCH will enter into agreements with each of the appropriate regional administrative units, articulating the regional plan of action and programmatic goals, identifying the responsibilities of the MCH and Regional Office, outlining the method of commodity and financial supply, assuring the appropriate availability of vehicles and personnel for training and supervision at all levels, and establishing appropriate reporting requirements.

Because of the national scope of the project and the necessity for a data system and baseline study capable of generating critical evaluation information, the project offers both a challenge and risk in terms of administration. The challenge lies in the efficient coordination of the health service, environmental sanitation and training activities to assure timely implementation. For example, the procurement system for refrigeration and medicines is critical for project success. Likewise, training and supervision must be coordinated so as to assure well trained community level personnel are in place on schedule. Moreover, the project, while national in design must incorporate flexible procedures to allow for regional variations in relation to community level organization and health priorities.

The risk of the Project focuses on several issues: 1) the possibility of long delays in Project execution due to resistances within the MCH bureaucracy to effective regional decentralization of decision making and control of resources, 2) lack of human resources within the regions especially in trained specialists in health care management, 3) lack of effective logistical support systems for distribution of medicines and equipment, and 4) political resistances to family planning.

However, the project planners have utilized several mechanisms to minimize the potential risks. These include: 1) the incorporation of project agreement conditions relating to procurement, decentralization, logistics, and operational planning; 2) policy level meetings with MCH officials to assure family planning information will be incorporated as an integral component of the primary health care delivery system; 3) ongoing planning and collaboration with MCH staff experienced in service delivery, environmental sanitation and data collection.

It has been determined that the project can be administrated effectively through the Office of the Director General for Program with the delegation of responsibilities to the respective administrative units responsible for each program component. The Project has the strong support of the President of Peru, the Director of the National Institute of Planning, the Minister of Health, Director Superior, the National Council on Health, the Medical Society, and the Health regions. Moreover, the new policy commitment to primary care and maternal and child health provide an excellent opportunity at this time, to support innovative cost effective projects within the MCH.

Implementing Agency

Responsibilities for Project Components

Ministry of Health

Office of the Director Superior

Office of the Director General of Program

- Coordination of baseline survey and studies

- Coordination of all project components
- Approval of all Regional Operational Plans

Directorate of Administration

- Control of medicines, equipment

Office of Information

- Collaboration with Regions on design and implementation of information system
- Training on information system

Directorate of Maternal Child Health/ Population

- Technical program support
- Norms in M.C.H. and Family Planning

Health Regions

- Training and Supervision
- Execution of Health Services
- Environmental Sanitation
- Health and Nutrition Education
- Implementation of Information System

HEALTH CARE DELIVERY

MINISTRY OF HEALTH

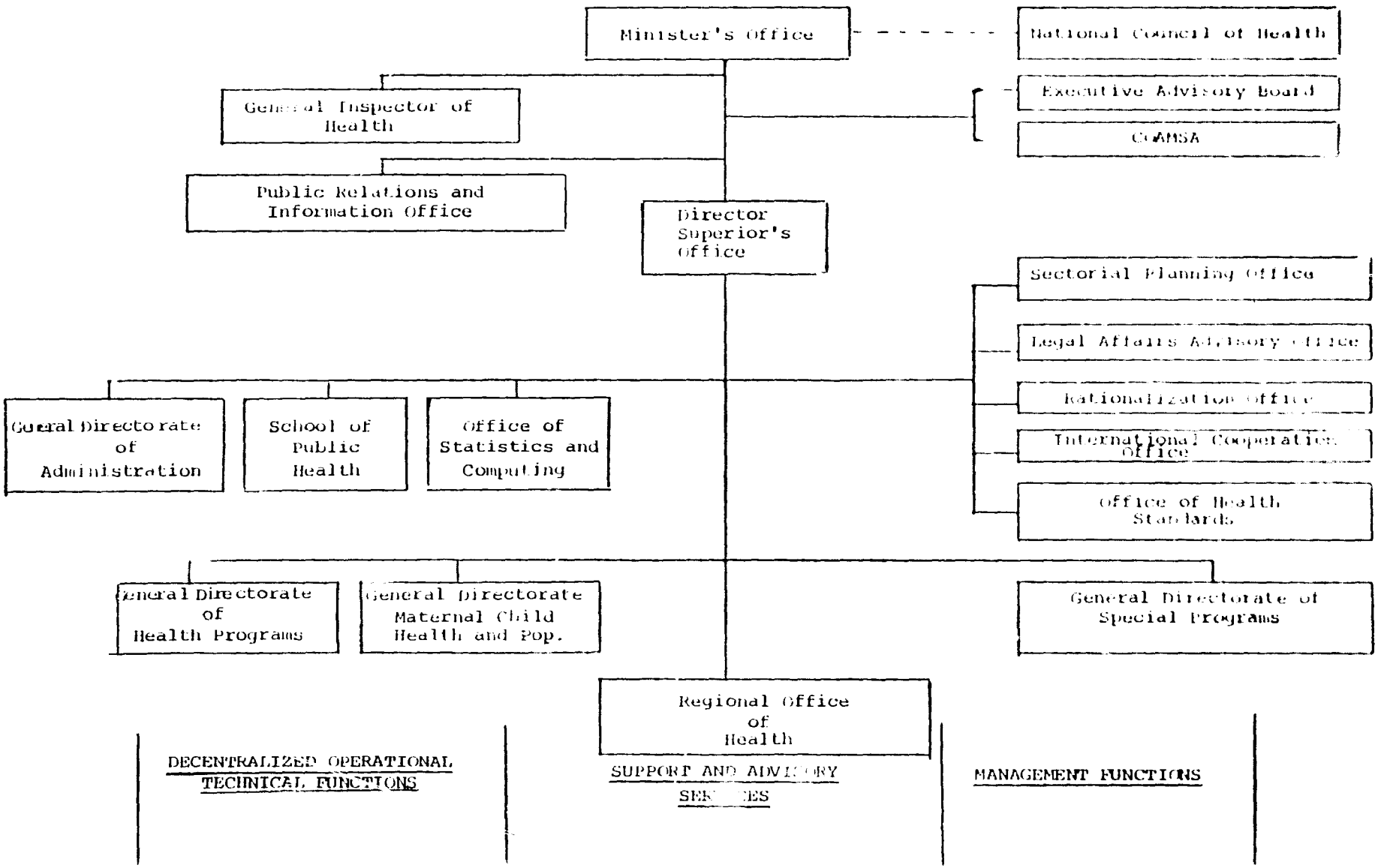
Levels	Responsible Organization	Functions
Technical Support	Specialized Centers Research Institutes	Highly specialized technical support to other levels
III	Regional Hospital	Health action for solving problems which require specialized resources and advanced technology
II	Main General Hospital General Hospital Health Center Sanitary Station	Moderate complex health action classified according to its resources
I	Community	Integrated health action particularly of promotion and protection carried out by each person, family and community

XII
II
III
IV
VII
VIII
V
X-A
X

STRUCTURAL ORGANIZATION CHART OF THE

MINISTRY OF HEALTH

PERU - 1979



2. Disbursement, Procurement and Contracting Procedures

Of the $7,150,000 grant and loan amount $3,980,000 is budgeted for the foreign currency cost of techical assistance and procurement of equipment and materials as shown in the summary financial plan. As this project is one of the first to be carried out with the MOH and given the limited staff resources available to the Ministry to implement this project, the Mission is making an exception to the country contracting policy as set forth in PD-68 and all procurement of goods and services will be performed by USAID. During the implementation of this and other projects with the MOH, the Mission will be working with its staff to begin developing the contracting capabilities required for the Ministry to administer and implement its own projects. At present, it is anticipated that the source, origin and nationality for technical assistance, equipment and materials to be purchased with foreign currency will be the U.S.

For local currency costs (estimated $3,170,000), it is presently planned that A.I.D. will make disbursements for project costs directly to the health regions with approval of the MOH central level. The exception will be for purchase of basic equipment and medicine which will be purchased centrally after formal agreement has been reached by MOH Central and Regional officials. Disbursements will be made on an advance basis with liquidation of previous advances required prior to the granting of a subsequent advance. Details of the advance and liquidation procedures will be worked out with central and regional personnel after the signing of the Agreement and subsequently confirmed in Implementation Letter No.1.

B. IMPLEMENTATION PLAN

ACTIVITY	DURATION	First Year												Second Year												Third Year											
		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
Seminar for Regional Directors	5 days	—	x											—	x											—	x										
Preparation of Operational Plans	60 days		—	x																																	
Equipment						—	x							—	x											—	x										
Training Courses Promoters-Midwives-Health Auxiliaries						—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	x
Medicines						—	x							—	x											—	x										
Initiation of Activities by promoter, midwife and auxiliary							—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	x
Supervision							—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	x
Evaluation and Monitoring of Project Progress								—	x					—	x						—	x				—	x						—	x			
Research Studies								—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	x

C. Evaluation Plan

Since this project constitutes the first major national USAID health intervention directly with the MCH, and will serve as a basis for the programming of future A.I.D. and other donor projects a thorough and continual process of evaluation is required. Effective USAID monitoring of the large and complex variety of activities subsumed under this Project during the limited period of three years is essential, and will be carried out by the Family Health Officer Project Manager and the Health/Nutrition Advisor.

Two in-depth evaluations, undertaken jointly by USAID, the MCH and the National Planning Institute (INP), will be included in the project agreement. After the initial six months of Project activities, a formative evaluation will be undertaken to determine the efficacy of administrative arrangments as well as resolve actual and potential problems in project implementation. The validity of the key project assumption--that effective coordination among the various levels of health institutions can be achieved--must be tested at this time. The information obtained as a result of this evaluation will provide feedback to project personnel and will be used to carry out the necessary adjustments and modifications normally required during the initial stages of project implementation. By this stage of the Project, all inputs should have been provided and most project activities will have begun. The evaluation will focus on the timeliness of the provision of inputs by both USAID and the MCH, as well as assess the results of initial training activities and initiation of health services, e.g., tuberculosis, immunization and oral rehydration campaigns in the Health Regions. The effectiveness of the training of sanitarians, promoters and midwives will also be assessed. The equipment and medicine procurement should be completed by the end of the sixth month. The effectiveness of the household survey of health, nutrition and family planning needs, which is of crucial importance for the final evaluation of the project will also be measured during the formative evaluation. This evaluation will necessarily rely heavily on monitoring reports completed by the A.I.D. project manager and Health/Nutrition Advisor.

The six month seminars funded by the project provides a built-in evaluation component and will assist USAID and the MCH, as well as local staff, to assess progress towards reaching the outputs and purposes of the Project. Information obtained at these evaluations will be used by USAID to complete the Project Evaluation Summary (PES).

The first in-depth evaluation will take place at the end of the year and will serve as a basis for programming further assistance to the MCH and the Health Regions. All major outputs should be fulfilled for the first year. The extent to which the Project purpose has been achieved will be determined by an evaluation of the quality of the methodology and data base developed by the MCH and the effectiveness of the on-going information system that has been developed and implemented. The effectiveness of the service delivery system will be assessed to assist A.I.D. and the MCH in the design of the major loan/grant project that presently contemplates the continuation of the services provided under this grant and loan. During the course of the follow-on loan, the effectiveness of the outputs produced by this project will be evaluated periodically.

The final evaluation will take place at the end of the third year measuring final goal achievement and fulfillment of all outputs.

D. Conditions, Covenants and Negotiating Status

To assure successful implementation of the project, the MCH must have met certain critical administrative and fiscal requirements prior to disbursement of A.I.D. funds. The following will be divided in the agreement between Conditions Precedent for initial disbursement and Secondary Conditions Precedent.

1. Covenant

MCH will covenant that it will provide the equivalent of $2,540,000 in counterpart funding during life of project.

2. Conditions Precedent to Initial Disbursement

a) The GCP will provide opinion of counsel acceptable to A.I.D. that this Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee in accordance with all of its terms.

b) A meeting will be held, including MCH Central level staff and the Regional Health Director, one designated regional representative, and USAID to discuss general program planning and implementation and to finalize plans for procuring medicine and equipment.

c) The MCH will name one person at the Central level and one person at each Regional level to coordinate all project

activities within his/her respective area and maintain contact with A.I.D. Project Manager. The Ministry will identify the persons from the MCH who will assist the regions in developing Regional plans and will make the necessary arrangements to assure money and time are available for their travel.

3. Secondary Conditions Precedent

a) Within three months of the signing of the loan/grant agreement or at a later date mutually agreed upon, the MCH will submit to USAID time-phased Regional Operational Plans, detailing each activity by months and financial requirements (MCH and A.I.D.) to accomplish activities. These will include a detailed Financial Plan, showing proposed expenditures.

b) Within three months of the signing of the loan/grant agreement or at a later date mutually agreed upon the MCH will submit to USAID a statement of its objectives agreed upon with UNFPA and PAHO in utilizing the resources available from USAID and UNFPA in a complementary fashion. The statement should identify the geographic or programatic areas where the two programs will be focussed and should provide for coordination of effort and for reporting to both parties the progress in all areas of activities being supported. While it is not the intent of USAID to make one project dependent upon the other; it is clear that there is sufficient similarity to make full communication and adequate coordination essential.

c) Within three months of the signing of this agreement or at a later date mutually agreed upon and prior to any disbursement for training programs by the regions the MCH will submit to USAID a general training plan including quarterly goals with training at various levels, identifications of the types and qualifications of personnel to provide courses at the various levels and a course outline for the several types of training which identifies both the general content and the didactic method.

d) Within three months of the signing of this agreement and prior to any disbursement for supervision by the regions, the Ministry of Health will submit to the USAID a plan for supervision at all levels of the project indicating the general norms (which can be modified in subsequent agreements with the regions) for supervision at all levels, i.e. objectives, tasks to be performed, frequency, numbers and types of personnel, costs, availability and needs of transportation, and assurances that the needed personnel time will be available.

e) Within three months of the signing of this agreement or at a later date mutually agreed upon the MCH will submit to the USAID a plan for quarterly reporting on activities performed and expenditures (both USAID and GOP) together with a format for projecting next quarter's activities and financial requirements.

This fiscal and activity reporting plan should include procedures for receiving and transmitting similar information from the regional programs to the USAID and assurance that such reports and requests for reimbursements can be transmitted by the MCH to the USAID in a period not to exceed fifteen days from their receipt from the Regional Office.

f) Within three months of the signing of this agreement or at a later date mutually agreed upon the MCH will submit to USAID a general statement of its expectations of how it will utilize the training materials, logistics procedures, and supervisory methods in the operations research activity in the Sur Medio Project as an input to the planning, implementation and evaluation of this project.

g) Within three months of the signing of this agreement or at a later date mutually agreed upon the MCH will submit to USAID preliminary documents outlining the information system and data forms to be utilized in the project.

h) Within three months of the signing of this agreement or at a later date mutually agreed upon the MOH will submit to USAID a proposed list of the individuals and subcontractors to be participants in the baseline survey and health studies.

i) Prior to disbursement for commodities, the MCH will provide for USAID a detailed list of its commodity needs, statement of the documentation necessary for their purchase, the identification of the person or persons in the Ministry responsible for this area of action and assurance that commodities provided under this project will be removed duty free from the customs within 30 days of their arrival and distributed to regional projects within a reasonable period of time.

j) Three months following the arrival in-country of major medicines procured under this project, the MCH will submit a report to USAID detailing the logistics system utilized to assure commodities are in place at the health post and community levels.

k) Prior to disbursement for regional implementation the MCH will enter into agreements concurred in by USAID with the appropriate regional administrative units articulating the regional plan of action and programatic goals, identifying the responsibilities

of the MCH and the Regional Office, outlining the method of commodity and financial supply, assuring the appropriate availability of vehicles and personnel for training and supervision at all levels, and establishing appropriate reporting requirements.

l) Within 6 months of the signing of this agreement or at a later date mutually agreed upon the MCH will submit to the USAID a general statement of arrangements for and programs in establishing evaluation procedures as well as a detailed plan of action for future evaluation activities.

The above mentioned requirements will be included in the Project Agreement and will be specifically addressed in prior negotiations between A.I.D. and MCH.

D. Conditions, Covenants and Negotiating Status

To assure successful implementation of the project, the MCH must meet certain critical administrative and fiscal requirements prior to disbursement of A.I.D. funds. These requirements will be divided in the agreement between Conditions Precedent for initial disbursement and Secondary Conditions Precedent.

1. Covenant

a) GOP will covenant that the MCH and the National Planning Institute (INP) working jointly with A.I.D. will carry out a formative evaluation and two in-depth evaluations during the implementation of the Project.

b) GOP will covenant to provide sufficient annual budget allocations following completion of the Project so as to assure continuity of the Project activities.

(c) GOP will covenant that Project activities will be implemented at the regional level through regional administrators.

2. Conditions Precedent to Initial Disbursement for Technical Assistance

Prior to the first disbursement of the Loan or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Borrower will, except as A.I.D. may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.

(a) An opinion of the Director General of the General Department of Legal Counsel of the Ministry of Health, or other counsel acceptable to A.I.D. to the effect that this Agreement has been duly authorized and/or ratified by, and executed on behalf of the Borrower, and that it constitutes a valid and legally binding obligation of the Borrower in accordance with all of its terms;

b) A statement of the name of the person holding or acting in the office of the Government of Peru specified in Section 9.2 of the Project Agreement and of any additional representative, together with a specimen signature of each person specified in such statement;

(c) A statement naming one person at the MOH Central level and one person at each regional level to coordinate all project activities within his her respective area and maintain contact with A.I.D. Project Manager.

3. Conditions Precedent to Initial Commodity Procurement

Prior to disbursement for commodity procurement, the MOH will furnish to A.I.D. a copy of the agreement among MOH Central level staff, the Regional Directors, and USAID on a commodity procurement plan for the first twelve months of implementation.

4. Conditions Precedent to Disbursements for any Purpose other than Initial Commodity Procurement or Technical Assistance

Prior to any disbursement of Loan or Grant funds or the issuance of any commitment documents under this Project Agreement for Loan or Grant funds for any purpose other than commodity procurement, Borrower shall furnish in form and substance satisfactory to A.I.D.;

(a) Time-phased Regional Operational Plans, detailing each activity by months and financial requirements (MOH and A.I.D.) to accomplish Project activities. These will include a detailed Financial Plan showing proposed expenditures, a general training plan, a staffing plan, information and evaluation systems, and a plan to carry out the baseline survey and health studies.

(b) An action plan which outlines the arrangements between the MOH and appropriate regional authorities which articulates the regional plans of action and programmatic goals, identifies the responsibilities of the MOH and Regional Office, outlines the method of community and financial supply, assures the appropriate availability of vehicles and personnel for training and supervision at all levels, and establishes appropriate reporting requirements.

(c) A statement of MOH objectives agreed upon with UNFPA and PAHO in utilizing the resources available from USAID and UNFPA in a complementary fashion. The statement should identify the geographic or programmatic areas where the two programs will be focussed and should provide for coordination of effort and for reporting to both parties the progress in all areas of activities being supported.

5. Condition Precedent to Distribution of Pharmaceuticals and Equipment

Prior to any distribution of pharmaceutical and equipment, the MOH will submit to A.I.D. a plan for the procurement, storage and distribution of commodities to the health posts; such plan will also describe maintenance requirements and procedures at both Central and Regional levels.

6. Negotiating Status

The proposed project has been developed by the USAID in collaboration with MOH personnel, in support of the GOP's National Plan for Extending Coverage of primary integrated health services to rural communities. The Minister and the Vice Minister actively support the program. There are no outstanding negotiation issues. In the judgement of the Mission, the Project is ready for formal approval and implementation.

LIST OF ANNEXES

A. Director's Certification

B. Logical Framework

C. Draft Authorization

D. Document of MCH on Primary Health Care (available in AID files)

E. Initial Environmental Examination

F. Chronology of Project Development

G. Project and Country Check List

H. Maps of the Health Region

I. Mission Response to Project Related Issues - AID/W

J. Statistical Tables

- Equipment Annex

- Other Statistical Tables

K. Draft Information System (Sur Medio and Integrated Health Projects)

L. MCH Primary Health Care Assistance Plan - Overall Objectives and Goals

M. Medicine List

ANNEX A

CERTIFICATION PURSUANT TO SECTION 611 (e) OF THE FOREIGN ASSISTANCE ACT OF 1961, AS AMENDED

I, Leonard Yaeger, the principal officer of the Agency for International Development in Peru, having taken into account among other factors, the maintenance and utilization of projects in Peru previously financed or assisted by the United States, do hereby certify that in my judgement the Ministry of Health has both the financial capability and human resources capability to effectively maintain and utilize the proposed Extension of Integrated Primary Health Project.

Leonard Yaeger, Director
USAID/Peru

AID No. 2011-721

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Total Project
From FY [illegible] to FY [illegible]
Total Funding [illegible]
Date Prepared [illegible]

Project Title & Number EXTENSION OF INTEGRATED PRIMARY HEALTH

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: To improve the health and well being of the rural population.	**Measures of Goal Achievement** Infant mortality reduced by 20%	National annual reports. Baseline surveys.	**Assumptions for achieving goal targets** Government of Peru will continue support of health services to rural and critical urban areas.
Project Purpose: To strengthen and extend basic health services to rural population with emphasis on community participation.	**Conditions that will indicate purpose has been achieved: End of project status.** 30% of total rural population has access to basic health services.	National and regional semi-annual reports.	**Assumptions for achieving purpose** The communities will continue to be actively involved in health program.
Outputs: Health Auxiliaries trained, equipped and in place Community promoters trained, equipped and in place Midwives trained, equipped and in place Information system established Children Immunized Improved water Waste disposal - latrines Pregnancies receiving attention (pre-and or post partum) Improved Housing Services for Infants Services for Pre-School Children	**Magnitude of Outputs:** 1,041 4,284 4,284 408.7 (each DPT, polio, BCG, measles) 305.2 (TBC reinforcement) 1,800 3,600 124.9 1.8 163.5 191.7	Information System Reports. Project Evaluations (every six months). (Same as above)	**Assumptions for achieving outputs** Commodities are ordered and arrive on time. Information system is implemented on a timely basis.
Inputs: I. AID Loan Funds A. Medical Equipment B. Medicines C. Educational materials and equip. D. Transport E. Supplies for water and waste disposal F. Data processing materials II. AID Grant Funds A. Technical Assistance B. Training and Supervision III. GOP A. Salaries B. Office and Medical Equipment C. Vehicles D. Maintenance	**Implementation Target (Type and Quantity)** (See Implementation Plan, Project Input Output Chart, and detailed project elements)	Logistics study included in project.	**Assumptions for providing inputs:** Regional operational plans are completed on a timely basis.

BEST AVAILABLE COPY

ANNEX C

PROJECT AUTHORIZATION

Name of Country/Entity: PERU

Name of Project: Extension of Integrated Primary Health

Number of Project: 527-0219

Number of Loan: _____ - _____

1. Pursuant to Section 104 of the Foreign Assistance of 1961, as amended, I hereby authorize the execution of a loan ("Loan") and a grant ("Grant") to the Republic of Peru ("Peru") for Extension of Integrated Primary Health involving planned obligations of not to exceed $5.8 million in loan funds and $1.35 million in grant funds over a four year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project.

2. The project consists of the creation and implementation of a system of integrated primary health care extension including the following elements: (1) provision of basic rural health services utilizing health auxiliaries, community promoters and nurse-midwives; (2) community education and support to basic sanitation activities; (3) training and supervision of health workers; (4) establishment of a basic health care information system and (5) studies and evaluation and technical assistance ("Project").

3. The Project shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

a. Interest Rate and Terms of Repayment

Peru shall repay the Loan to A.I.D. in U.S. Dollars within twenty-five years from the date of first disbursement of the Loan, including a grace period of not to exceed ten (10) years. Peru shall pay to A.I.D. in U.S. Dollars interest from the date of first disbursement of the Loan at the rate of (a) two percent (2%) per annum during the first ten (10) years, and (b) three percent (3%) per annum thereafter, on the outstanding disbursed balance of the Loan and on any due and unpaid interest accrued thereon.

b. Source and Origin of Goods and Services (Grant)

Goods and services financed by A.I.D. under the Grant shall have their source and origin in Peru or in the United States except

as A.I.D. may otherwise agree in writing.

c. Source and Origin of Goods and Services (Loan)

Goods and services, except for ocean shipping, financed by A.I.D. under the Grant shall have their source and origin in Peru or in countries included in A.I.D. Geographic Code 941, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Loan shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States or Peru.

d. Condition Precedent to Initial Commodity Procurement

Prior to disbursement for commodity procurement, the MOH will furnish to A.I.D. a copy of agreement in form and substance satisfactory to A.I.D. among MOH Central level staff, the Regional Directors, and USAID on a commodity procurement plan for the first twelve months of implementation.

e. Conditions Precedent to Disbursement for any Purpose other than Initial Commodity Procurement or Technical Assistance

Prior to any disbursement of Loan or Grant funds or the issuance of any commitment documents under this Project Agreement for Loan or Grant funds for any purpose other than commodity procurement, or technical assistance, Peru shall furnish in form and substance satisfactory to A.I.D.

(1) Time-phased Regional Operational Plans, detailing each activity by months and financial requirements (MOH and A.I.D.) to accomplish Project activities. These will include a detailed Financial Plan showing proposed expenditures, a general training plan, a staffing plan, information and evaluation system, and a plan to carry out the baseline survey and health studies.

(2) A statement of MOH objectives agreed upon with UNFPA and PAHO in utilizing the resources available from USAID and UNFPA in a complementary fashion. The statement should identify the geographic or programmatic areas where the two programs will be focussed and should provide for coordination of effort and for reporting to both parties the progress in all areas of activities being supported.

(3) An action plan which outlines the arrangements between the MOH and appropriate regional authorities which articulates the regional plans and programming goals, identifies the responsibilities of the MOH and Regional Office, outlines the method of community and financial supply, assures the appropriate availability of vehicles and personnel for training and supervision at all levels, and establishes appropriate reporting requirements.

f. Condition Precedent to Distribution of Pharmaceuticals and Equipment

Prior to any distribution of pharmaceuticals and equipment, the MOH will submit to A.I.D. a plan for the procurement, storage and distribution of commodities to the health posts; such plan will also describe maintenance requirements and procedures at both Central and Regional levels.

g. Peru shall covenant, except as A.I.D. may otherwise agree in writing:

(1) To carry out jointly with A.I.D. a formative evaluation after the initial six months of Project activities and two in-depth evaluations of the Project - one at the end of the first year and the second at the end of the third year.

(2) That it will continue to provide sufficient annual budget allocations following completion of the Project so as to assure continuity of the Project activities.

(3) That project activities will be implemented at the regional level through regional administrators designated in accordance with the terms of the Project Agreement; and that funding provided for the Project will be utilized directly to support activities at the regional level

h. The following waivers to A.I.D. regulations are hereby approved:

U.S. and local procurement is authorized under the Grant portion of the Project.

Leonard Yaeger, Director
USAID/Peru

Clearances:HEN:JBallantyne:
CD:GWachtenheim:
FHO:HKaufman:
PROG:LSmucker:

RLA:JKessler:css 9/6/79

ANNEX E

DEPARTMENT OF STATE
AGENCY FOR INTERNATIONAL DEVELOPMENT LAC/DR-IEE-79-46
WASHINGTON D C 20523

ASSISTANT
ADMINISTRATOR

[illegible]

Location : Peru

Project Title : Extension of Primary Health Care, 527-0219

Funding : First FY: $5,000,000

Life of Project: First FY 1979 - LOP - FY 79-81

Mission Recommendation:

Based on the Initial Environmental Examination, the Mission has concluded that the project will not have a significant effect on the human environment and therefore recommends a Negative Determination.

The Development Assistance Executive Committee of the Bureau for Latin America and the Caribbean has reviewed the Initial Environmental Examination for this project and concurs in the Mission's recommendation for a Negative Determination.

AA/LAC Decision:

Pursuant to the authority vested in the Assistant Administrator for Latin America and the Caribbean under Title 22, Part 216.4a, Environmental Procedures, and based upon the above recommendation, I hereby determine that the proposed project is not an action which will have a significant effect on the human environment, and therefore, is not an action for which an Environmental Impact Statement or an Environmental Assessment will be required.

Assistant Administrator for
Latin America and the Caribbean

Date

Clearances:
LAC/DR:Environmental Advisor:ROtto
DAEC Chairman:MBrown

INITIAL ENVIRONMENTAL EXAMINATION

Project Location: Peru

Project Title: Extension of Primary Health Care

Project Number: 527-0219

Funding: First FY: 5,000,000

Life of Project: 5,000,000

IEE Prepared by: Edilberto Alarcón USAID/Peru
Environmental Coordinator

The USAID/Peru project committee for the Extension of Primary Health Care project has undertaken a complete Initial Environments Examination (IEE) of the project environmental impacts and has arrived at a recommendation for a Negative Determination as indicated in the Threshold Decision Section.

Concurrence: Date:

I have reviewed the Initial Environmental Examination prepared by the Project Committee for the Extension of Primary Health Care project and concur in the Threshold Decision recommendation for a Negative Determination.

Leonard Yaeger, Director
USAID/Peru

AA/LA Decision:

Based upon the Development Assistance Executive Committee review of the Project Identification Document, including the Initial Environmental Examination for the Extension of Primary Health Care project, I approve the Threshold Decision for a Negative Determination.

Assistance Administrator for
Latin America

I. Examination of Nature, Scope and Magnitude of Environmental Impacts:

a) Project Description:

This project will support the Ministry of Health efforts to extend primary health care to the majority of Peru's population mainly through fostering community self help and self sufficiency.

Project funds will be used to provide training to health workers, to purchase minimal equipment, materials and basic medicines for health posts, to purchase bycicles and mules for the use of health auxiliaries and to develop data collection for essential health statistics. There will also be a component of technical assistance in several aspects of training and management and for general project evaluation.

b) Identification and Evaluation of Environmental Impacts:

The project's possible environmental effects have been carefully reviewed following the order established in the Impact Identification and Evaluation Form.

It has been concluded that the project will not have any significant impact with regard to changing the character or use of the land or causing irreversible or inefficient commitments of natural resources. The project interventions will not adversely affect the quality or ecological balance of the water, nor will produce undesirable atmospheric impacts. On the contrary, they will support community efforts to protect water sources. The project's impacts on health and on cultural and socio economic patterns will be very positive. In general, the project will improve the health of the people by providing preventive health services, environmental sanitation and curative care specially focused on the health of mothers and infants. Community participation will be strengthened and cleanliness and health care habits will be substantially improved. The reduction of mortality and disease rates will in turn produce beneficial economic effects by reducing expenditures on medicines and generally increasing the productivity.

II. Recommendation for Environmental Action:

Based on the careful review and assessment of the possible environmental impacts, the project committee recommends a Threshold Decision for a Negative Determination.

PROJECT: EXTENSION OF PRIMARY HEALTH CARE

Project N° [illegible]

Attachment to Annex
Initial Environmental
Examination (IEE)

IMPACT IDENTIFICATION AND EVALUATION FORM

Impact Areas and Sub-areas	Impact Identification and Evaluation 1/
A. LAND USE	
1. Changing the character of the land through:	
a. Increasing the population----------	N
b. Extracting natural resources----------	N
c. Land clearing----------	N
d. Changing soil productivity capacity----	N
2. Altering natural defenses----------	N
3. Foreclosing important uses----------	N
4. Jeopardizing man or his works----------	N
5. Other factors----------	None
B. WATER QUALITY	
1. Physical state of water----------	N
2. Chemical and biological states----------	L
3. Ecological balance----------	N
4. Other factors----------	None

1/ Use the following symbols: N - No environmental impact
L - Little environmental impact
M - Moderate environmental impact
H - High environmental impact
U - Unknown environmental impact

July 1979

IMPACT IDENTIFICATION AND EVALUATION FORM

C. ATMOSPHERIC

1.	Air additives ----------	N
2.	Air pollution ----------	N
3.	Noise pollution ----------	N
4.	Other factors ----------	None

D. NATURAL RESOURCES

1.	Diversion, altered use of water ----------	N
2.	Irreversible, inefficient commitments -----	N
3.	Other factors ----------	None

E. CULTURAL AND SOCIOECONOMIC

1.	Altering physical symbols ----------	N
2.	Changes of cultural traditions ----------	M
3.	Changes in population ----------	M
4.	Other factors ----------	None

F. HEALTH

1.	Changing a natural environment ----------	N
2.	Eliminating an ecosystem ----------	N
3.	Other factors ----------	None
	- Improved General Health Conditions ------	H

G. GENERAL

1.	International impacts ----------	N
2.	Controversial impacts ----------	N
3.	Larger program impacts ----------	N
4.	Other factors ----------	None

ANNEX F

Chronology of Major Project Actions Development - 1978 and 1979

6/78 PID written on Health Planning and Information Development.

9/78 Discussions with project committee, MOH, and AID/W representative regarding the modification of project to include a model service component in only one region - Centro Medio.

11/78 Recommendation by MOH representatives to modify project components to include a service delivery system in Centro Medio. Region submitted Health Plan for Services which was utilized to determine priorities for service component of the project. Representatives of International Programs (MOH) and Director Superior emphasized the need for a service at the Regional level, including MOH and Population.

1/78 Letter sent to MOH confirming modification of project to correspond with MOH stated policy objectives, including service component in Centro Medio as verified in meeting with the Director Superior. Meeting was held to review the letter and policy.

2/78 Meetings with John Massey, AID/W and MOH representatives regarding project components to detail project elements and specify budget allotments for each component.

3/78 Final project document presentation to project committee - no action taken.

6/78 Meeting of Mission Director and Minister of Health regarding Primary Health Care Plan and Potential USAID support. Centro Medio and Health Information components incorporated in larger health project.

7/78 Meetings with Ballantyne, Twentyman and Kaufman with Dr. Moreno to discuss project development for large AID loan and grant ($5 million). Joint Commission formed to develop project.

7/78 PID developed for extension of Integrated Primary Health Care - Sandoval; PID approved in AID/W.

8/78 Project Paper developed for $7 million loan and grant.

8/78 Project authorized.

ANNEX G

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable generally to projects with FAA funds and project criteria applicable to individual fund sources: Development Assistance (with a subcategory for criteria applicable only to loans); and Economic Support Fund.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE?
HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PRODUCT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 79 App. Act Unnumbered; FAA Sec. 653 (b); Sec. 634A. (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than $1 million over that figure)?	Congressional Notification is in process.
2. FAA Sec. 611(a)(1). Prior to obligation in excess of $100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?	(a) - Yes. (b) - Yes.
3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?	Supreme Decree is expected to be issued promptly.
4. FAA Sec. 611(b); FY 79 App. Act Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973?	N/A
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?	The Mission Director has so certified.
6. FAA Sec. 209. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	The Project is specific to Peru and therefore not susceptible for implementation as a regional Project. While Project could be financed as a multilateral project no other agencies have expressed an interest.

9.1.a.

basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?	(b) - Not related to cooperative development. (c) - Is so designed. (d) - Project aimed at health services for women and will thereby improve their status, as providers and participants in health system. (e) - N/A.
b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: (include only applicable paragraph which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.)	Health and Population - see financial plan for detailed plan.
(1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;	N/A
(2) [104] for population planning under sec. 104(b) or health under sec. 104(c); if so, extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems and other modes of community research.	See detailed project description; all these activities are included.
(3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;	N/A
(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:	N/A
(i) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;	A U.S. University and private consultants will supply T.A. on a contract basis.
(ii) to help alleviate energy problems;	N/A
(iii) research into, and evaluation of, economic development processes and techniques;	N/A
(iv) reconstruction after natural or manmade disaster;	N/A

B.

3. Project Criteria Solely for Economic Support Fund

a. FAA Sec. 531(a). Will this assistance support promote economic or political stability? To the extent possible, does it reflect the policy directions of section 102? N/A

b. FAA Sec. 533. Will assistance under this chapter be used for military, or paramilitary activities?

REGIONALIZACION ADMINISTRATIVA DEL SECTOR SALUD - 1977

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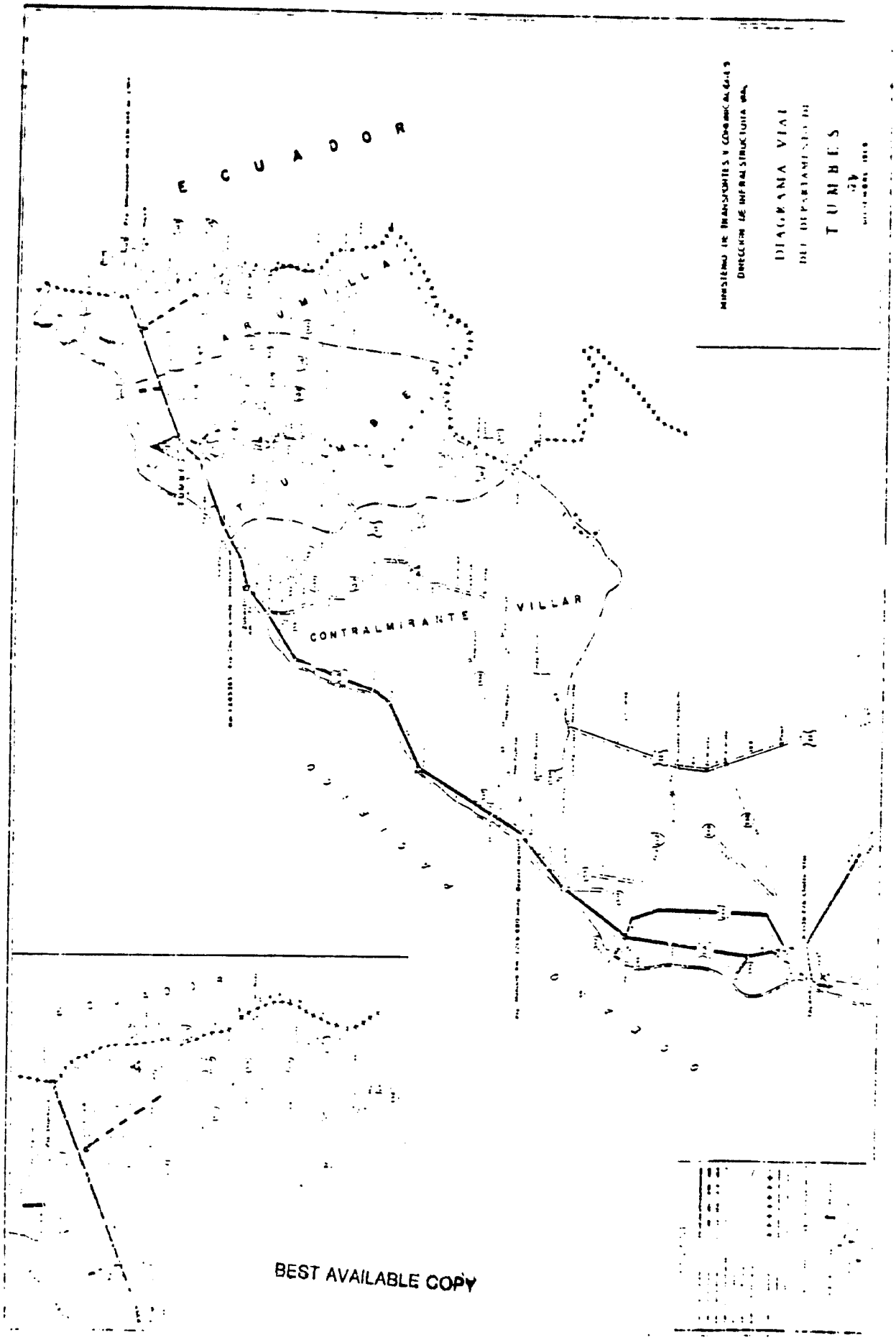

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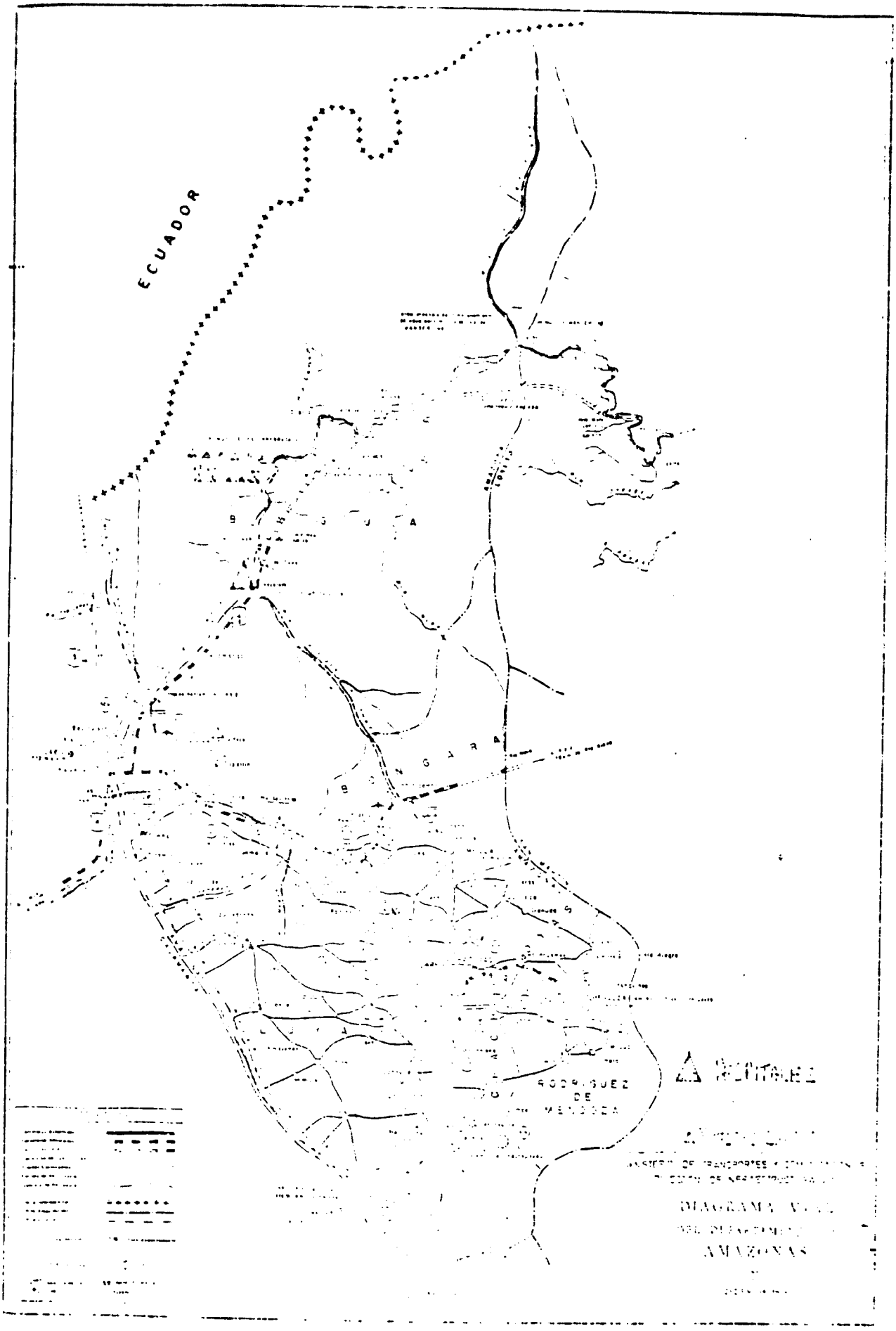
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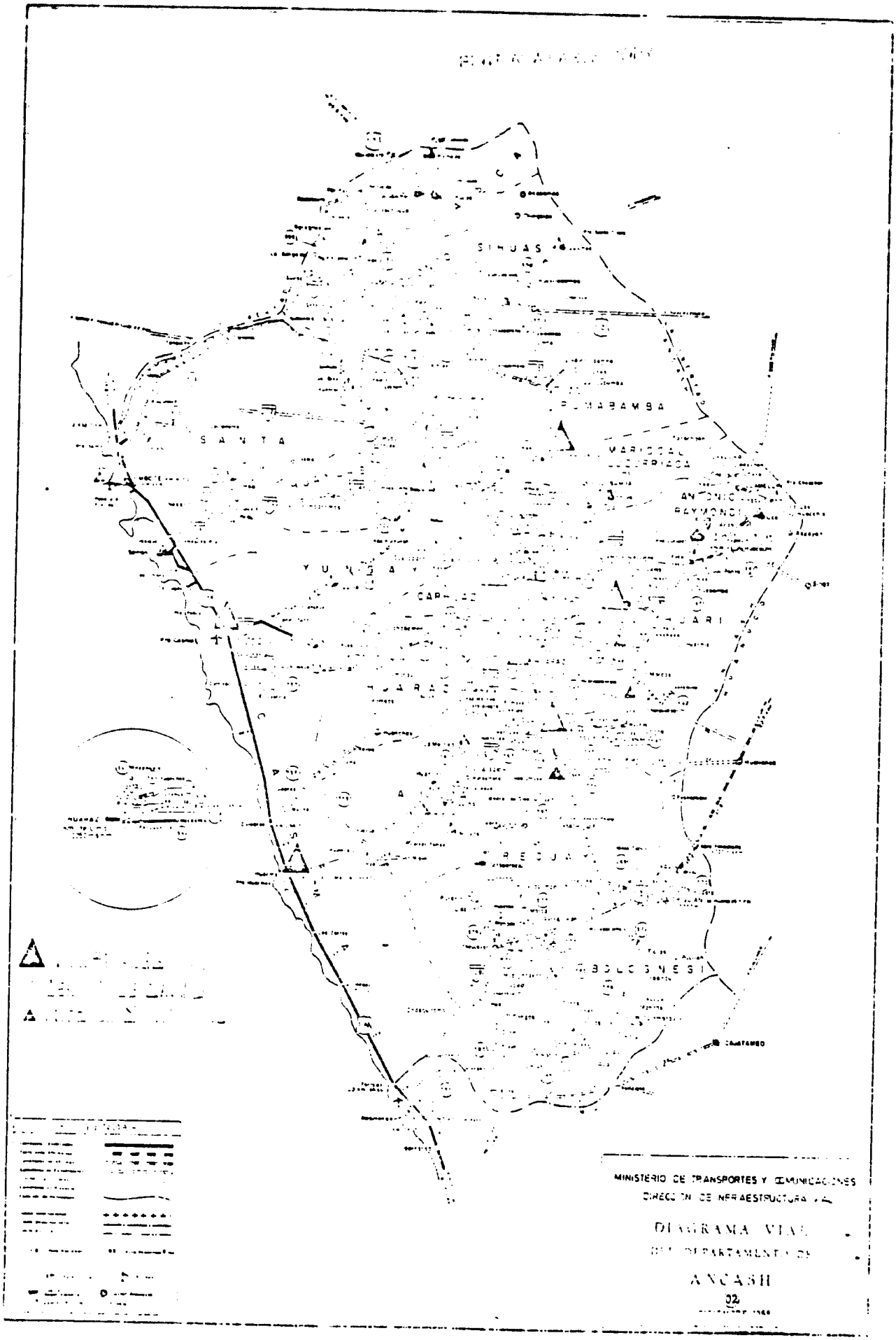
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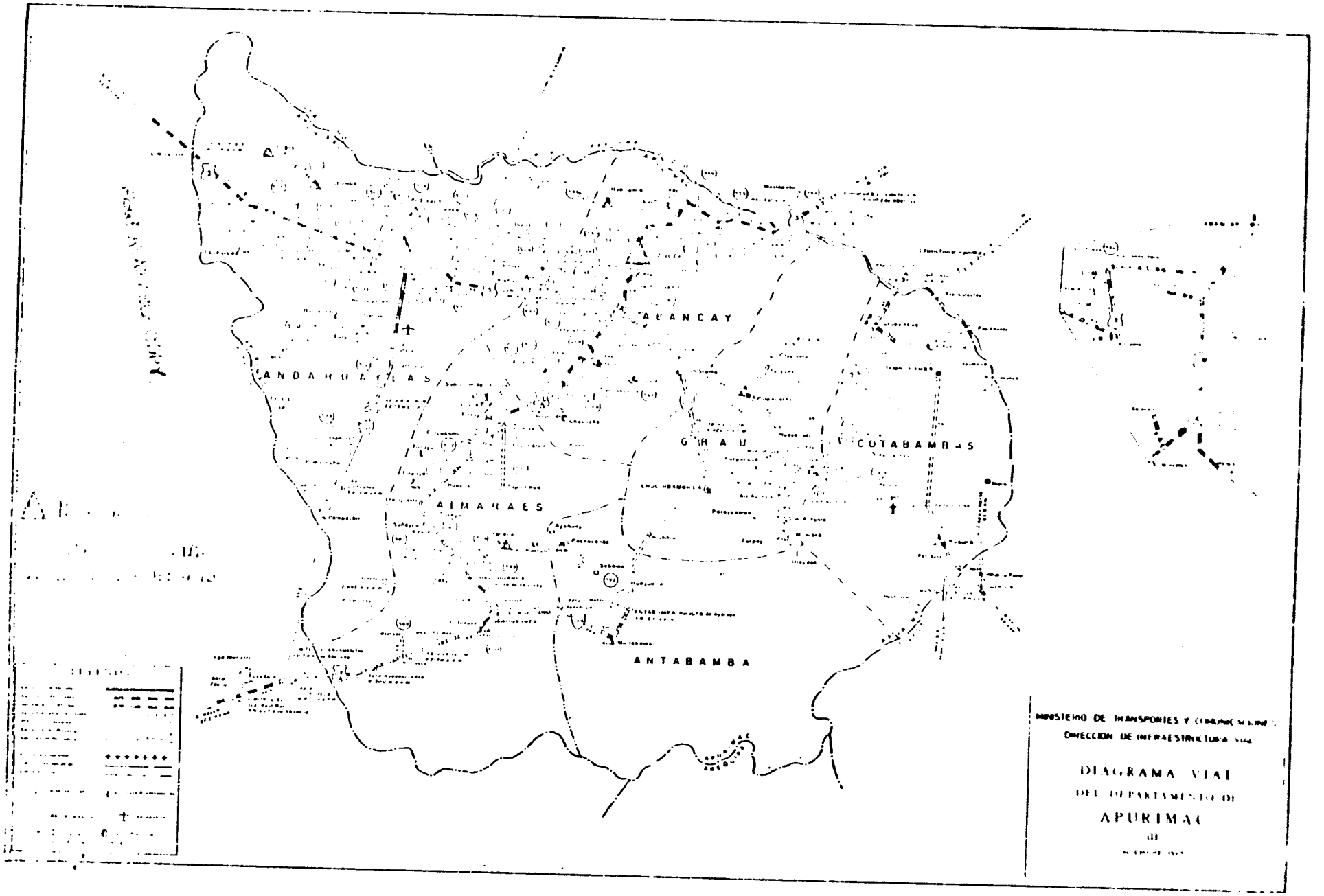
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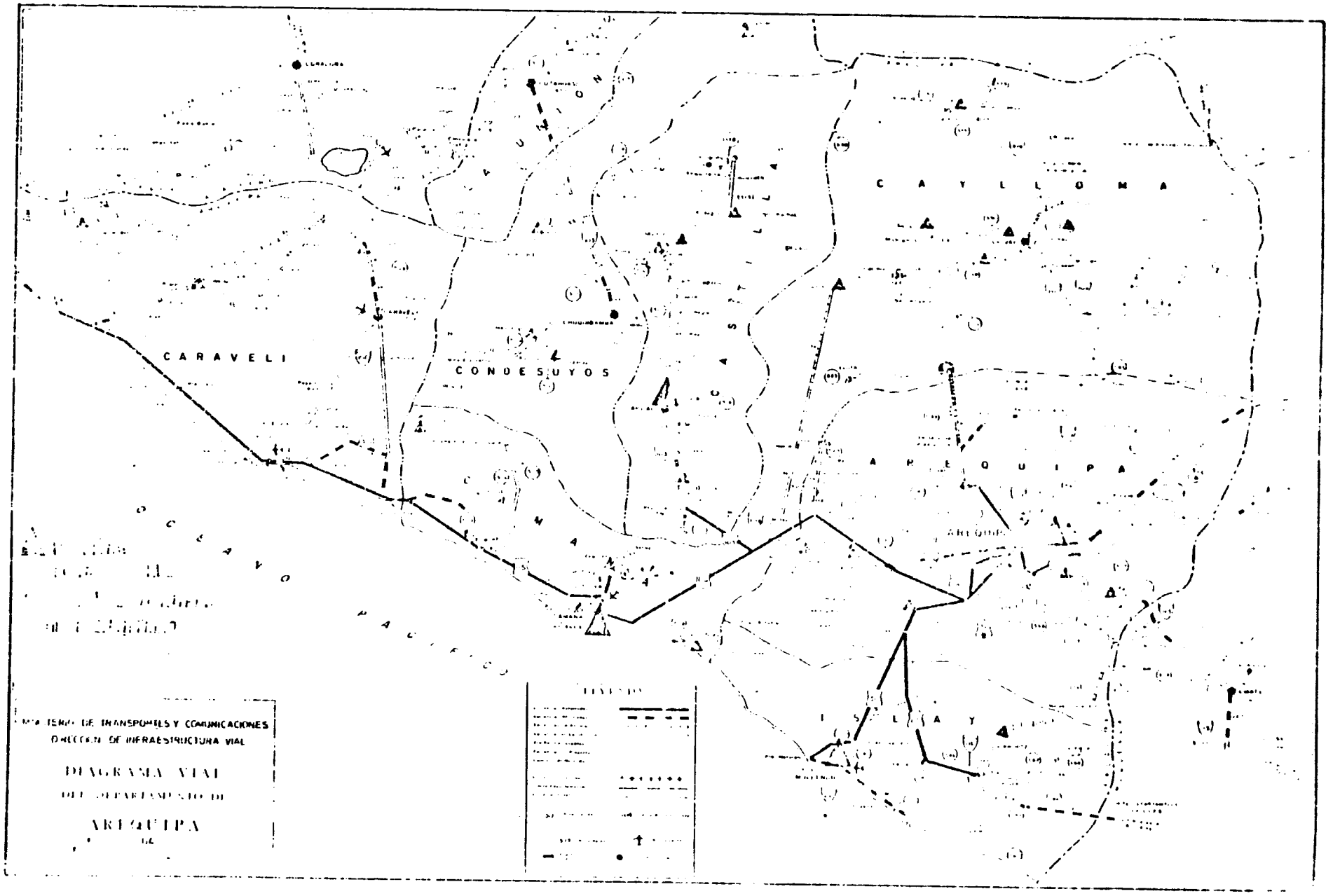

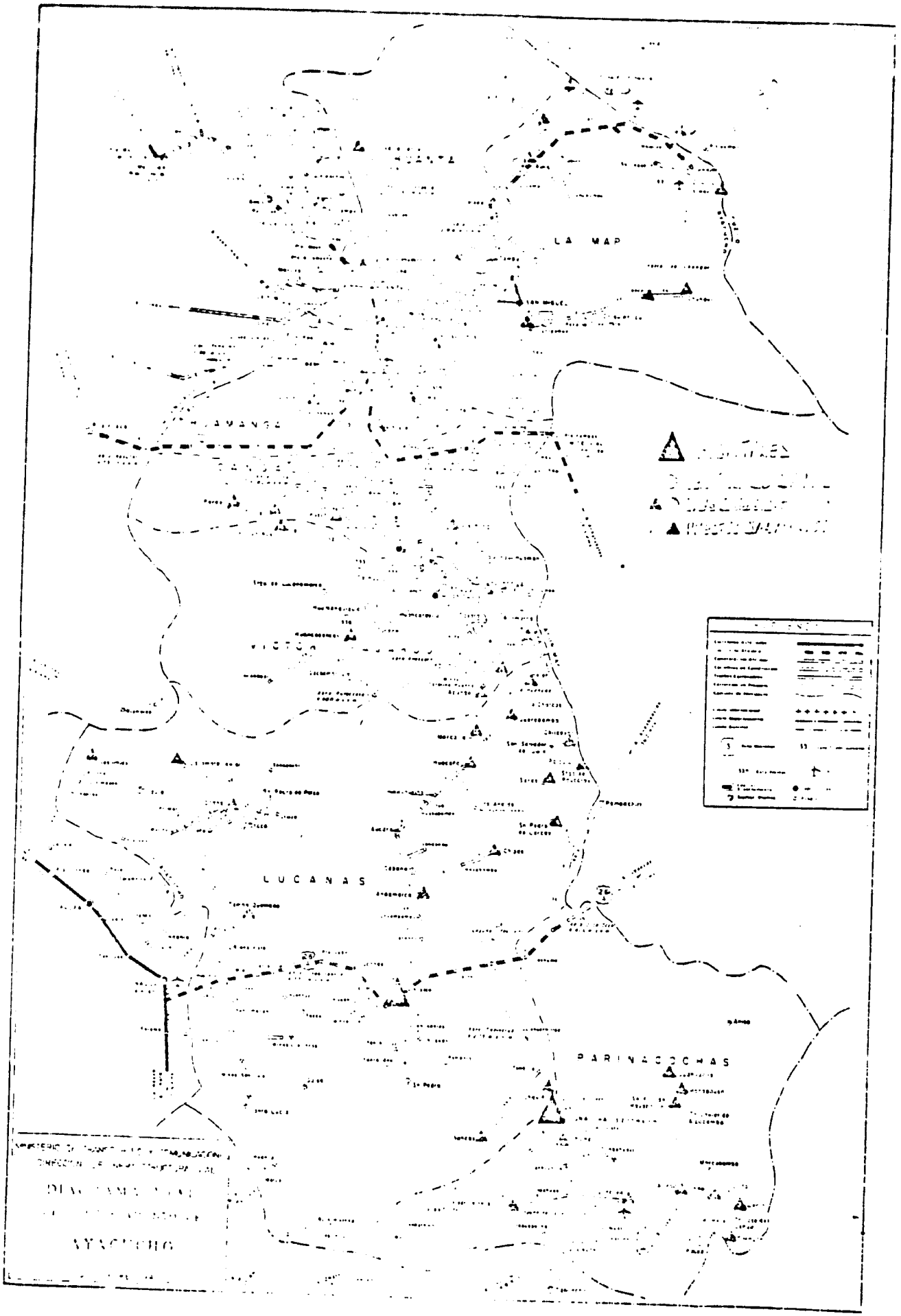
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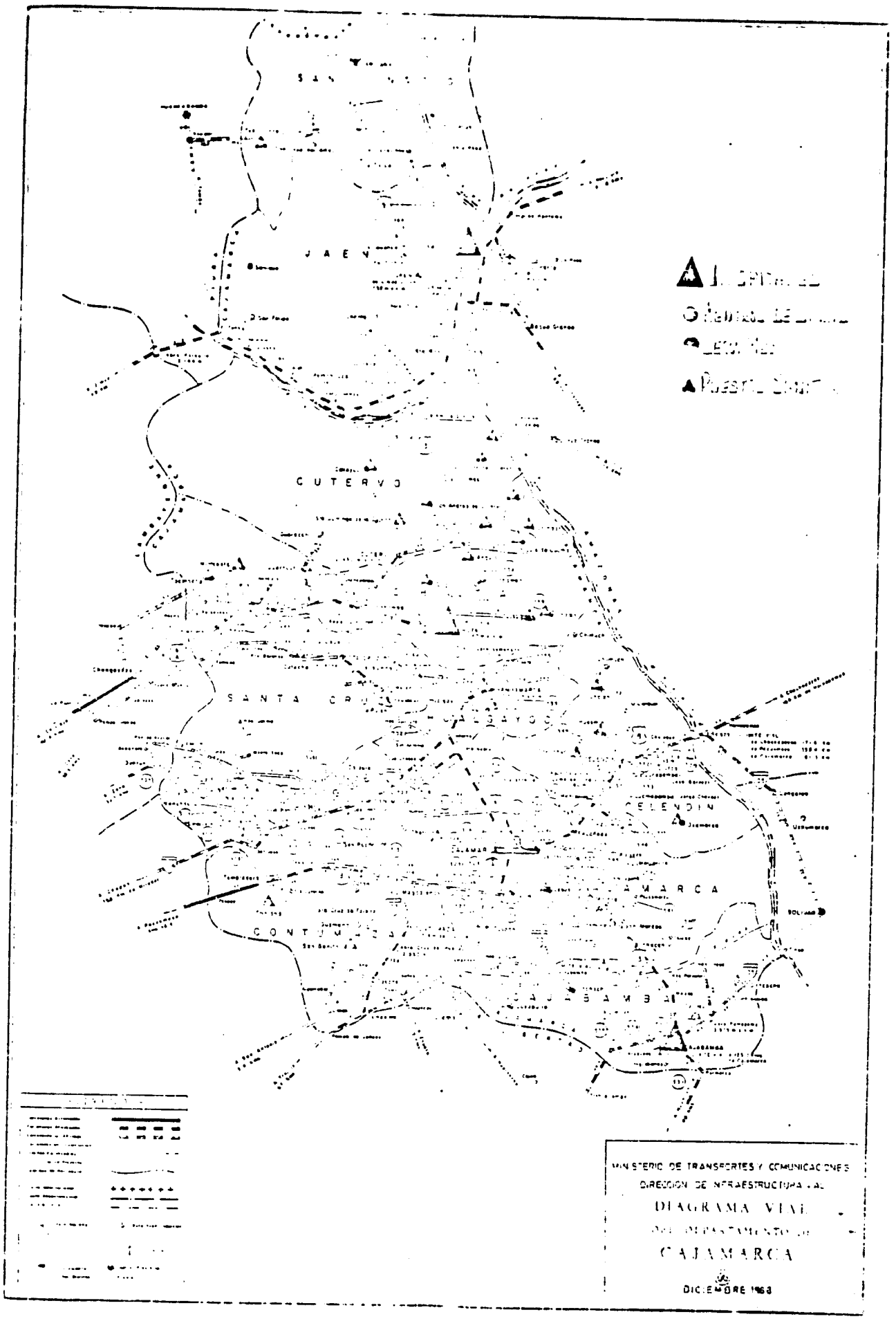
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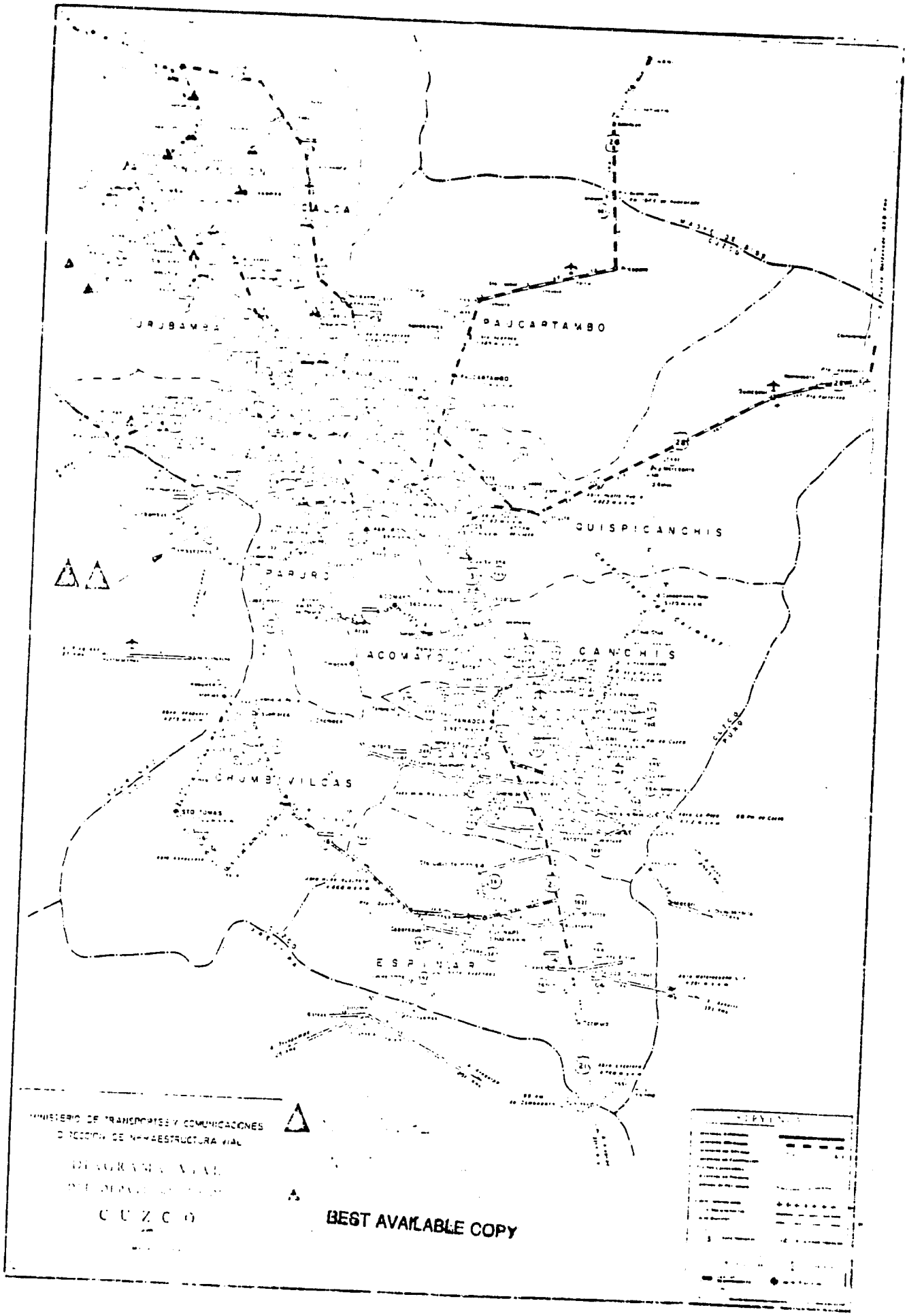

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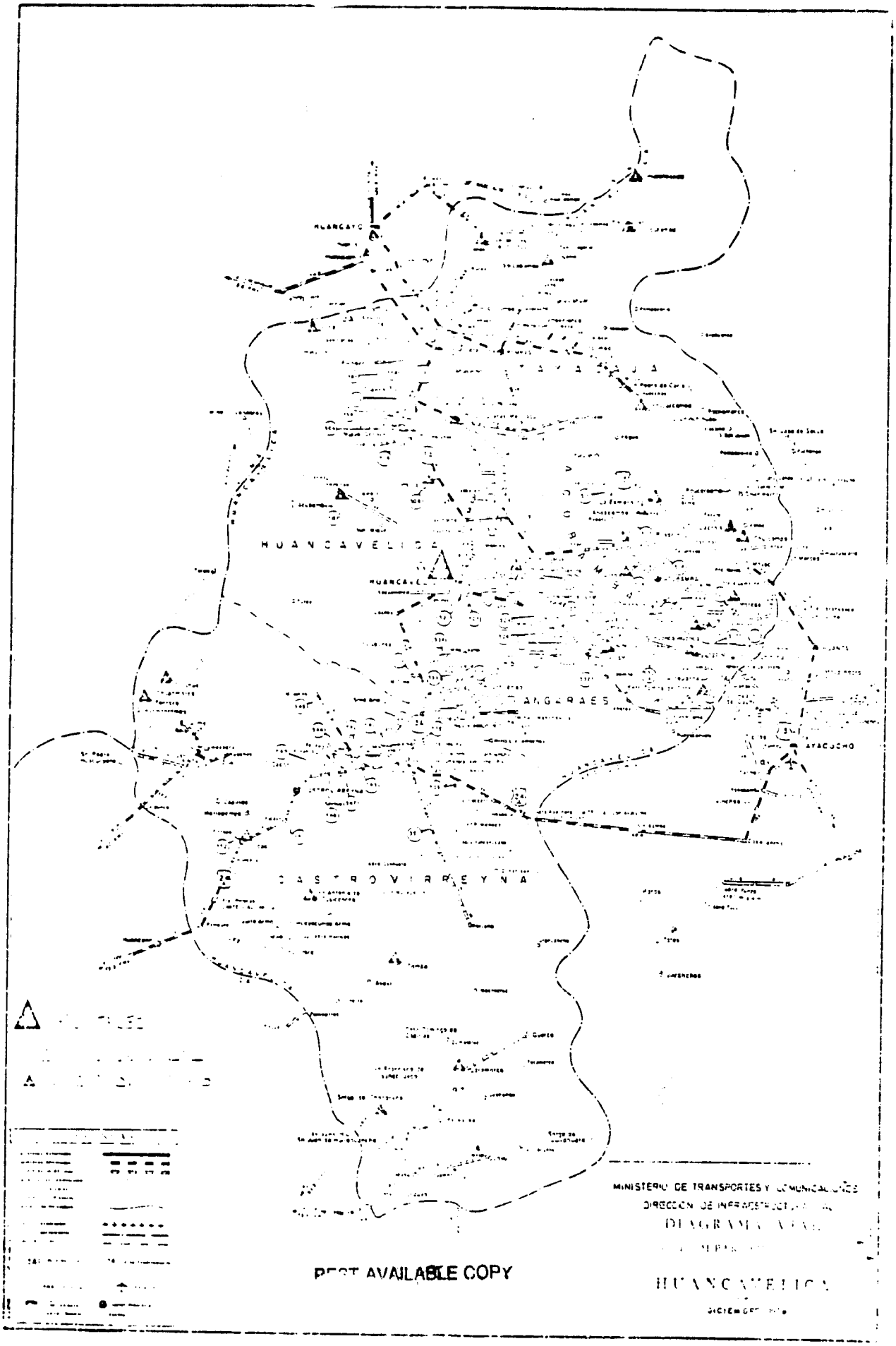

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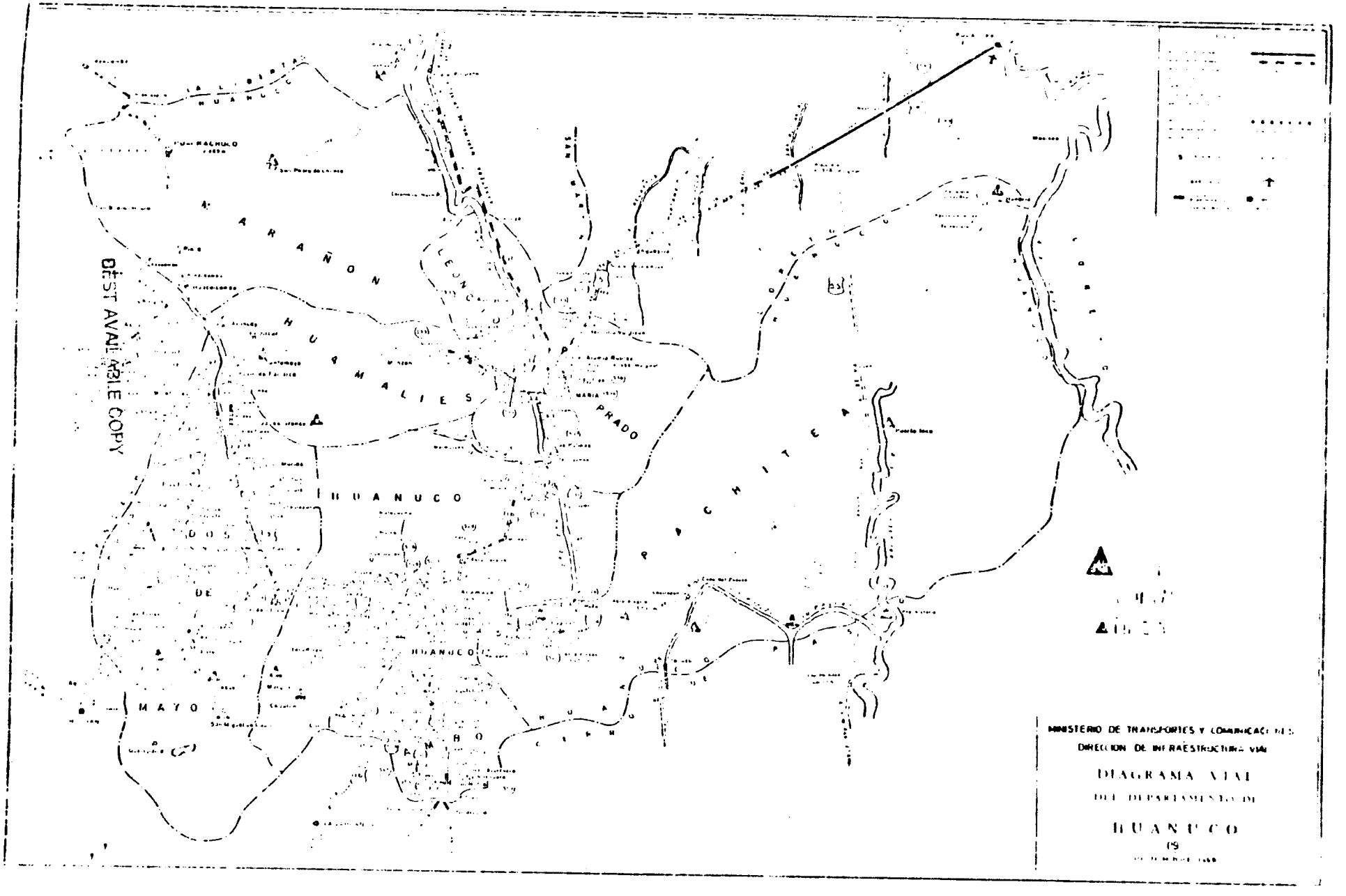

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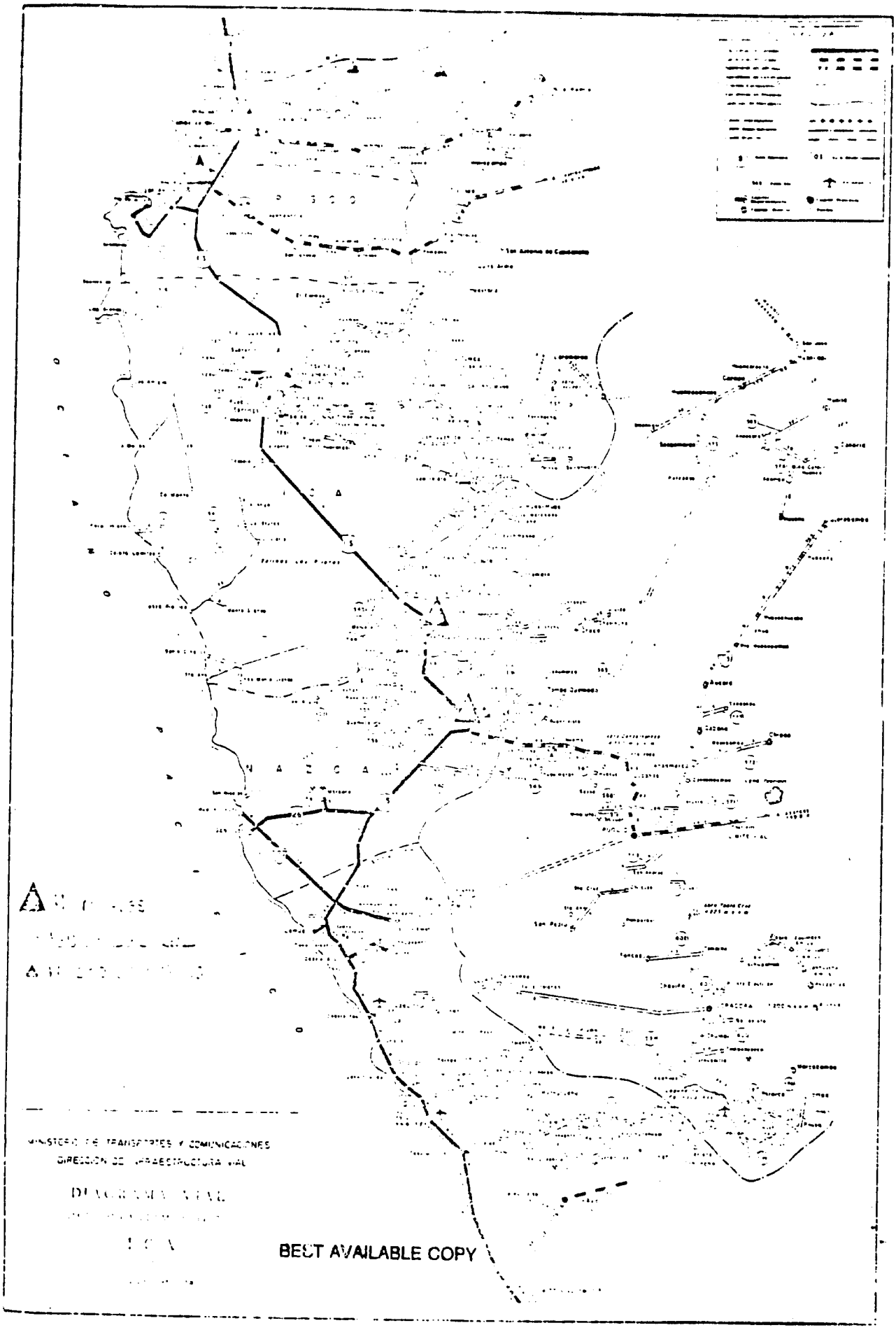

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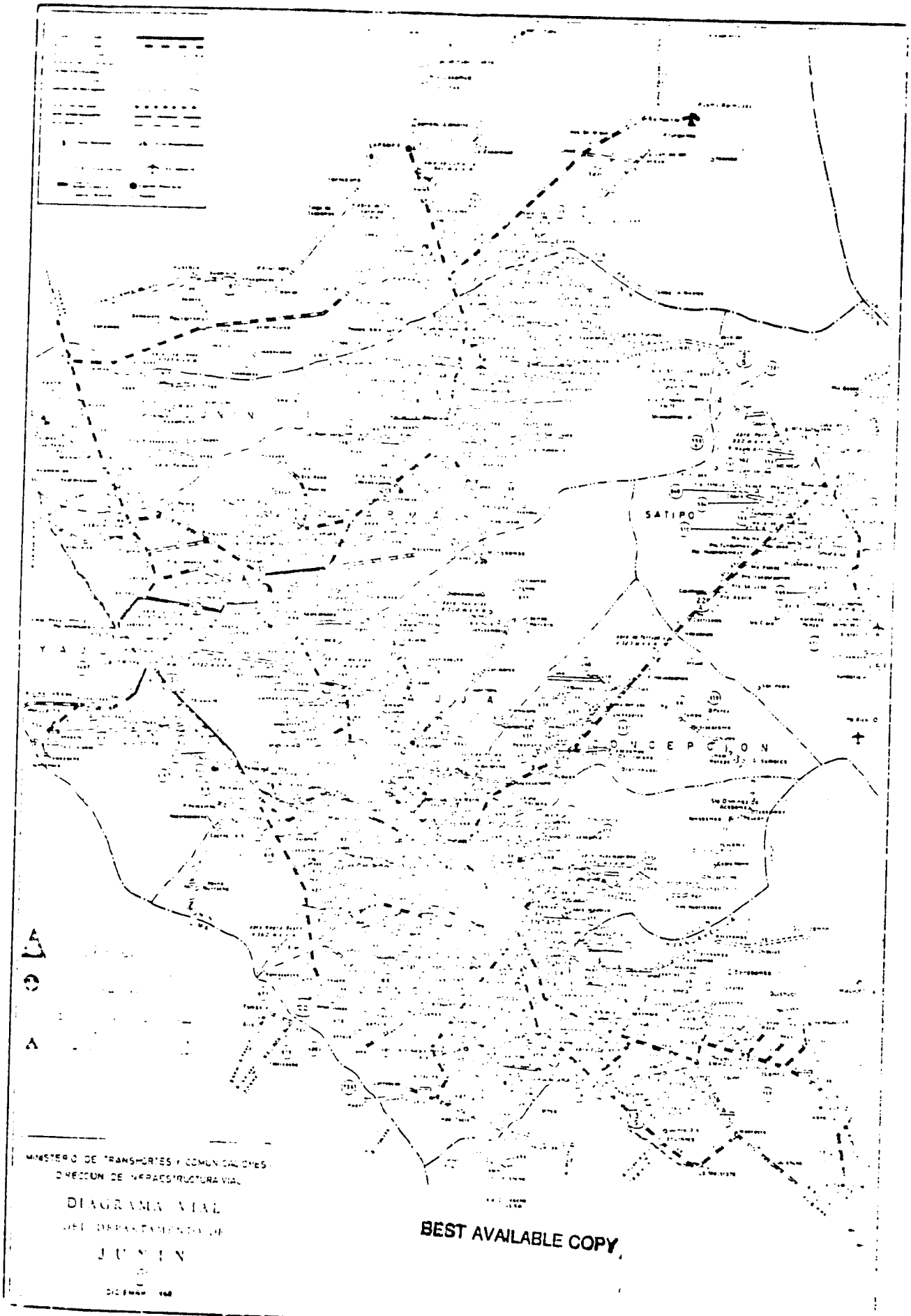

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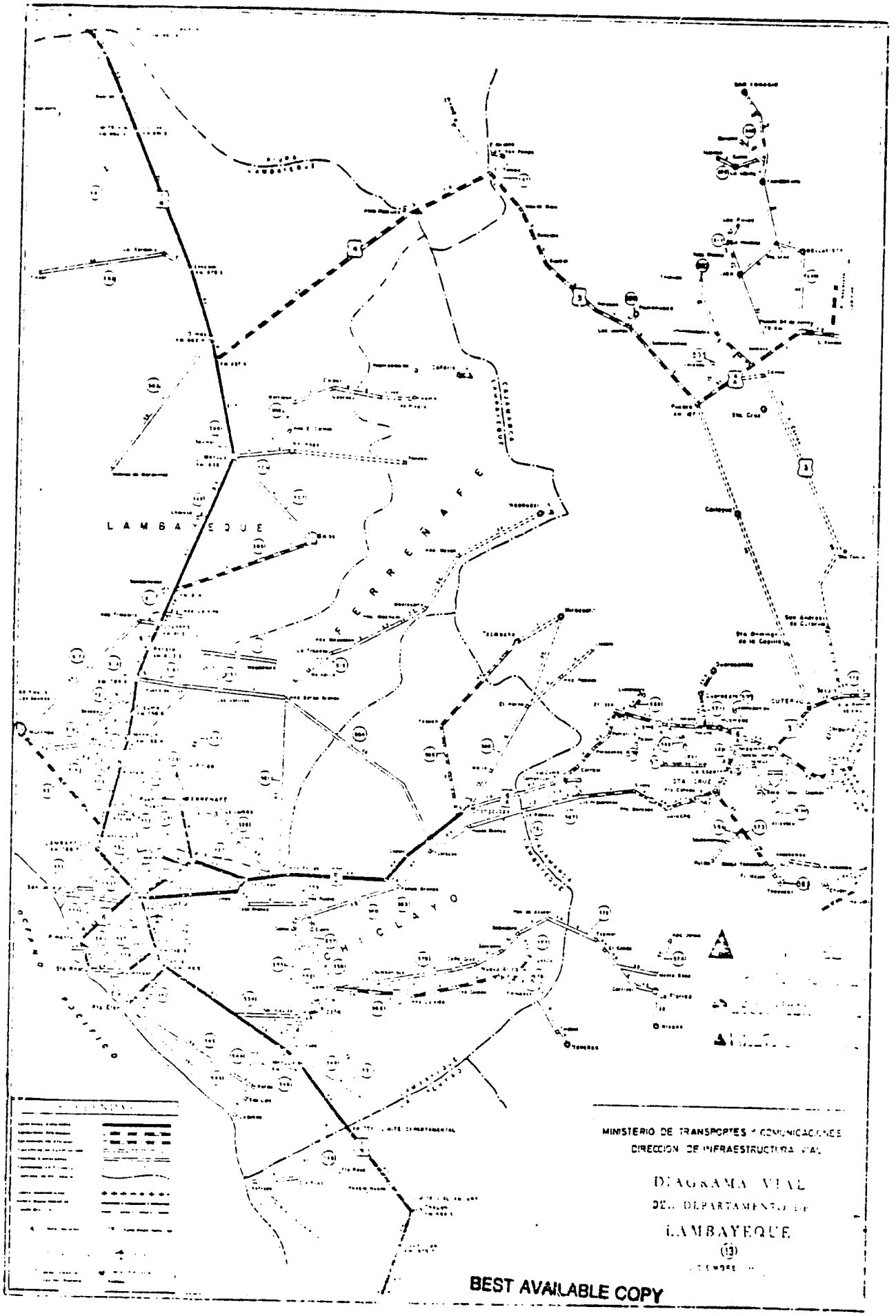

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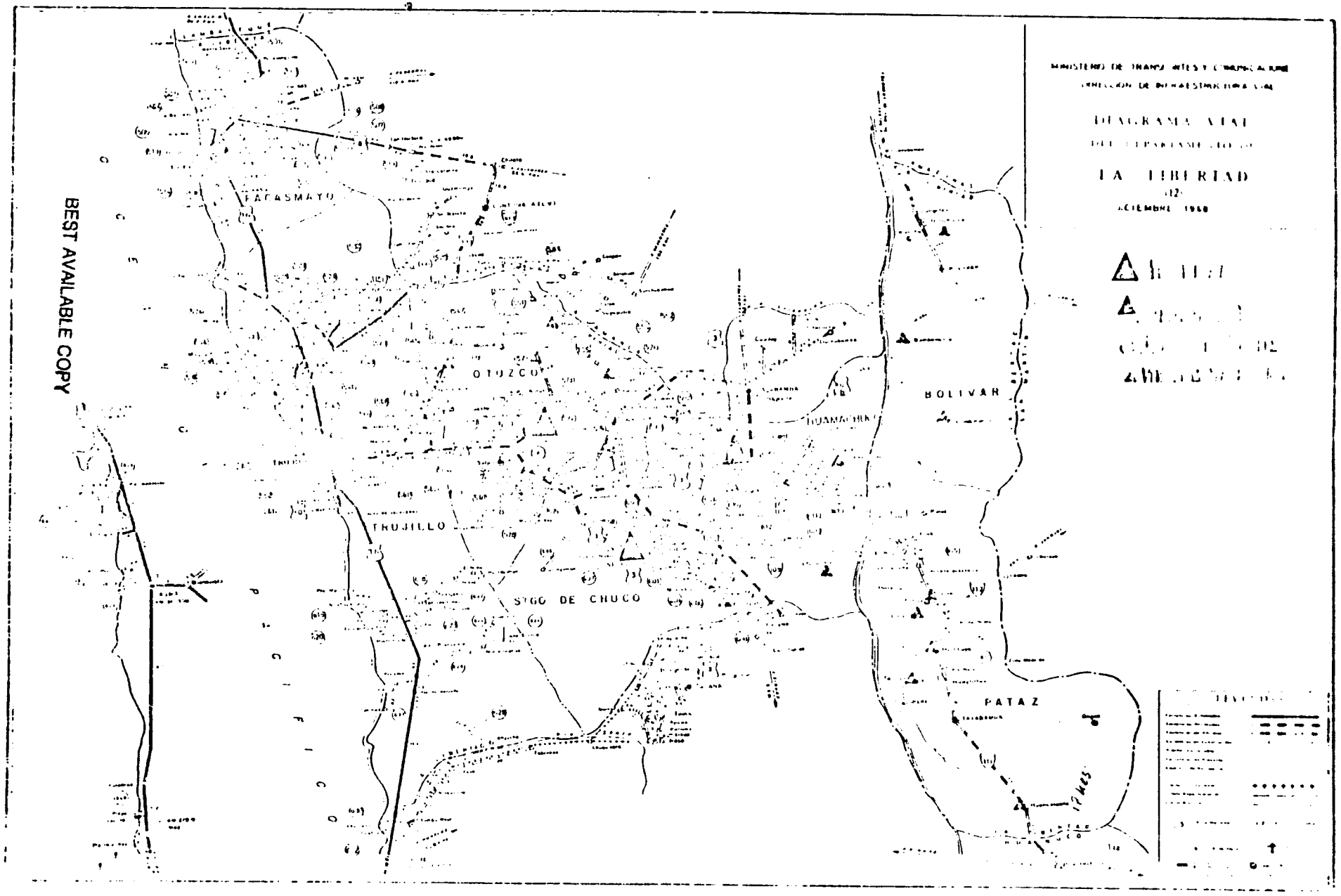

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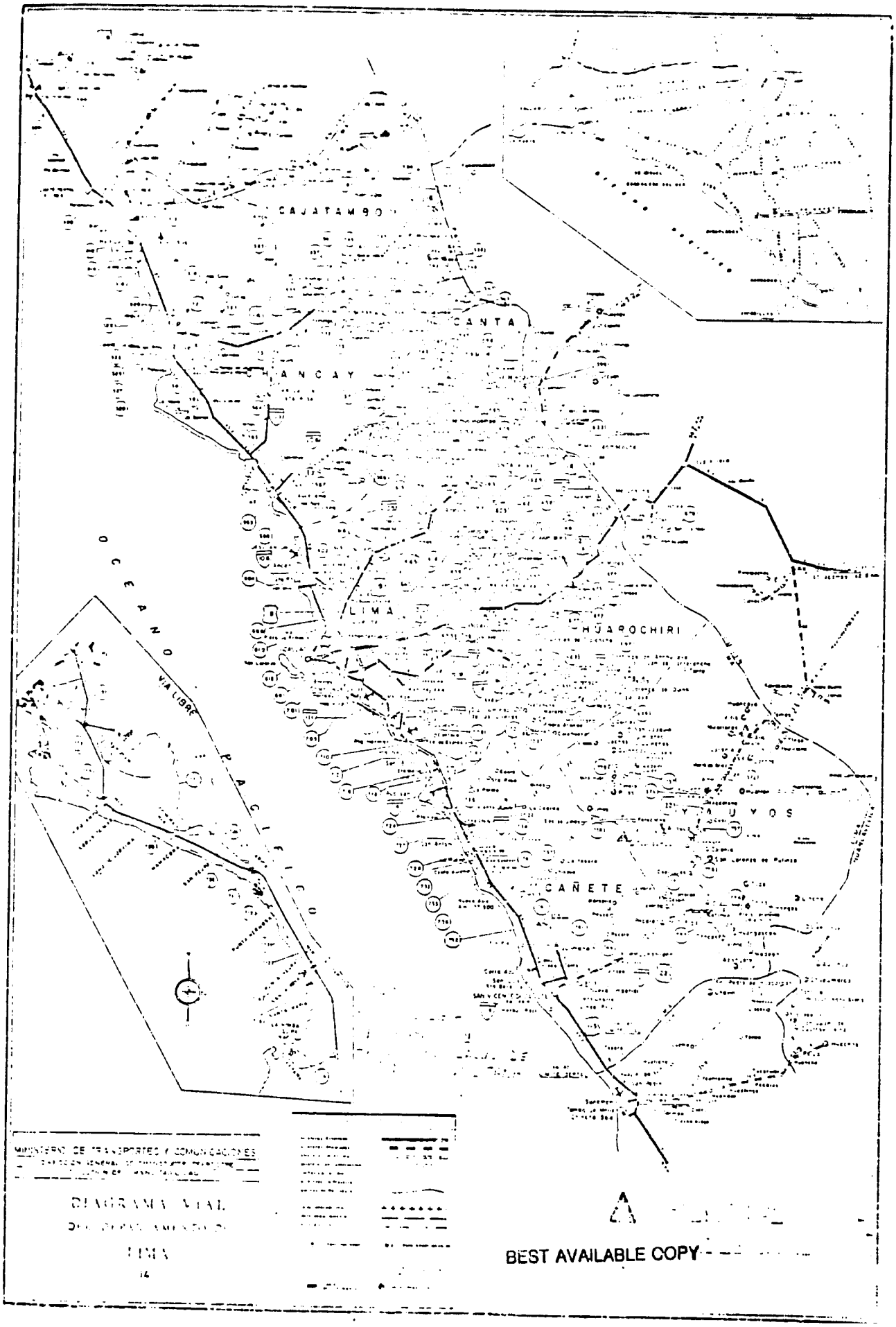

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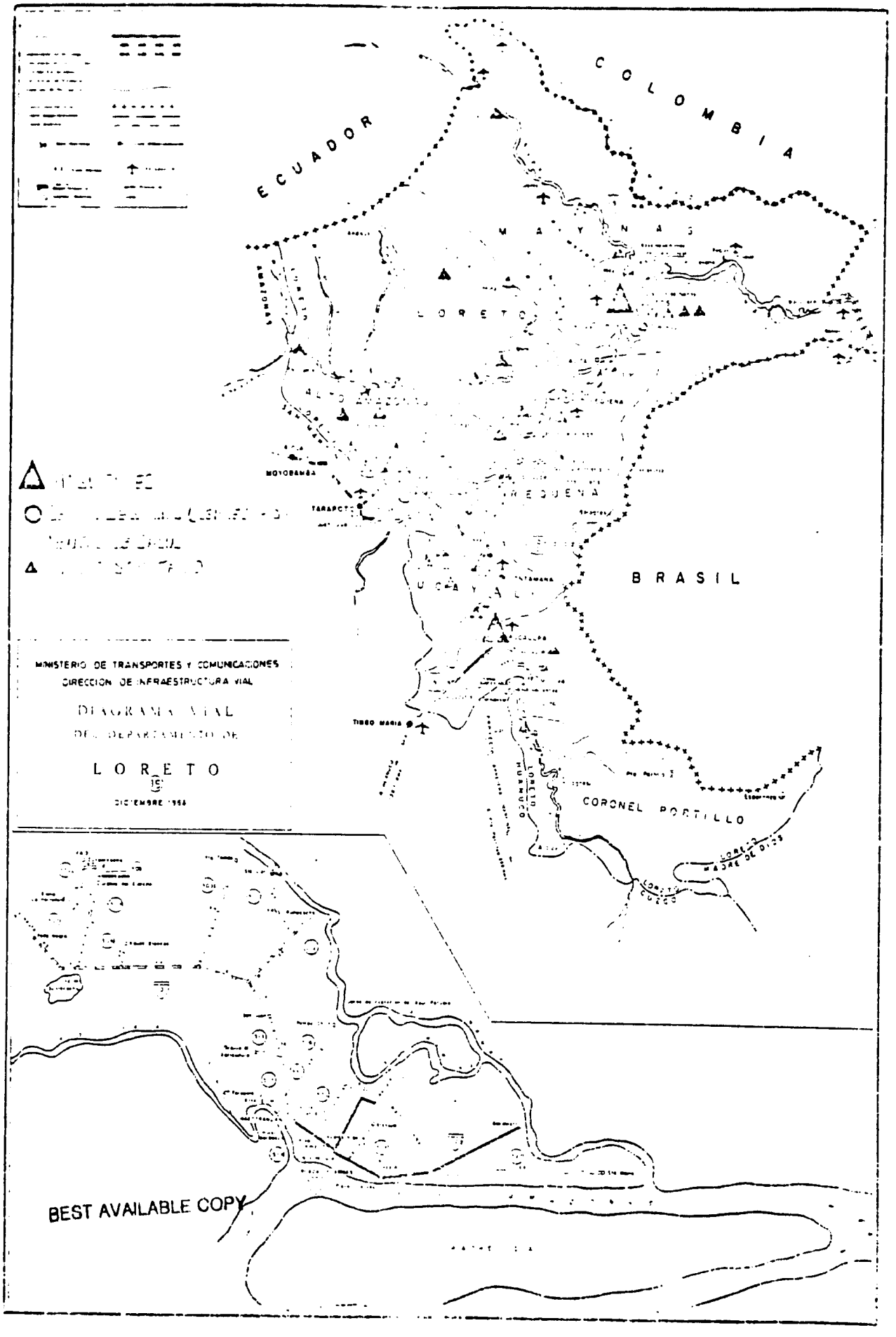

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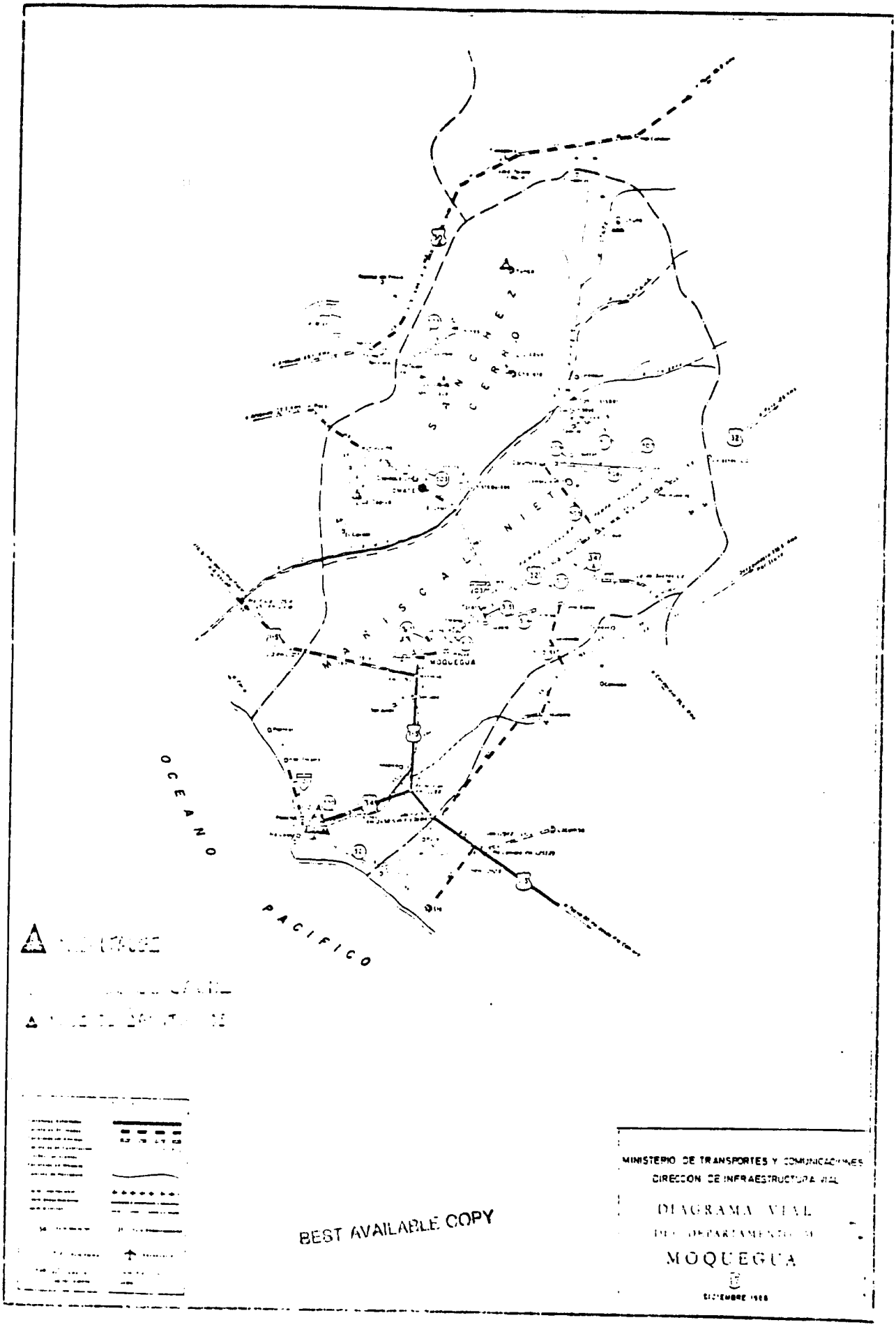

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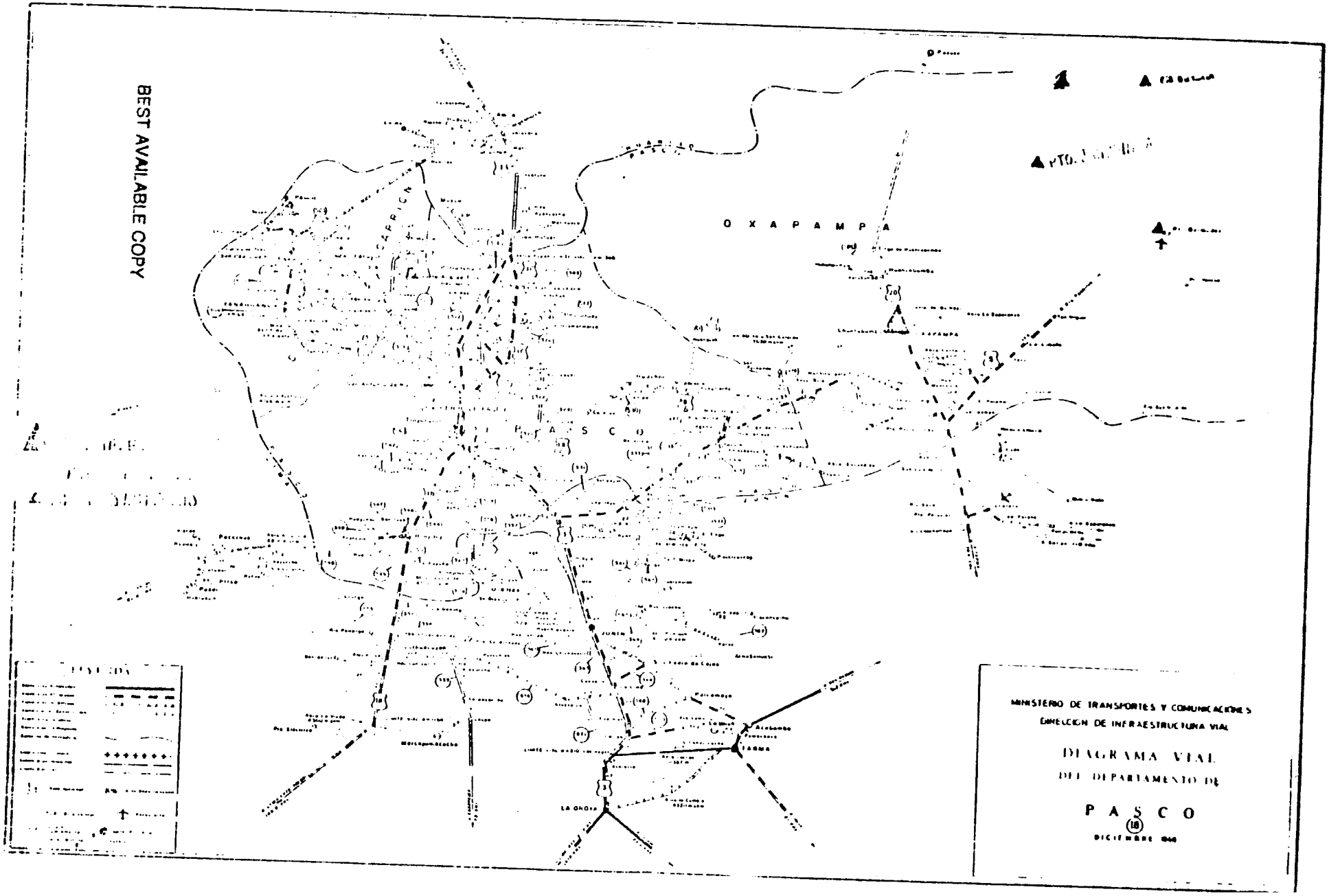

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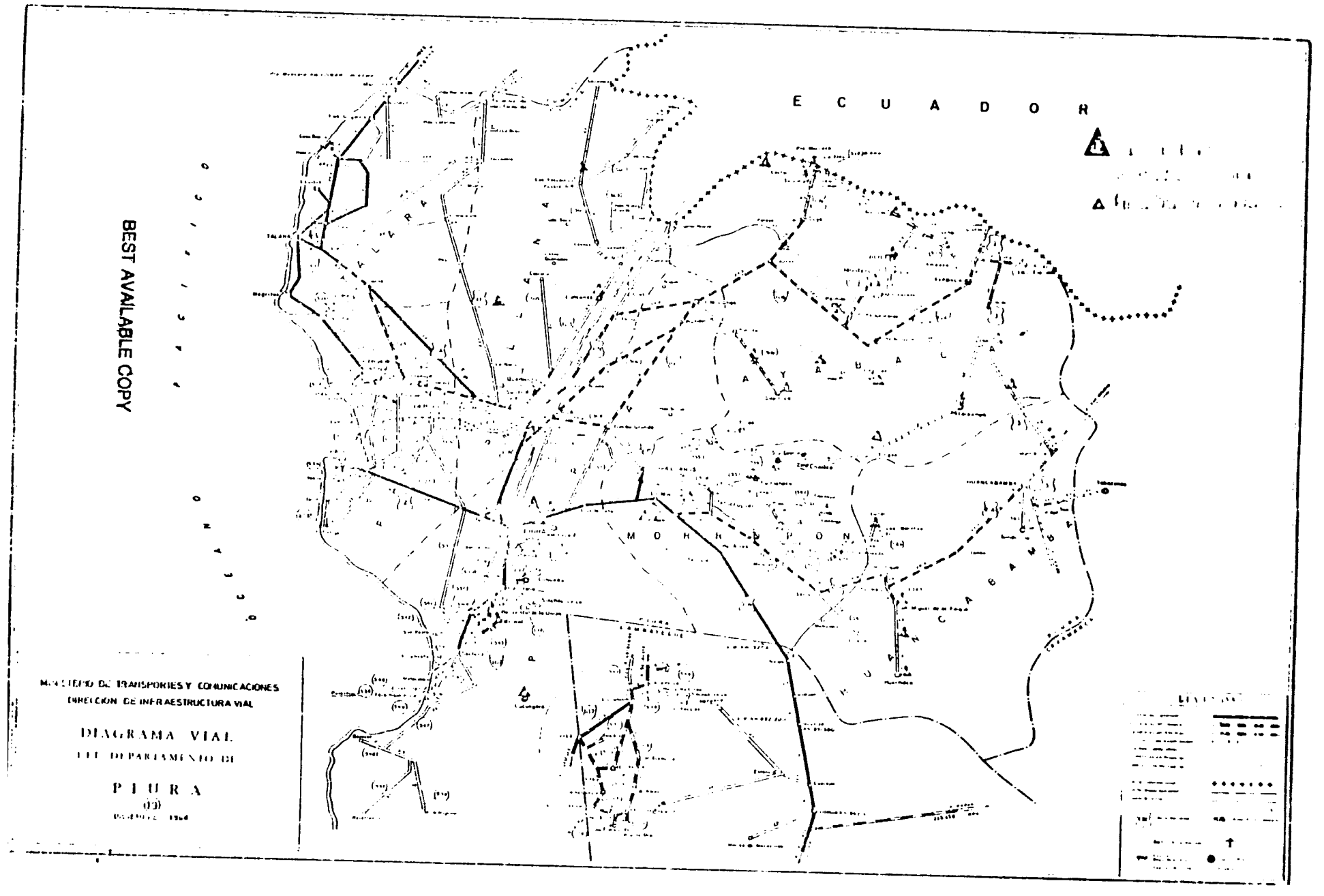

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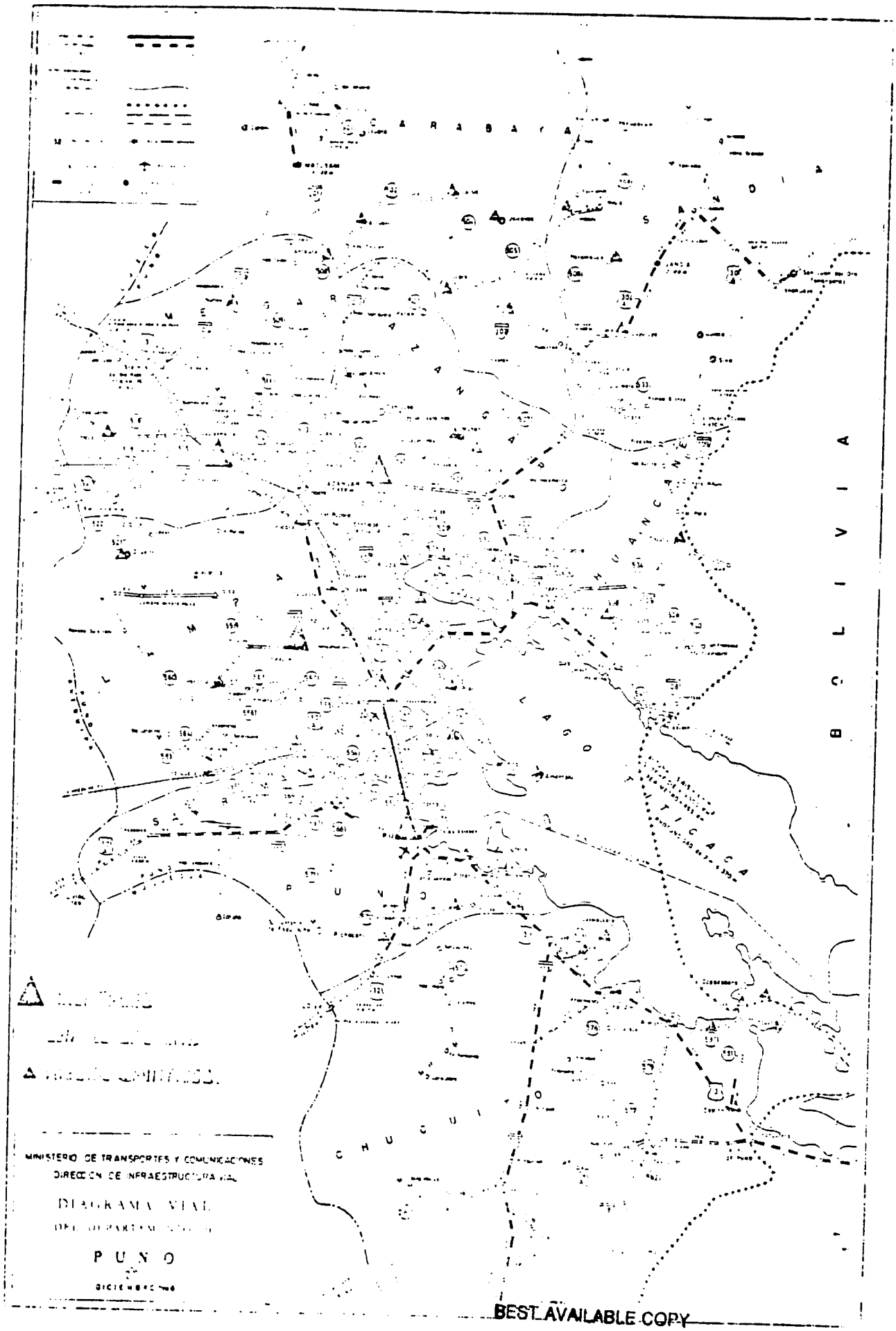

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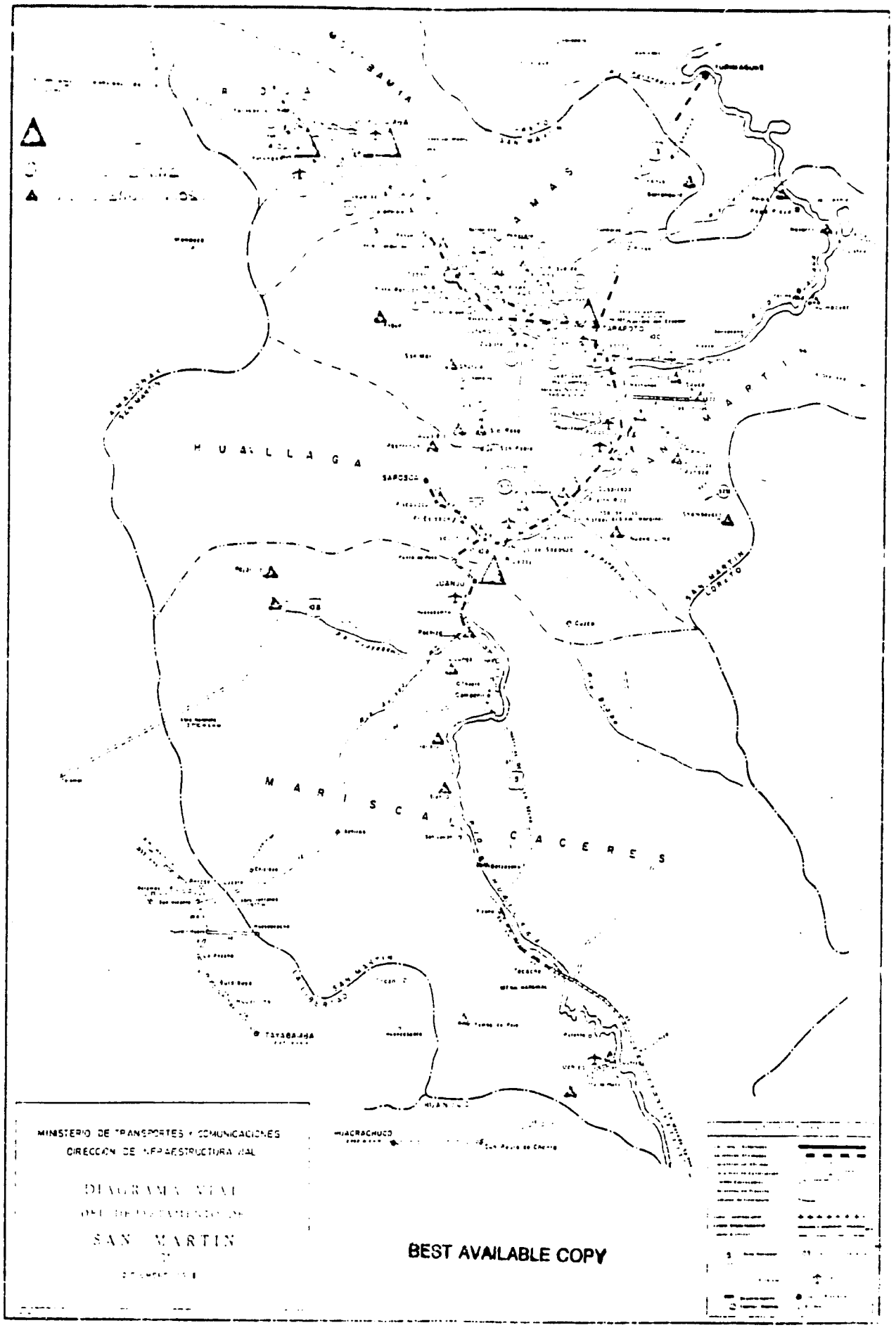

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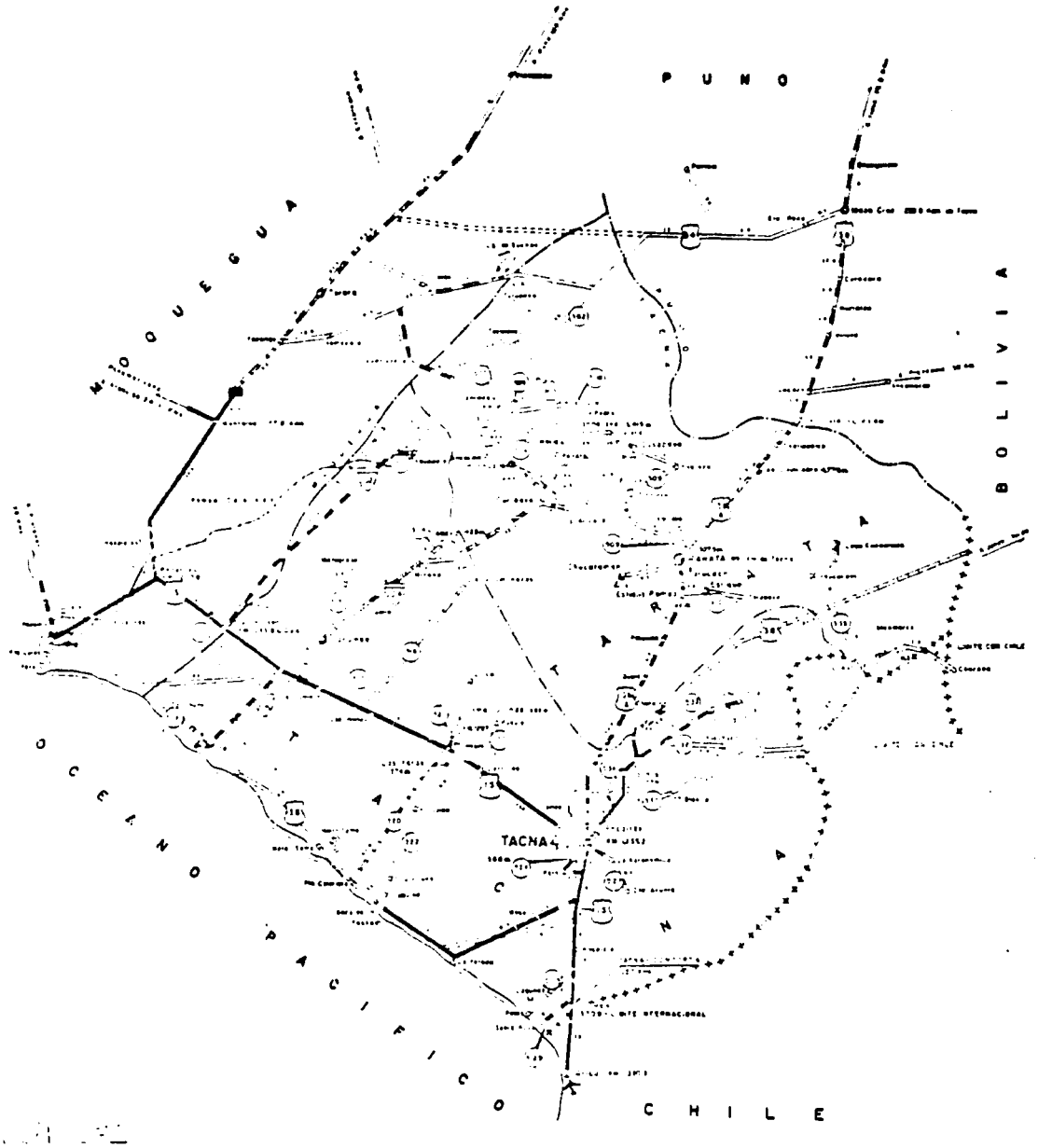

MINISTERIO DE TRANSPORTES Y COMUNICACIONES
DIRECCION DE INFRAESTRUCTURA VIAL

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ANNEX I

Mission Response to Project Related Issues - AID/W

1. Geographic Focus

The MOH refused to consider the possibility of pilot program support in several regions. The rational was reasonable from its perspective since there have been many so-called "pilot projects" resulting in a severe national level allocation disequilibrium of MOH resources. The GOP is committed to equalizing resource accessibility in rural areas and has emphasized its preference of reaching the entire Peruvian population with minimal level preventive services rather than providing grandiose health services to a few. The AID-funded Sur Medio Project in Maternal Child Health and Population was the last pilot project approved under the current MOH administration.

Since this Project has a comprehensive scope and includes ample support for experimentation in delivery systems, fees, evaluation activities and family planning innovations, it will serve as a basis for experimentation for the MOH's large scale national program. Implementation has already begun in the Sur Medio Project in critical areas of training, information, financial planning and baseline surveys, since Sur Medio implementation will be approximately six months ahead of each stage of execution in the present project, the Mission and MOH.

Each Region will develop its own operational plan which will be approved as a condition precedent to project implementation at the regional level. Thus, in reality, the national program will be implemented in a rational incremental manner to assure efficient and effective utilization of resources.

2. Population Strategy

The Project provides an excellent opportunity to accelerate GOP efforts to operationalize its population policy. The implementation of the Project will assure availability of family planning education within the GOP's integrated primary health care plan.

The Mission has recognized that a rural health delivery project in no way meets the needs of the whole population. Therefore, the Mission has requested and received approval for inclusion in the project of a marginal urban area demonstration area to implement a community based Integrated Primary Health program within one large Lima pueblo joven (500,000 population). Thus, the strategy of the Mission is to demonstrate the demand of services within the marginal urban areas, paving the way for a large scale marginal urban Integrated Primary Health program in FY '80 or '81.

3. Financial Analysis

(See financial plan)

4. Counterpart Funds

(See financial plan)

5. Relationship with other AID and Donor Projects

(See Strategy)

This Project in no way duplicates the UNFPA Project. First, the UNFPA Project includes hospitals and health centers closest to the Regional Hospitals, while the A.I.D. Project focuses upon the community level, sanitary posts and health centers in the least accessible areas. Moreover, the UNFPA project has been seriously delayed (now for over four years) and current distribution of supplies, contracting of personnel and equipment is enmeshed in a series of political, administrative and legal problems which will not be resolved in the near future.

The Mission has coordinated with PAHO in relation to the information system and anticipates no serious problems in the implementation of the national information system. The baseline survey has been coordinated with ONE and no problems are anticipated since all data and questions have been syncronized with the World Fertility Survey.

If UNFPA ever resolves its problems with contraceptive and equipment distribution and is prepared to initiate community level activities as part of their overall plan, USAID will then collaborate on the designation of remaining rural areas to be served as part of the FY 80 loan and grant.

Any condition precedent in relation to UNFPA activities is hopelessly premature at this stage and for the foreseeable future.

6. Implementation Arrangements

(See detailed description and implementation)

7. Intragovernmental Relations

The Health Region in the areas of decentralized regional development is an independent health region and not dependent on the MOH for major policy and program decision making at the Regional level. However, these regions function in relation to norms and policies set by the Central level MOH, especially in relation to MOH project funds. Thus, for purposes of this project, the health regions will function in a similar manner under approved Regional Operational Plans utilizing equipment and medicine provided in the project. Each Regional Project implementation

will necessarily reflect Regional priorities and operating styles. Moreover, many of the Regions supported under the decentralized system obtain resources directly for limited regional based activities and often have more effective coordination with other sectors, especially at the community level.

8. Commodities

A condition precedent has been included in the project. Moreover, plans are approved and underway to have the consultant services of CDC staff experts in logistics to assist the MOH before the project is ready for implementation.

9. Communications Equipment - dropped

10. Social Analysis - See section

ANNEX J

EQUIPMENT ANNEX

Budget - Summary of Equipment for Health Post

1.	Office equipment	260
2.	Medical equipment	790
3.	Cold chain	600
4.	Supplies and Expendable Property	100
5.	Supplies and Non-Expendable Property	600
6.	Other basic equipment	200
7.	Furniture	50
	Cost Per Post	2,600

Furniture (Local Purchase)

Benches to seat four people	2
Night table	1

Office Equipment
(Local Purchase)

Small Desk	1
Steel Chairs	3
Cabinet for documents and files	1

Medical Equipment
(Local Purchase)

Medical cabinet	1
Instrument cabinet	1

Single Bed with head board	1
Double panel screen	1
Dressing cart	1
Examining table	1
Stand for intravenous application	1

Cold Chain
(Local Purchase)

Refrigerator	1
Thermal Boxes	1

NON-EXPENDABLE PROPERTY
(foreign purchase)

Dressing jar	2
Pus basin 475	2
Irrigator-complete	1
Tensiometer HG	1
Biauricular stethoscope	1
Fetoscope	1
Instrument tray	1
Adult scale with meter	1
Pediatric scale	1
Dressing forceps	1
Dissecting scissors 15 cms	2
Sterilizer forceps 21 cms	1
Mosquito forceps	2
Kelly forceps	2
Straight surgical scissors 14 cms	2
Medium-Size Graves speculum	2
Surgical Blade Handle	1
Probes	1
Directors enucleators	1
Otoscope	1
Metal tongue depressors	1
Streel bedpan	1
Steel urinal	1

Hand brush	1
Oral Thermometer	3
Rectal Thermometer	3
Hypodermic syringe 10cc	2
Hypodermic syringe 5 cc	5
Hypodermic syringe 2 cc	10
Rubber bulb 30 cc	1
Surgical blades	1 doz
Straight suture needle 75 mm	6
Tuberculin syringe	4
Hypodermic needles	3 doz
Inoculating loop	1
Bunsen burner	1
Slides	150
Rectal tube 20	1
Rectal tube 24	1
Melaton tube 14	2
Flashlight	1
Suture needle, circle	6
Gloves	3 doz

MISCELLANEOUS (local purchase)

plastics, equipment, furniture

FSC - GSA Supply
Catalog 1977

MINIMUM EQUIPMENT FOR PROMOTOR

(Foreign purchase)

6 each	Oral and rectal thermometers
1 each	Metric tape
1 each	Flashlight
24 each	Battery 1.5 v.
1 box	Cover glass

- - - - - - -

1 each	Needle holder
1 each	Dissecting scissors with teeth
2 each	Mosquito forceps, straight and curved
1 each	Straight scissors
1 box	Razor blade
12 each	Suture thread and needles
10 each	Hypodermic syringes of 2, 10 and 20 cc.
36 each	Hypodermic needles
1 each	Metal dispenser for 20 cc syringes
2 each	Trays with lid
1 each	Stainless steel drum
1 each	Allis Forceps
1 each	Kerosene stove

- - - - - - -

1 each	Back pack
1 each	Soap dispense

1 each	Surgeon's hand brush
1 each	Notebook and report forms

Supplies (local purchase)

100 cc.	Alcohol
100 cc.	Benzene
100 cc.	Hydrogen peroxide
50 cc.	Mecurochrome
50 cc.	Iodine
50 cc.	Gencian Violet
1 bot.	Sulfa (powder)
1 bot.	Salve
1 bot.	Butesin Picrate
1 roll	Cotton, 113 grm.
10 each	Gauze, 76 x 76
1 roll	Adhesive tape
2	Soap

MINIMUM EQUIPMENT FOR TRADITIONAL MIDWIFE
(foreign source)

1 each	Sterilization pan 222 x 82 x 41
1 each	Kerosene stove
1 each	Spring pediatric scale, 7 kls.
1 each	Measuring tape
1 each	Cases for midwives
1 set	Circular trays
1 each	Transparent plastic apron
1 each	Transparent plastic bag
1 each	Plastic sheet, 2 yards
1 each	Dropping bottle
1 each	Bottle with screw cap
1 each	Surgeons' hand brush
1 roll	Non-Sterile absorbent cotton, 113 grs.
20 each	Non-sterile gauze
1 each	Plastic soap dispense
2 each	Band Soap (80 grs.)
2 each	Towels 30 x 51 cms.
1 each	Forcep
1 each	Round edge scissors (14 cms.)
2 each	Frabric caps
1 box	Sticks, nail cleaners
4 each	Flashlight
1 each	Battery

1 each	Vinyl folder
1 each	Sterile cord 1.50
1 tube	Ophtalmic ointment
1 each	Rubber aspiration bulb

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Supplies (local purchase)

100 cc.	Alcohol
100 cc.	Hydrogen peroxide
100 cc.	Mecurochrome
50 cc.	Iodine
50 cc.	Gencian Violet
1 bot.	Sulfa (powder)
1 roll	Adhesive tape, 1 inch

OTHER STATISTICAL TABLES

Annual Food Consumption Per Capita
in Kilos

M.E.F. M-Alim (1971-72)

Products	Lima		Rural Areas	
	kilos/year	grs/days	kilos/year	grs/day
White Potato	42	115	100	270 per day
Fresh milk	40	109	10	30
Common rice	30	82	16	40
French style bread	28	76	4	10
Refined sugar	19	52	4	10
Beef	15	41	3	10
Onion	13	35	4	10
Spaghetti	12	32	7	20
Other bread	5	13	9	20
Yucca	3	8	17	50
Brown sugar	1	2	11	30
Dry corn	-		16	40

Percentage Distribution of Food Consumption

Per Capita in Peru (1971 - 72)

	Peru	Lima	Rural Area
Potatoes	31.2%	14.2%	45.2%
Cereals and by-products	23.5	21.9	23.8
Vegetables and by-products	8.4	13.1	5.2
Milk and by-products	7.6	14.1	3.4
Meat	5.7	7.6	3.4
Fruits and by-products	5.7	10.6	2.3
Sugar and by-products	5.1	5.0	4.6
Legumes	4.1	3.1	4.6
Liquor	1.9	1.2	2.5
Fish and seafood	1.8	3.4	0.7
Others	5.0	5.8	4.3
T O T A L	100 %	100 %	100 %

Analysis of family expense structure,
Agreement MEF-ENCA

Percentage Distribution of Food Expense

Per Capita

Peru 1971 - 72

	Rural Area	City of Lima	Peru
Cereals and by-products	27.5	17.9	22.5
Tubers and roots	24.1	5.5	13.2
Others *	18.1	19.9	19.5
Meat	14.1	27.7	22.6
Legumes	6.1	3.0	4.3
Milk and by-products	4.7	11.7	8.0
Vegetables and by-products	3.7	7.2	5.5
Fruits and by-products	1.7	7.1	4.4
T O T A L	100.0	100.0	100.0

Family expense analysis
Agreement MEF - ENCA

* Including oils, fats, sugars, fish, seafood, soda water, infusions, eggs, liquors, spices and salt.

INMUNIZATIONS - N° OF CHILDREN TO BE VACCINATED

VACCINE DOSES TO BE APPLIED

	1979	1980	1981	1982	1983
Total Population of Children per year	285.2	270.3	272.0	273.6	275.2
Population of Children to be immunized per year	74.3	134.8	199.6	243.9	275.2
10 - year old population	55.7	100.5	149.7	182.9	206.4
Antipolio (3 Doses)	222.9	404.4	598.8	731.7	825.6
Triple (3 Doses)	222.9	404.4	598.8	731.7	825.6
Anti measles (1 Dose)	74.3	134.8	199.6	243.9	275.2
BCG (1 Dose) First Vaccine	74.3	134.8	199.6	243.9	275.2
BCG (1 Dose) Reinforcement	55.7	100.5	149.7	182.9	206.4

Ten Primary Causes of Morbidity in Infants under One Year According to Hospital Records - Peru 1977*

Cause	Number
Enteritis	6,247
Pneumonia	2,584
Other causes of stillborn births	1,766
Symptoms of disease condition, not clearly defined	1,239
Congenital lesions/anomalies at birth	1,387
Enemias	482
Meningitis	390
Fractures, burns, etc.	349
Measles	345
Tuberculosis	141

Source: Monthly Statistical Bulletins - Statistical Department, Ministry of Health (January to October, 1977).

Note: Data for November and December, 1977 furnished by Statistical Office.

* Hospitals only, doesnot include centers, posts or unreported incidence.

Ten Primary Causes of Morbidity in Infants from 1 to 5 Years Old According to Hospital Records - Peru 1977.

Cause	Number
Enteritis and other diarrheic conditions	2,829
Fractures, burns, adverse effects from chemical substance and other traumatisms	2,414
Pneumonia, bronchitis and influenza	1,910
All other infectious and parasitical diseases	875
Anemias	723
Measles	683
Systems of disease not clearly defined	663
Appendicitis, intestinal obstruction, hernias	343
Tuberculosis	332
Congenital anomalies	327

Source: Statistical Department - Ministry of Health

NUMBER OF HEALTH CENTERS AND EFFECTIVE BEDS PER HEALTH REGIONS ACCORDING TO ITS TYPE

MINISTRY OF HEALTH - PERU 1978

HEALTH REGIONS	HOSPITALS N°	HOSPITALS BEDS	HEALTH CENTERS N°	HEALTH CENTERS BEDS	SANITARY STATIONS N°	OTHERS N°
	107	15,327	403	625	1,154	6
NORTH WESTERN	11	797	70	58	232	1
MIDNORTHERN	23	1,610	55	74	107	2
ORDELORETO	3	411	10	49	78	
MID EASTERN	3	350	6	36	57	
CENTER	10	916	58	76	150	
MID SOUTH	7	613	20	-	58	1
SOUTH WESTERN	8	1,767	26	51	98	
SOUTH EASTERN	8	1,131	25	63	155	
SOUTHERN PLATEAU	5	344	15	124	90	
SAN MARTIN	4	216	10	-	98	
LIMA	25	7,172	108	94	31	

SOURCE: BASIC INFORMATION ON HEALTH INFRASTRUCTURE 1978
PLANNING SECTORIAL OFFICE M.H.

PERSONNEL BY HEALTH REGIONS ACCORDING TO ITS TYPE

MINISTRY OF HEALTH - PERU 1976

HEALTH REGIONS	TOTAL	PHYSICIANS	OBSTETRICIANS	NURSES	NURSE-AIDES	OTHERS
T O T A L	27,682	2,013	546	2,164	8,344	14,615
NORTH WESTERN	2,264	151	37	93	828	1,155
MID NORTHERN	2,627	153	46	147	795	1,485
CENTER	1,653	86	31	113	523	900
MID EASTERN	574	29	9	25	194	317
MID SOUTH	1,137	100	25	92	320	600
SOUTH WESTERN	2,604	216	39	225	827	1,297
SOUTH EASTERN	1,472	93	15	62	556	746
SOUTHERN PLATEAU	780	33	11	45	303	388
EAST	1,461	68	12	35	563	783
LIMA	13,110	1,084	321	1,327	3,435	6,943

MINISTERIO DE SALUD

ANEXO K

OFICINA SECTORIAL DE ESTADISTICA E INFORMATICA

FICHA FAMILIAR

Ambito Administrativo .....

Area Administrativa .....

Distrito de Salud .....

Localidad .....

Ficha Familiar Nº

Fecha de Inscripción: .....

I. JEFE DE HOGAR

Apellido Paterno	Apellido Materno	Nombre

Provincia	Calle	Nº	Int.	Manzana	Lote

II. COMPOSICION FAMILIAR

Nº DE ORDEN	APELLIDOS Y NOMBRES	RELACION CON JEFE FAMILIA	SEXO	FECHA DE NACIMIENTO			CAMBIOS DE FINITIVO	
				DIA	MES	AÑO	CLAVE	FECHA
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

III. CARACTERISTICAS DE LA VIVIENDA

	CONCEPTO	AÑOS				CONCEPTO	AÑOS		
TIPO DE VIVIENDA	Casa				ELIMINACION DE BASURAS	Enterrar			
	Casa Independiente					Incineración			
	Casa de Vecindad					Curso de agua			
	Chozas					Otros			
	Otros					Recolección Pública			
POSESION DE VIVIENDA	Propia				COCINA	Independiente			
	Alquilada					Compartida			
	Anticresis					Anticresis			
ABASTECIMIENTO DE AGUA	Red Pública Instalaciones Interior				ELIMINACION DE EXCRETAS	Inodoro			
	Pozo					Baño			
	Cisterna					Letrinas			
	Río					Río			
	Acequia					Campo			
	Manantial								

SESI [illegible]

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IV. VISITAS DOMICILIARIAS

FECHA	OBJETIVO	ACCIONES O RECOMENDACIONES REALIZADAS

INVENTARIO DE RECURSOS COMUNALES

I. RES[illegible] [illegible]:

LOCALIDAD .....

A[illegible] C[illegible]	☐ Sí ☐ No	Alumbrado Eléctrico	☐ Sí ☐ No	Mercado	☐ Sí ☐ No
P[illegible] A[illegible]	☐ Sí ☐ No	Puesto Sanitario	☐ Sí ☐ No	Tiendas	☐ Sí ☐ No
P[illegible] m[illegible]	☐ Sí ☐ No	Puesto Policial	☐ Sí ☐ No	Com. de Desarrollo Comun.	☐ Sí ☐ No
P[illegible] A[illegible]	☐ Sí ☐ No	Iglesia o Capilla	☐ Sí ☐ No	Salón Comunal	☐ Sí ☐ No
P[illegible] Río	☐ Sí ☐ No	Boticas o Farmacia	☐ Sí ☐ No	Huertos Comunales	☐ Sí ☐ No
[illegible] Correo	☐ Sí ☐ No	Cooperativa de Produc.	☐ Sí ☐ No	Huertos Escolares	☐ Sí ☐ No
Telégrafo	☐ Sí ☐ No	Hoteles o Posadas	☐ Sí ☐ No	Clubes Deportivos	☐ Sí ☐ No
Teléfono	☐ Sí ☐ No	Restaurantes.	☐ Sí ☐ No	Club de Madres	☐ Sí ☐ No

Viviendas con Refrigeradora Eléctrica . Viviendas con Refrigeradora a Kerosene

Escuela: ..... N° Maestros: ..... N° Grados: ..... N° Alumnos: .....

Escuela: ..... N° Maestros: ..... N° Grados: ..... N° Alumnos: .....

Recursos Naturales: .....

II. REGISTRO DE: Recursos Humanos.

APELLIDOS Y NOMBRES	DOMICILIO, CALLE, N°	EDAD-SEXO HOM.	FEM.	ESCOLARIDAD	ACTIV. QUE PRACTICA

SES: 504-79

movo.

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MINISTERIO DE SALUD

AMBITO ADMINISTRATIVO.....

AREA HOSPITALARIA.....

CENTRO SALUD.....

CENTRO BASE DE SALUD.....

OFICINA SECTORIAL
DE ESTADISTICA E INFORMATICA

1. FICHA DE LOCALIDAD (CARTOGRAMA)

LOCALIDAD

ENCUESTADOR

SIGNOS CONVENCIONALES

Carretera	Cerca	Puente
Camino	Río	Capilla
Cultivo Permanente	Montaña	Casa

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MINISTERIO DE SALUD

OFICINA SECTORIAL
DE ESTADISTICA E INFORMATICA

FICHA DE SIGNOS Y SINTOMAS DE ENFERMEDADES TRANSMISIBLES

CENTRO BASE DE SALUD ..... F.F.No. [ ][ ][ ][ ]

FECHA DE LA CONSULTA ..... FECHA PROBABLE DEL INICIO DE LA ENFERMEDAD .....

APELLIDOS Y NOMBRES .....

EDAD: ..... SEXO: Masculino [ ] 1

Femenino [ ] 2

FECHA DE DEFUNCION: .....

DOMICILIO: Distrito ..... Localidad .....

Calle ..... No ..... Manzana ..... Lote .....

	SINTOMAS Y SIGNOS PRINCIPALES	SI	NO		SINTOMAS Y SIGNOS PRINCIPALES	SI	NO
01	Fiebre (a)			13	Sensible a Ruboeos		
02	Escalofrios			14	Pus y ardor al orinar		
03	Sudoracion			15	Ulceras (Chancro en la piel, ulceras y genitales)		
04	Perdida de peso			16	Dolor de garganta		
05	Tos (b)			17	Zonas anestésicas y manchas en la piel		
06	Vómitos			18	Contracciones de boca		
07	Catarro Oculo-Nasal			19	Expectoracion (c)		
08	Conjuntivitis			20	Piel y conjuntivas amarillas		
09	Convulsiones			21	Parálisis de los miembros		
10	Hidrofobia (Rechazo el agua)			22	Otros síntomas (Especifique)		
11	Erupciones cutáneas (d)				.....		
12	Diarrea (e)				.....		

(a) Anotar temperatura en grados centígrados
(b) Paroxística quintosa con estridor (Coqueluchoide) (PQ)
(c) Blanco mucosa (BM), amarillo purulenta (AP), roja con sangre (RH)
(d) Manchas rojo perdusca o máculas (M), pápulas (Pa), ampollas (A) pústulas (PU), costras (C)
(e) Con moco (M), con sangre (S), pujo (P).

TIPO DE MUESTRA REMITIDA: .....

REMITIDO A: .....

IMPRESION DIAGNOSTICA POR EL AUXILIAR SANITARIO: .....

INDICACIONES DEL AUXILIAR SANITARIO: .....

.....

.....

NOMBRE DEL AUXILIAR SANITARIO: ..... Firma: .....

INFORME DEL MEDICO:

DIAGNOSTICO: .....

TRATAMIENTO INDICADO POR EL MEDICO: .....

FECHA DE DEVOLUCION AL CENTRO BASE DE SALUD: ..... [ ][ ][ ][ ][ ][ ]
D D M M A A

NOMBRE DEL MEDICO: .....

FIRMA DEL MEDICO: .....

SES 101-79

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INSTRUCCIONES GENERALES PARA EL DILIGENCIAMIENTO DE LA FICHA DE SIGNOS Y SINTOMAS DE ENFERMEDADES TRANSMISIBLES (SES: 101-70)

FINALIDAD

- Servir de Hoja Clínica que permita al Médico, conjuntamente con el resultado del análisis de la muestra recibida, diagnosticar la enfermedad que aqueje al paciente del Centro Base de Salud que hace la Inter-consulta.

DEFINICION DE TERMINOS

ENFERMEDADES TRANSMISIBLES

Son enfermedades debidas a un agente infeccioso específico o a sus productos tóxicos que se manifiestan por la transmisión de ese agente o sus productos del reservorio al huésped susceptible, ya sea directamente de una persona o animal, o indirectamente por conducto de una planta o animal huésped intermediario, de un vector o del ambiente inanimado.

CASO NUEVO

Se llama Caso Nuevo de una determinada enfermedad a la persona a quién se diagnostica y registra dicha enfermedad por primera vez en el período que dura el proceso evolutivo de la misma.

DISTRITO DE RESIDENCIA HABITUAL

Se denomina así al Distrito donde la persona ha establecido su hogar.

[illegible] ENERALES

- Debe diligenciarse esta Ficha cuando se trate de un caso nuevo de cualquiera de las siguientes enfermedades: Paludismo, Tuberculosis respiratoria, [illegible], Sífilis, Blenorragia, Peste, Viruela, Leishmaniasis, Lepra, Influenza.
- Esta Ficha (SES: 101) debe remitirse al Centro de Salud y Área Hospitalaria más cercana conjunta esta con la muestra [illegible].
- Al retornar la Prueba Médica, de la Ficha con el diagnóstico [illegible] se debe notificar esta [illegible] al Centro de Salud o al Área Hospitalaria [illegible].
- Para notificar el caso en el Formulario respectivo (SES [illegible]) [illegible] quienes [illegible] Difteria.
- [illegible] Difteria.

[illegible] DE LA [illegible]

[illegible]

[illegible] Anotar el número [illegible] en la Ficha Familiar [illegible] en la Ficha Familiar [illegible] Anotar la fecha probable de inicio de la Enfermedad. Anotar la fecha probable, teniendo en cuenta el perfil de incubación de la misma.

F.F. O: Anotar el número de la Ficha Familiar asignada a la familia.

Apellidos y Nombres: Anotar con letra de imprenta los solicitados y en el orden en que se indica.

Edad: Anotar la edad en meses o años cumplidos, seguida de la letra M o A respectivamente.

Sexo: Marcar con un aspa en el recuadro correspondiente.

Fecha de Defunción: Anotar lo solicitado en números arábigos.

Domicilio: Anotar lo más claramente posible la dirección de la persona, haciendo las indicaciones pertinentes que permitan ubicar rápidamente el domicilio.

4.2. Cuerpo del Formulario

Síntomas y Signos Principales: Anotar con un aspa en la columna NO cuando no exista el síntoma en referencia, cuando exista el síntoma que se solicita anotar con un aspa en la columna SI en los casos en que no se da un indicativo más preciso de lo que se solicita.

Síntomas más Importantes y muestras a remitir [illegible] al Análisis de Laboratorio:

PALUDISMO: Fiebre, escalofríos, sudoración profusa, este cuadro se repite [illegible], cada [illegible] días, [illegible] con el personal de Epidemiología [illegible] muestras de sangre [illegible] al Centro de Salud del cual depende.

[illegible]: Fiebre alta, tos, [illegible], erupciones cutáneas, [illegible] en la cara y [illegible] generalizada. [illegible] la enfermedad [illegible].

[illegible]: [illegible] al Centro de Salud.

RABIA HUMANA: Se [illegible] de tres [illegible] la mordedura con saliva y jugo.

Tipo de Muestra Remitida: Anotar si se trata de expectoración, [illegible] de [illegible] Anotar el nombre del Centro de Salud o Hospital al que se remitió la muestra.

Impresión diagnóstica por el Auxiliar Sanitario: Anotar la impresión diagnóstica de enfermedad de acuerdo a los síntomas y signos registrados, que [illegible] aqueje al paciente.

Indicaciones del Auxiliar Sanitario: Anotar las [illegible] indicadas.

Nombre del Auxiliar Sanitario: Registrar en letras de imprenta el nombre y sello del Auxiliar Sanitario.

Informe del Médico:

Diagnóstico: Será registrado por el Médico que hace la Inter-consulta.

Tratamiento indicado por el Médico: Anotar el tratamiento que el paciente debe continuar en su Centro Base de Salud.

Fecha de Devolución al Centro Base de Salud: Registrar en números arábigos el día, mes y año en [illegible] cuadros correspondientes.

Nombre del Médico: Registrar en letra de imprenta [illegible] del Médico que realizó la Inter-consulta.

[illegible] RESPONSABILIDAD DEL [illegible]

- El llenado de esta Ficha es de responsabilidad del Auxiliar Sanitario y debe llenarse cada vez que se presente un paciente con la sintomatología anotada en la Ficha [illegible] de la enfermedad [illegible].

- [illegible] PARA EL [illegible]

[illegible]

Si [illegible] por el Auxiliar Sanitario [illegible] Médico. El [illegible] del [illegible] Estadística [illegible] Área [illegible] del caso y [illegible] Ficha [illegible] documento fuente [illegible] Sexual (SES: 101) [illegible] Tuberculosis [illegible] Enfermedades [illegible].

Archivo

Las Fichas recibidas por el Establecimiento o Área con los diagnósticos definitivos debe archivarse en el Centro Base de Salud, específicamente en la Ficha Familiar del paciente.

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MINISTERIO DE SALUD

OFICINA SECTORIAL DE ESTADISTICA E INFORMATICA

ESTABLECIMIENTO .....

LOCALIDAD .....

FICHA FAMILIAR No

HOJA CLINICA

APELLIDO PATERNO	APELLIDO MATERNO	NOMBRE

I. VACUNACIONES

AÑO	B.C.G.		ANTIPOLIOMIELITICA ORAL TRIVALENTE			DIFTERIA PERTUSIS TETANOS (D.P.T.)			ANTISARAMPIONOSA	ANTITIFOIDICA		ANTITETANICA				ANTIHEPATITICA	ANTI-DOLICHA		OTROS	
												Gestantes		Otros						
	P.N.	R.N.	1a	2a	3a	1a	2a	3a		1a	2a	1a	2a	1a	2a		1a	2a	1a	2a
81-84																				

II. ATENCIONES

FECHA	EDAD	PESO	TALLA	TEMP.	PULSO	RESP.	P.A.	MOTIVO DE LA ATENCION Anotar diagnóstico, o síntomas y signos, tratamiento, condición de Madre gestante o Lactante, etc.

SES: 302-79.

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ATENCIONES

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	MOTIVO DE LA ATENCION Anotar Diagnósticos o Síntomas y signos, tratamiento, condición de madre, lactante o lactante, etc.

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AMBITO ADMINISTRATIVO .....

AREA HOSPITALARIA .....

CENTRO DE SALUD .....

CENTRO BASE DE SALUD .....

LOCALIDAD .....

REGISTRO DE ENTREGAS DE ALIMENTOS MEDICAMENTOS Y OTROS

MES ..... AÑO ....

FECHA	APELLIDOS - NOMBRES	CANTIDADES ENTREGADAS									
		ALIMENTOS		MEDICAMENTOS					ANTICONCEPTIVOS		
		MADRE	NIÑO	ANTI ANEMIC	ANTI PARASIT.	SUERO ORAL	VITAM.	OTROS	CICLO	COCOR.	

1

Ambito Administrativo.....

Area Hospitalaria.....

Centro de Salud.....

Centro Base de Salud.....

Localidad.....

.....

.....

F.Fam. N°.....

Nombre.....

.....

Enviado a .....

Fecha de envío.....

Motivo de la Transferencia.....

.....

.....

.....

.....

SES. 398-79.

2

TRANSFERENCIA

Ambito Administrativo.....

Area Hospitalaria.....

Centro de Salud.....

Centro Base de Salud.....

Localidad.....

F.Fam. N°.....

Nombre.....

Enviado a.....Fecha.....

Motivo de la Transferencia.....

.....

.....

.....

Nombre del Remitente Firma

INFORME DE LA ATENCION BRINDADA

Recibido en:.....

Servicio:..... Fecha.....

Atención realizada.....

.....

.....

.....

Tratamiento:.....

.....

Citado para:.....

Fecha Cita:.....

Nombre del Profesional que Atendió Firma

3

TRANSFERENCIA

Ambito Administrativo.....

Area Hospitalaria.....

Centro de Salud.....

Centro Base de Salud.....

Localidad.....

F.Fam. N°.....

Nombre.....

Enviado a.....Fecha.....

Motivo de la Transferencia.....

.....

.....

.....

Nombre del Remitente Firma

INFORME DE LA ATENCION BRINDADA

Recibido en:.....

Servicio:.....Fecha.....

Atención realizada.....

.....

.....

.....

Tratamiento:.....

.....

Citado para:.....

Fecha Cita:.....

Nombre del Profesional que Atendió Firma

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MINISTERIO DE SALUD

AMBITO ADMINISTRATIVO .....
AREA HOSPITALARIA .....
CENTRO DE SALUD .....

ESTABLECIMIENTO .....

[ ] C. BASE SALUD
[ ] COMUNAL

OFICINA SECTORIAL
DE ESTADISTICA E INFORMATICA

LOCALIDAD .....

Mes ..... Año .....

REGISTRO DIARIO DE ACTIVIDADES

	ACTIVIDADES	DIA DEL MES 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
MADRES	Gestantes Captadas.																																
	Gestantes, Parturientas y Puérperas Transferidas.																																
	Controles a Gestantes.																																
	Atención de Parto Normal.																																
	Control de Puerperio Normal.																																
	Exodoncia a Gestantes.																																
NIÑOS	Recien nacidos Captados.																																
	Recién Nacidos Transferidos.																																
	Control de Crecimiento y Desarrollo de Menores de 1 año (Sano)																																
	Atención a Menores de 1 año (Enfermo).																																
	Control de Crecimiento y Desarrollo de 1-5 años (Sano)																																
	Atención a niños de 1-5 años (Enfermo).																																
	Control de Crecimiento y Desarrollo 6-14 años. (Sano).																																
	Atención a niños de 6-14 años (Enfermo)																																
	Exodoncia a niños de 6-14 años.																																

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MINISTERIO DE SALUD

ESTABLECIMIENTO. ..... ☐ C.BASE SALUD ☐ COMUNAL

OFICINA SECTORIAL DE ESTADISTICA E INFORMATICA

LOCALIDAD .....

MES. ..... AÑO .....

REGISTRO DIARIO DE ACTIVIDADES

	ACTIVIDADES	DIA DEL MES																															TOTAL
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
ADUL.	Atención a Enfermos																																
	Exodoncias																																
SANEAMIENTO	Protección de manantiales																																
	Clorinacion de agua																																
	Instalacion de letrinas																																
	Eliminación adecuada de basuras (Obras sedrcanas)																																
	Mejoramiento de viviendas.																																
	Control de Zoonosis (perros eliminados)																																
VIGILANCIA	Sintomáticos transferidos																																
	BK muestras tomadas																																
	Seguimiento de TBC (atencion)																																
	Seguimiento de Venéreas (atencion)																																
	Seguimiento de																																
DESARROLLO COMUNAL	Huertos y Campos comunales formado																																
	Charlas educativas.																																
	Reuniones comunales.																																
	Empíricas captadas.																																
	Visita domicitiaria.																																

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MINISTERIO DE SALUD

ESTABLECIMIENTO..... [ ] C. BASE SALUD
[ ] COMUNAL

REGISTRO DIARIO DE ACTIVIDADES

DIRECCION SECTORIAL
DE ESTADISTICA E INFORMATICA

LOCALIDAD .....

MES..... AÑO.....

	ACTIVIDADES	DIA DEL MES																															TOTAL
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
INTIEGAS	Antianémicos																																
	Antiparasitarios																																
	Vitaminas																																
	Suero Oral																																
	Raciones para Madres																																
	Raciones para Niños																																
OTROS	Primeros Auxilios																																
	transferencias																																
	Curaciones																																
	Inyectables																																
	Cirugía Menor																																
HECHOS VITAL.	Nacimientos Ocurridos																																
	Defunciones Ocurridas																																
ASP. LEGAL	Reconocimiento Periciales																																
	Autopsias																																

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MINISTERIO DE SALUD

OFICINA SECTORIAL DE ESTADISTICA E INFORMATICA

INFORME MENSUAL DE VACUNACIONES

ESTABLECIMIENTO: ..... CODIGO: [ ][ ][ ][ ][ ] MES [ ][ ] AÑO [ ] HOJA NUMERO [ ][ ]

GRUPO ETAREO EN MESES Y AÑOS	a) B.C.G.		b) ANTIPOLIO ORAL TRIVALENTE			c) D.P.T.			d) ANTISA-RAMPION	e) ANTITETANICA Gestantes		ANTITETANICA Otros		f) ANTITI-FOIDICA		g) ANTIRRABICA	h) ANTICOLERA		i) OTRAS
	Pv	Rv	1 D	2 D	3 D	1 D	2 D	3 d		1 D	2 D	1 D	2 D	1 D	2 D		1 D	2 D	
00 TOTAL																			
01 - 3 Meses																			
02 3 - 5 Meses																			
03 6 - 8 Meses																			
04 9 - 11 Meses																			
05 1 Año																			
06 2 Años																			
07 3 Años																			
08 4 Años																			
09 5 Años																			
10 6 - 14 Años																			
11 15 - 44 Años																			
12 45 y más años																			

RABIA:

1. Personas Mordidas .....
2. Que Inician Vacunación .....
3. Que Completan Vacunación .....
4. N° Vac.Antirrábicas Colocadas .....

Nombre y Apellido del Responsable de la Elaboración

V° B° del Jefe del Establecimiento

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MINISTERIO DE SALUD

REGION DE SALUD .....

AREA HOSPITALARIA .....

OFICINA SECTORIAL DE ESTADISTICA E INFORMATICA

RESUMEN MENSUAL DE LA CONSULTA EXTERNA POR REGULACION DE FECUNDIDAD

ESTABLECIMIENTO ..... CODIGO [ ][ ][ ][ ][ ] MES [ ][ ] AÑO [ ][ ]

GRUPO DE EDADES	CONSULTAS								CESI			
	PRIMERAS				SUB-SIGUIENTES							
	D.I.U.	PILDORA	CONDON	OTROS	D.I.U.	PILDORA	CONDON	OTROS	D.I.U.	PILDORA	CONDON	OTROS
-15 años												
15-19 años												
20-24 años												
25-29 años												
30-34 años												
35-39 años												
40-44 años												
45 y más años												

SPS: 227

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AMBITO ADMINISTRATIVO
AREA HOSPITALARIA .....
CENTRO BASE DE SALUD .
LOCALIDAD ..

RESUMEN DEL CENSO DE POBLACION Y VIVIENDA

FECHA .....

No. DE ORDEN	No. DE F. FAMILIAR	POBLACION																VIVIENDA																												
		NIÑOS					MUJERES 15-49					HOMBRES 15-49	AMBOS SEXOS		TODAS LAS EDADES			TIPO DE VIVIENDA				DORMT.			ABASTECIMIENTO DE AGUA						ELIMINACION BASURA						COCINA			ELIMINACION EXCRETA					
		- 1 año	1-4	5	6-14	TOTAL	Primeras Madres	Puerperas		Otras	TOTAL		50-64	65 y más	Masculino	Femenino	TOTAL	Casa Independiente	Casa Vecindad	Choza	Otra	No.	No. Cuartos	Animales	Red Pública	Pozo	Aljibe	Río	Arroyo	Manantial	Enterrar	Incinerar	Quemar	Recolectar	Fosa	Otro	Indep.	Jerarq.	Arrimados	Inodoro	Retirados	Letrinas	Río	Campo

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No. DE ORDEN	No. DE F. FAMILIAR	POBLACION — NIÑOS					MUJERES 15-49					HOMBRES 15-49	AMBOS SEXOS		TODAS LAS EDADES			VIVIENDA — TIPO DE VIVIENDA				DORMT.			ABASTECIMIENTO DE AGUA						ELIMINACION BASURA					COCINA			ELIMINACION EXCRETAS				
		< 1 año	1-4	5	5-14	TOTAL	Embarazadas	Puérperas		Otras	TOTAL		50-64	65 y más	Masculino	Femenino	TOTAL	Casa independiente	Casa vecindad	Choza	Otros	No.	No. camas	Animales	Red pública	Pozo	Lluvia	Río	Acequia	Manantial	Entierro	Incinerada	Carro aseo	Campo	Recolección priv.	Indep.	En dormitorio	Animales	Inodoro	Notadero	Letrinas	Río	Campo
	TOTAL																																										

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MINISTERIO DE SALUD

OFICINA SECTORIAL
DE ESTADISTICA E INFORMATICA

AMBITO ADMINISTRATIVO .....
AREA HOSPITALARIA .....
CENTRO BASE DE SALUD .....

INFORME ..... DE ACTIVIDADES

	ACTIVIDADES	TOTAL Aux.San Especial	TOTAL Promotor
MADRES	Embarazadas Captadas		
	Gestantes, Parturientas y Puérperas Transferidas		
	Controles a Gestantes		
	Atención de Parto Normal		
	Control de Puerperio Normal		
	Exámenes a Gestantes		
NIÑOS	Recién Nacidos Captados		
	Recién Nacidos Transferidos		
	Control de Crecimiento y Desarrollo menores de 1 año (Sano)		
	Atención de Menores de 1 año (Enfermo)		
	Control de Crecimiento y Desarrollo de 1-5 años (Sano)		
	Atención a niños de 1-5 años (Enfermo)		
	Control de Crecimiento y Desarrollo 6-14 años (Sano)		
	Atención a niños de 6-14 años (Enfermo)		
	Exámenes a niños de 6-14 años		
S.T.	Atención a Enfermos		
	Exámenes		
SANEAMIENTO	Protección de Manantiales		
	Cloración de agua		
	Instalación de letrinas		
	Eliminación adecuada de basuras (zonas aciduas)		
	Mejoramiento de viviendas		
	Control Zoonosis (perros eliminados)		
T.P.A.	Sintomáticos transferidos		
	Nº Muestras tomadas		

	ACTIVIDADES	TOTAL Aux.San Especial	TOTAL Promotor
EPIDEMIOLOGIA	Seguimiento de T.B.C. (Atención)		
	Seguimiento de Venéreos (Atención)		
	Seguimiento de		
MEDICINA COMUNITARIA	Huertas y Grupos Comunales formados		
	Charlas Educativas		
	Saunienes Comunales		
	Empíricas captadas		
	Visita Domiciliaria		
ENTREGAS	Antianémicos		
	Antiparasitarios		
	Vitaminas		
	Suero Oral		
	Raciones para Madres		
	Raciones para Niños		
INJECTABLES	Primeros Auxilios		
	Transferencias		
	Curaciones		
	Inyectables		
	Cirugía Menor		
HECHOS VITALES	Nacimientos Ocurridos		
	Defunciones Ocurridas		
ASPECTO SOCIAL	Reconocimientos Periódicos		
	Autopsias		

PROMOTORES CAPTADOS		PROMOTORES INFORMANTES		HORAS TRABAJADAS		HORAS PARA INFORMANTES	

SES: 307-79

FIRMA DEL ENCARGADO SANITARIO DEL ESCRITO

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APELLIDOS .....

NOMBRES .....

[illegible] .....

FECHA DE INSCRIPCION :

DIA	MES	AÑO	F.F. o H.CLINICA No.

DIRECCION

Nombre de la Calle, Jr. Av. Carretera, etc	No. Km. Lote	Piso	Int. Lot	Teléfono

DIRECCION DE UN AMIGO O FAMILIAR

Nombre de la Calle, Jr. Av. Carretera, etc	No. Km. Lote	Piso	Int. Lote	Teléfono

TARJETA INDICE DE REGULACION DE FECUNDIDAD

SES: 501-79

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FECHA CITA	FECHA CONCURR.	EDAD A LA FECHA	METODO EN USO	CANT. ENT.	FECHA CITA	FECHA CONCURR.	EDAD A LA FECHA	METODO EN USO	CANT. ENT.

ANNEX L

MCH Primary Health Care Assistance Plan: Overall Objectives and Goals

The overall MCH Primary Health Care Assistance Plan will be implemented on a national level through the 14 Health Regions. The incorporation of rural localities and rural health delivery systems (health posts and centers) will be gradual and progressive:

Population Scope: The Plan will serve the rural population which currently lacks access to basic health services:

Population in Thousands	1979	1980	1981	1982	1983
Total Population of Rural Area	5'762.8	5'800.0	5'836.2	5'871.1	5'905.7
Rural Population to be included	1'500.0	1'392'0	1'284.0	1'057.0	680.0
Rural Population to be included/accumulated	1'500.0	2'892.0	4'284.0	5'233.0	5'905.7
% of Target Population to be offered services	26.0%	49.9%	73.4%	89.1%	100%

Scope of Health Services: The Plan is focused on the Sanitary Posts and Health Centers:

	1979	1980	1981	1982	1983
Existing Health Posts	1,200				
Health Posts to be included	312	288	264	216	120
Health Posts to be included/accumulated	312	600	864	1,080	1,200
Coverage:	26.0%	50.0%	72.2%	90.%	100%
Existing Health Centers	400	500	500	500	
Health Centers to be included/yr.	156	144	132	68	
Health Centers to be included/accumulated	156	300	432	500	
Coverage:	39%	60%	86%	100%	

ACTIVITIES TO BE PERFORMED WITH PROJECT FINANCING

Health Center: Integral Maternal and Child Health Care, including prenatal control, childbirth, simple gynecological services, fertility regulation and infertility treatment and education. Services will be provided at the sanitary post and community level.

Health Post	Community	
Health Auxiliaries	Promotor	Midwives
Immunizations; anti-polio-triple-anti measles; BCG	Immunications; anti-polio, triple-anti-measles; BCG	
Control TBC (medicines, treatment) Contact control (treatment)	Control TBC (medicines, treatment) Contact control treatment	
Maternal Health - Pre-Natal Normal control - Normal childbirth care - Normal Post-partum control - Maternal child health and fertility regulation information, services and referral (IUD)	Maternal Child Health and fertility regulation information and referral	Maternal Health Normal Pre-Natal control; Post-partum control and child-birth services, maternal child health and fertility regulation information and referral
Child health Newborn control Growth and development control of infants - Pre-school child growth and development control	Child health Growth and development control of infants Pre-school child growth and development control	Child health Newborn control

First aid and care of child-immunizations	First aid and care of child-immunizations	First aid and care of child-immunizations
Basic environmental health	Basic environmental health	Basic environmental health
Protection of springs	Protection of springs	
Use of latrines	Use of latrines	
Waste disposal	Waste disposal	
Education for health and family life	Education for health and family life	Education for health and family life
Referrals to Health Centers	Referrals to Sanitary Post and/or Health Centers	Referrals to Sanitary Posts and/or Health Centers

Extension of Integrated Primary Health Care

Purpose: To substantially improve health conditions of the rural population, especially the health of mothers and children.

General objectives	Specific objectives
1. To greatly reduce the morbi-mortality of rural population caused by controllable infectious, parasitic and transmissible diseases, and high risk pregnancies giving priority to mothers and children.	1. To contribute to the reduction of morbi-mortality caused by controllable infectious, parasitic diseases and communicable diseases.
2. To support community level health service delivery to rural areas by providing required basic services and resources needed to extend integrated primary health care to underserved communities.	2. To contribute to the reduction of morbi-mortality caused by high risk pregnancies.
	3. To contribute to the reduction of morbi-mortality of the maternal/child population.
	4. To contribute to the improvement of basic community health.
	5. To assist in satisfying the demand for first aid and for morbidity of minors.
	6. To contribute to improved nutritional levels in the community, especially for mothers and children.
	7. To provide education for environmental health, maternal child health and fertility regulation.

	Programmatic Areas
	1. Upgrading the health service system, especially for health posts, health centers and community level personnel. 2. Supporting rural communities in environmental sanitation, community education and health services. 3. Developing basic community health activities through health and development committees and traditional health workers.

TOTAL AND RURAL POPULATION BY ADMINISTRATIVE AREAS
YEARS: 1979-80-81-82-83 *

	1979		1980		1981		1982		1983	
	TOTAL	RURAL	TOTAL	RURAL	TOTAL	RURAL	TOTAL	RURAL	TOTAL	RURAL
T O T A L	17,293.0	5,762.8	17,779.4	5,800.0	18,278.5	5,836.2	18,790.2	5,871.5	19,314.7	5,906.7
H.R. ORDE NORTH	1,136.8	432.2	1,161.8	435.0	1,187.3	437.7	1,213.3	440.3	1,239.8	442.9
HOSPITAL AREAS LAMBAYEQUE CAJAMARCA	1,780.2	945.0	1,824.1	951.2	1,869.1	957.1	1,915.2	962.9	1,962.3	968.5
H.R. MIDNORTH	975.1	328.4	1,000.4	330.6	1,026.4	332.6	1,052.9	334.6	1,080.1	336.6
H.R. ORDEMIDNORTH	917.5	420.6	937.3	423.4	957.7	426.0	978.6	428.6		431.1
H.R. CITY CITY OF LIMA	5,320.6	247.8	5,536.6	249.4	5,758.3	250.9	5,985.6	252.4	6,218.6	253.9
H.R. MID SOUTH	645.3	213.2	659.5	214.6	674.0	215.9	688.9	217.2		218.5
H.R. WESTERN SOUTH	694.3	115.2	714.8	116.0	735.8	116.7	757.3	117.4	779.4	118.1
H.R. ORDETAM	226.5	40.3	234.1	40.6	241.8	40.8	249.8	41.1	258.0	41.3
H.R. MID EASTERN	663.7	380.3	676.6	382.8	689.7	385.1	703.1	387.5		389.7
H.R. CENTER	1,593.6	783.7	1,628.2	788.8	1,663.8	793.7	1,700.3	798.5		803.1
H.R. ORDESO	1,204.4	743.4	1,220.5	748.2	1,237.0	752.8	1,254.0	757.4		761.8
H.R. ORDEPUNO	888.2	616.6	899.5	620.6	911.0	624.4	922.9	628.2	935.1	631.9
HOSPITAL AREAS SAN MARTIN AMAZONAS	581.4	236.2	602.5	237.8	624.3	239.2	646.7	240.7	669.8	242.1
H.R. ORDELORETO	664.8	259.3	682.9	261.0	701.6	262.6	720.9	264.2		265.7

* See explanation on following page.

Total and Rural Populations in Peru per year -
Bulletin of Demographic Analysis N° 20

Total Population per Administrative Areas
M.H.
1978

= Estimated Population by Health Regions -
1977 - 1982
M.O.H. - Statistics and Computing
Sectorial Office

Rural Population by Areas

= Estimation and Projection based on Census Data
of 1972
Population by Departments and Provinces - Rural - Urban

The percentage of each rural area in each department was estimated with respect to the total rural population in Peru.

These percentages have been used for the distribution of the total rural population between 1979 and 1983.

ANNEX M

MEDICINE LIST

1. VACCINE: To protect 100% of infant population subject to programming:

	1979	1980	1981
Infant population subject to programming (in thousands)	74.3	134.8	199.6

2. ANTIPOLIO: Unit cost US$0.03

	1979	1980	1981
Number of doses - No. of infants by 3+25% for losses (in thousands)	278.6	514.4	748.5
Total Cost - No. of doses by $0.03	$8,358	$15,432	$22,455

3. DPT: Unit Cost US$0.05

	1979	1980	1981
No. of doses (No. of infant population by 3+25% for losses (in thousands)	278.6	514.4	748.5
Total Cost - No. of doses per ($0.05)	$13,930	$25,720	$37,425

4. ANTI-MEASLES: Unit Cost US$0.37

	1979	1980	1981
No. of doses - No. of infant population + 25% for losses (in thousands)	92.9	168.5	249.5
Total Cost - No. of doses by $0.37	$34,373	$62,345	$92,315

5. **BCG**: Unit Cost US$ 0.05

	1979	1980	1981
No. of doses = No. of infant population + 25% for losses (in thousands)	92.9	168.5	249.5
Total Cost No. of doses by $0.05	$4,645	$8,425	$12,475

To reinforce in 100% the BCG doses for 10 year old children subject to programming

	1979	1980	1981
10-year old Population	55.7	100.5	149.7

BCG - reinforcement doses

	1979	1980	1981
No. of doses = 10 year old population + 25% for losses (in thousands)	69.6	125.6	187.1
Total Cost = No. of doses by $0.05	$3,480	$6,280	$9,355

6. MISCELLANEOUS MEDICINES:

Basic medicines are included for first aid services and basic medical treatment. These quantities are estimated percentages based on current usage.

	1979	1980	1981
Yearly Cost	$403.6	$370.8	$328.9

CRITERIA FOR ESTIMATING YEARLY QUANTITY OF MEDICINES

MEDICINES	POPULATION		Quantity per treatment	Unit Cost
Gravol (for vomiting)	Total population	5	6 tablets	$0.02
Buscapina Compound (for stomach aches)	5-year old population	0.05	3 tablets	0.03
Homeatropina (same as above for infants)	Children - less than 5 years	20	1 bottle drops	0.11
Aluminum Hydroxide (for stomach acidity)	Children - 5 years and older	20	6 tablets	0.02
Antidiarretics without neomycin	Children - less than 5 years	100	1 bottle liquid	0.12
Vitamins	Children - less than 5 years	100	1 bottle drops	0.05
Ferrous sulfate (for anemia)	Pregnants women	40	168 caps	0.01
Ferrous gluconate (for anemia for babies)	Pre-School Children	30	1 bottle liquid	0.31
Gantrisin ophtalmic (for eyes)	Newborn children Total population	65 1	1 bottle drops	0.67
Aspirin	Children-older than 5 years	20	4 tablets	0.01
Antalgin (for fever)	Children-older than 5 years	1	1 tablets	0.13
Antalgin (for fever)	Total Population	1	2 ampules	0.04
Vitagrip (for cough)	Pre-school	20	1 bottle liquid	0.72

MEDICINES	POPULATION		Quantity per treatment	Unit Cost
Tiabendazol (for parasites)	Pre-school	20	1 bottle	0.63
Chlorofeniramine maleate (for allergies)	Total Population	0.1	8 tablets	0.01
Penicillin	Total Population	3	5 amuples	0.34
Oralyte (Oral rehydration)	Infant Population Pre-school	100 100	2 envelopes 1 envelope	0.10

Claculations are based on the population to be incorporated each year and are not cumulative.

It is expected that the communities will be able to purchase a portion of the medicines starting with the second year of project implementation.

QUANTITY AND COST OF MEDICINES

Total Population	1,500,000	1,392,000	1,057,000
Children - 5 years and older	1,202,800	1,116,100	1,031,100
Less than 5-years (includes infants)	297,200	275,900	259,000
Pregnant Women	87,300	76,300	70,400
Pre-School Children (1-4 years)	222,900	211,000	193,100
Newborn and/or infants	74,300	64,900	59,800

	Quantity	Cost	Quantity	Cost	Quantity	Cost
1. Gravol	450,000	$ 9,000	417,600	$ 8,352	385,200	$ 7,704
2. Buscapina	18,042	541	16,742	502	15,467	464
3. Homoatropina	59,440	6,538	55,180	6,070	51,800	5,698
4. Aluminum Hydroxide	443,360	28,867	1,339,320	26,786	1,237,320	24,746
5. Antidiarretics ($.10 per doses)	297,200	35,664	275,900	33,108	259,000	31,020
6. Oralyte	371,500	37,150	340,800	34,080	312,700	31,270

	Quantity	Cost	Quantity	Cost	Quantity	Cost
7. Vitamins	297,200	$ 14,860	275,900	$ 13,795	259,000	$ 12,950
8. Ferrous Sulfate	5,866,560	58,666	5,127,360	51,274	4,730,880	47,309
9. Ferrous Gluconate	66,870	20,730	63,300	19,623	57,930	17,958
10. Gantrisin Ophtalmic	63,295	42,408	56,105	37,621	49,440	33,125
11. Acetyl Salicylic Acid	962,240	9,622	892,880	8,929	824,880	8,249
12. Antalgin	12,028	1,564	11,161	1,451	10,310	1,340
13. Antalgin inyectable	30,000	1,200	27,840	1,114	21,140	846
14. Diabendazol	44,580	28,086	42,200	26,586	38,620	24,331
15. Vitagrip	44,580	32,098	42,200	30,384	38,620	27,806
16. Chlorofeniraminel	12,000	120	11,136	111	8,456	85
17. Clemizol Penicillin	225,000	76,500	208,800	79,992	158,550	53,907
TOTAL	----	$403,614	----	$370,778	----	$328,868