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UNCLASSIFIED

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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
Washington, D. C. 20523

PERU

PROJECT PAPER

INTEGRATED HEALTH AND FAMILY PLANNING

AID/LAC/P-074

Project Number: 527-0230

Loan Number: 527-U-076

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT <b>PROJECT DATA SHEET</b>		1. TRANSACTION CODE <input type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete	Amendment Number _____	DOCUMENT CODE 3
2. COUNTRY/ENTITY PERU		3. PROJECT NUMBER 527-0230		
4. BUREAU/OFFICE LA		5. PROJECT TITLE (maximum 100 characters) Integrated Health/Family Planning		
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 11 23 18 5		7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4) A. Initial FY 81 B. Quarter 4 C. Final FY 85		

8. COSTS (\$000 OR EQUIVALENT \$) =

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	3198	2,395	5,593	6,750	4,050	10,800
(Grant) PN	(1,593)	( - )	(1,593)	(5,145)	(1,655)	(6,800)
(Loan) HE	(1,605)	(2,395)	(4,000)	(1,605)	(2,395)	(4,000)
Other U.S.						
Host Country	-	520	520	-	3,600	3,600
Other Donor(s)						
<b>TOTALS</b>	<b>3,198</b>	<b>2,915</b>	<b>6,113</b>	<b>6,750</b>	<b>7,650</b>	<b>14,400</b>

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HE	500		510				4,000	6,800	4,000
(2) PN	400	440				1,593			
(3)									
(4)									
<b>TOTALS</b>						<b>1,593</b>	<b>4,000</b>	<b>6,800</b>	<b>4,000</b>

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)  
 400      500

11. SECONDARY PURPOSE CODE  
 400

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	B. Amount
BR	
BU	
BW	

13. PROJECT PURPOSE (maximum 480 characters)

1. Basic primary health services in marginal urban areas strengthened and service delivery capability of MOH health centers reinforced.

2. Family planning services expanded and integrated into the public and private health sector and national population policy formulation and research analysis reinforced.

14. SCHEDULED EVALUATIONS

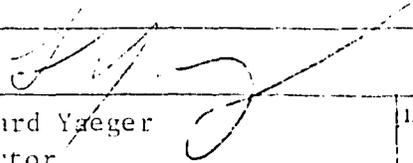
Interim	MM YY	MM YY	Final	MM YY
	07 82	07 83		12 85

15. SOURCE OF FUNDS AND SERVICES  
 000     941     Local     Other (Specify) \_\_\_\_\_

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a \_\_\_\_\_ page TP Amendment)

# BEST AVAILABLE DOCUMENT

17. APPROVED BY

Signature: 

Title: Leonard Yaeger, Director

Date Signed: MM DD YY  
 4 28 81

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

PROJECT AUTHORIZATION

Name of Country: Peru  
Name of Project: Integrated Health/Family Planning  
Number of Project: 527-0230  
Number of Loan: 527-U-076

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, hereby authorize the Integrated Health/Family Planning project for Peru (the "Cooperating Country") involving planned obligations of not to exceed Four Million United States Dollars (\$4,000,000) in loan funds ("Loan") and Six Million Eight Hundred Thousand United States Dollars (\$6,800,000) in grant funds ("Grant") over a five 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 ("Project") consists of: (i) strengthening basic primary health services in marginal urban areas and reinforcing the service delivery capabilities of the health centers of the Peruvian Ministry of Health and; (ii) expanding and integrating family planning services in Peru into the public and private health sector and reinforcing national population policy formulation and research analysis.

3. The Project Agreement which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, 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

The Cooperating Country shall repay the loan to A.I.D. in U.S. Dollars within twenty-five (25) years from the date of the first disbursement of the Loan, including a grace period of not to exceed ten (10) years. The Cooperating Country shall pay to A.I.D. in U.S. Dollars interest from the date of first disbursement of the Loan at the rate of (i) two percent (2%) per annum during the first ten (10) years, and (ii) 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 of Origin of Goods and Services (Loan)

Goods and services, except for ocean shipping, financed by A.I.D. under the Loan shall have their source and origin in the Cooperating Country 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 Cooperating Country or of countries included in A.I.D. Geographic Code 941.

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

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

d. Condition Precedent to Initial Disbursement (Loan and Grant)

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, the Cooperating Country shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D., evidence that an official Project Representative has been designated.

e. Condition Precedent to Disbursement for the Activities of any Implementing Organization Except the Ministry of Health (Loan and Grant)

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement to finance the activities of any Implementing Organization under the Project, except the Ministry of Health, the Cooperating Country shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D., the agreement between the Ministry of Health and each Implementing Organization which describes their mutual responsibilities under the Project.

f. Condition Precedent to Disbursement for Project Activities other than Initial Technical Assistance Activities (Loan and Grant)

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, to finance any Project activity other than initial technical assistance, the Cooperating Country and each Implementing Organization shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D., an Operational Plan for Family Planning and Primary Health. Each Operational Plan shall include a Staffing Plan, a Supervision Plan, a Technical Assistance Plan, a Procurement and Distribution Plan, a Financial Plan, and a Training Plan. The Operational Plan of the Ministry of Health may be submitted in parts, by health regions. Disbursement may be made for activities in a specific health region or for a specific Implementing Organization once the Operational Plan for that region or for the particular Implementing Organization has been approved by A.I.D.

(g) Condition Precedent to Disbursement for Project Activities for Calendar Year 1983 and 1984 (Loan and Grant)

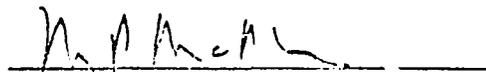
Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, for any Project activity in Calendar Year 1983 or Calendar Year 1984, respectively, the Cooperating Country and each Implementing Organization shall, except as A.I.D. may otherwise agree in writing, furnish to

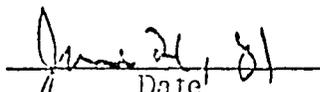
A.I.D. in form and substance satisfactory to A.I.D., an Operational Plan for such year. Each Operational Plan shall include a Staffing Plan, a Supervision Plan, a Technical Assistance Plan, a Procurement and Distribution Plan, a Financial Plan, and a Training Plan. Operational Plans shall reflect the recommendations of the annual evaluations conducted under the Project. The Operational Plan of the Ministry of Health may be submitted in parts, by health region. Disbursement may be made for activities in a specific health region or for a specific Implementation Organization once the Operational Plan for that region or for the particular Implementation Organization has been approved by A.I.D.

h. Covenants

The Cooperating Country shall covenant that, unless A.I.D. otherwise agrees in writing, it will:

- (1) Establish a community distribution system for health and family planning services before the completion of Project activities.
- (2) Not carry out any Project activities or use Loan or Grant funds to support the performance of abortions as a method of family planning, motivate or coerce any person to practice abortions, perform involuntary sterilizations as a method of family planning or coerce or provide any financial incentive to any person to undergo sterilizations.
- (3) Provide sufficient annual budget allocations following completion of A.I.D. financing to ensure:
  - (a) continuity of Project activities, including maintenance of Project funded equipment;
  - (b) supervision by health personnel of the activities which were funded under the Project; and
  - (c) continuance of the incentive program for health personnel assigned to rural areas during the life of the Project.

  
\_\_\_\_\_  
Administrator

  
\_\_\_\_\_  
Date

Clearances:

GC/LAC:BVeret: BV/15 date 6-3-81

LAC/DR:NParker: --- date ---

AAA/LAC:EWCoyle: --- date ---

LAC/DR:MBrown: 45 date 6/1/81

AAA/PPC:CPaolillo: --- date ---

GC:JRBolton: --- date 5-17-81

LAC/SA:WRhodes: --- date ---

GC/LAC:DAAdams: ckg 5/2/81: R29183

PROJECT PAPER

INTEGRATED HEALTH/FAMILY PLANNING

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ACRONYMS

ADIFAM	-- Association for the Integrated Development of the Family
AMIDEP	-- Multidisciplinary Association for Population Research and Training
ALAFARPE	-- National Association of Pharmaceutical Laboratories
ASPEFAM	-- Peruvian Association of Medical Schools
CARE	-- Cooperation for American Relief Everywhere
CECOAAP	-- Center of Agrarian Cooperatives for Sugar Production
DIGA	-- Ministry of Health Directorate of Administration
FPIA	-- Family Planning International Assistance
GOP	-- Government of Peru
IBRD	-- International Bank for Reconstruction and Development (World Bank)
IDB	-- Inter-American Development Bank
IEC	-- Information, Education, and Communication
INE	-- National Institute of Statistics
IPSS	-- Peruvian Social Security Institute
IUD	-- intra-uterine device
MCHP	-- Directorate of Maternal-Child Health and Population (MOH)
MOH	-- Ministry of Health
PAHO	-- Pan-American Health Organization
UNFPA	-- United Nations Fund for Population Activities
UNICEF	-- United Nations International Children's Educational Fund

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PART I. PROJECT SUMMARY AND RECOMMENDATIONS

- A. Face Sheet (Attached)
- B. Recommendations

It is recommended that a loan of \$4,000,000 and a grant of \$6,800,000 be authorized to the Government of Peru to assist in the development of the project for Integrated Health/Family Planning with disbursement over a four and one-half year period, beginning in FY 81 and terminating in FY 86.

C. Summary Project Background

In recent years, Peru's most serious health problems--extremely high rates of infant, child, and maternal mortality--have been exacerbated by an unstable economy, rapid population growth, and increasing rates of migration from rural to urban areas. Faced with these problems, the GOP has been unable to expand government services quickly enough to keep pace with the rapid population growth that is occurring nationwide and especially in the cities. The result has been an overburdening of the health, education, and other governmental service infrastructure and increasing pressure on resources (food, energy, cultivable land, and water) and urban job creation.

Both public and private sector efforts to meet Peru's overwhelming health needs have proved inadequate. Most of the urban services provided are curative hospital services, such as emergency, maternity, and out-patient care, which in addition to being costly, reach just a fraction of the population. Only a few public health facilities in Peru currently offer routine integrated health and family planning services, and even fewer of these focus on the community level using paraprofessionals.

While some Peruvian officials have long expressed their concern for the public health and demographic consequences of Peru's rapid population growth, reluctance to take any concrete action reflected the belief that Peru possessed large areas of fertile, unsettled lands in the Amazon watershed and that the settlement of these lands and general economic and social development would eventually resolve the population problem. This view predominated until 1976, when the GOP, recognizing the population problem and reversing its previous policy of non-involvement in demographic matters, established population policy guidelines as part of a national development plan.

When the present government came into power in July 1980, concrete commitment to implementing this policy was expressed in the public speeches of the Peruvian President, Prime Minister, and Minister of Health. Through the proposed Project, AID is responding to this high-level commitment to implement a nationwide family planning program within the framework of the national primary health system and, at the same time, to expand its ongoing primary health project to include selected urban areas.

D. Summary Project Strategy

The proposed Project is an integral component of the AID-supported health and population sector program in Peru. The strategy of the Project is to support the GOP's initiative to strengthen primary health care in marginal urban areas and to integrate family planning into the public and private health delivery systems. The Project complements the Mission sector strategy which, as stated in the FY 1983 CDSS, is to support the expansion of government services using low-cost models for the delivery of health and family planning as well as other social services. With this Project, the Mission will strengthen the overall health sector system--data collection and analysis, policy formulation, and the tiered system of health and family planning service delivery.

Responding to the underutilization and/or lack of basic preventive health services in pueblos jóvenes and building on the experience of the AID-financed rural Primary Health Project, the proposed Project will support a community-based health service delivery system in pueblos jóvenes in three cities (Lima, Chimbote, and Arequipa), administered by promoters and traditional midwives. The Project will demonstrate the feasibility and cost-effectiveness of providing preventive health care at the health center level and below, in contrast to high-cost curative services in hospitals.

In response to the lack of access to contraceptives nationwide, the proposed Project is designed to integrate a new service activity, family planning, into the current activities in the health sector. The Project will build upon and complement the ongoing private sector activities, supported by AID central funds and other donors. In addition, the Project will provide technical assistance and financial resources to help to strengthen the institutional capacity of the MOH to implement its health and population programs effectively; it will support both public and private research activities in an effort to coordinate data collection and analysis for policy formulation at the national level.

E. Summary Project Description

The proposed four and one-half year Project, Integrated Health/Family Planning, will cost an estimated \$14,400,000. AID will provide \$10,800,000--\$4,000,000 in health loan funds and \$6,800,000 in population grant funds; the GOP will contribute \$3,600,000 in counterpart funds. The goal of the Project is to assist the GOP to improve the health and well-being of the Peruvian poor. The purpose of the Project is two-fold: 1) to strengthen basic primary health services in marginal urban areas and reinforce the service delivery capability of MOH health centers, and 2) to expand and integrate family planning services into the public and private health sector and reinforce national population policy formulation and research analysis.

At the end of the Project, the following conditions will indicate that the Project purpose has been achieved:

1. The MOH will be operating an integrated health/family planning delivery system in both rural and marginal urban areas, providing basic health care as well as family planning services to a large segment of the Peruvian population, including approximately 50% of the marginal urban population in the target areas.

2. Both public and private institutions will have increased their capacity to provide family planning services so that the prevalence of effective contraceptive methods will double from 15% to 30% among women at risk. National population policy formulation and population research will be coordinated through the National Population Council.

The Project will be implemented through the Directorate of Maternal-Child Health and Population (MCHP) of the Ministry of Health. This unit is also currently responsible for implementing the Mission's "Extension of Primary Health Care" Project. Building upon the experience gained under that Project, the proposed Project will expand and reinforce urban primary health services and will support a nationwide family planning effort. As in the previous Project, both activities will be implemented through a decentralized, tiered referral system, beginning with a community-based health promoter and leading to regional hospitals. The Project will finance US and local technical assistance, in-country training, supervision, and evaluation to insure that the different levels of the delivery system are equipped to provide the required services.

The Project will focus on two activities: 1) the strengthening of urban primary health service delivery and reinforcement of health centers, and 2) the integration and expansion of family planning services.

1. Strengthening of Urban Primary Health Service Delivery and Reinforcement of Health Centers

Health-focused activities include the strengthening of primary health services in selected marginal urban areas and the reinforcement of existing health centers. Approximately 300 rural health centers and 50 urban health centers will receive equipment for basic primary health. In addition, the Project will finance training for professional and paraprofessionals in public health and management; provision of basic medicines; supervision and logistics management; and the training of urban health promoters who will distribute basic health supplies and refer patients to health centers or hospitals when further medical attention is needed.

2. Integration and Expansion of Family Planning Services

The population activities of the Project will promote the effort to institutionalize family planning by providing contraceptive services within the public health structure, including family planning equipment for the health centers mentioned above as well as 50 hospitals and a phased-in program of community-level delivery by paraprofessional promoters. The Project will provide family planning information and education through community-based activities well as mass media promotion. It will also support the expansion of private sector family planning programs and will stimulate and coordinate national population policy and research analysis.

F. Summary Financial Plan

The total cost of the Project is estimated to be \$14,400,000. AID will contribute \$10,800,000, or 75% of total Project costs, in loan and grant funds. Loan funds (\$4,000,000) will finance the health component of the Project, including equipment, vehicles, medicines, training, administrative support, information and education, and supervision. Grant funds (\$6,800,000) will finance the population component of the Project, including contraceptives, technical assistance, training, research and evaluation, equipment, and administrative support. The GOP will provide \$3,600,000, or 25% of total Project costs, for medicines, equipment and maintenance, training, administrative support, supervision information and education, and research.

SUMMARY BUDGET

(US \$000)

<u>Investment Category</u>	<u>Total</u> (1)	<u>A. I. D.</u>		<u>GOP</u>	<u>Grand Total</u> (1) + (2)
		<u>Loan</u>	<u>Grant</u>	<u>Total</u> (2)	
I. <u>Equipment, Vehicles and Maintenance</u>	1,110	825	285	710	1,820
II. <u>Medicines &amp; Contraceptives</u>	4,600	600	4,000	950	5,550
III. <u>Training</u>	1,140	480	660	580	1,720
IV. <u>Logistic System/Administrative Support</u>	480	395	85	400	880
V. <u>Information &amp; Education</u>	500	500	-	200	700
VI. <u>Supervision</u>	700	700	-	500	1,200
VII. <u>Technical Assistance &amp; T.A. Support</u>	680	-	680	170	850
VIII. <u>Research &amp; Evaluation</u>	480	-	480	90	570
sub-Total:	9,690	3,500	6,190	3,600	13,290
IX. <u>Contingencies &amp; Inflation</u> (Average = 12%)	1,110	500	610	-	1,110
TOTAL:	10,800	4,000	6,800	3,600	14,400
	75%			25%	100%

Projected Grant obligations by fiscal year are as follows:

FY 81: \$1,593,000  
 FY 82: \$2,307,000  
 FY 83: \$1,500,000  
 FY 84: \$1,400,000

TOTAL: \$6,800,000

G. Summary Findings

The Project Development Committee has concluded that the Project is administratively, technically, and economically feasible and consistent with the development objectives of the GOP and those objectives set forth in USAID's CDSS document. These Project analyses are found in Section IV of the Project Paper.

H. USAID/Peru Project Development Committee

1. USAID Staff

George Wachtenheim	Capital Development
Mary Likar	Capital Development
Edward Kadunc	Capital Development
Cesar Espino	Capital Development
Janet Ballantyne	Health, Education and Nutrition
Helene Kaufman	Family Health Office
Michael Rogal	Assistant Controller
Danilo Cruz-DePaula	Program
Steve Whitman	Regional Legal Advisor
Gloria Nichtawitz	Consultant
Ellen Alderman	Consultant
John Holley	Consultant

2. TDY Assistance

Maura Brackett	AID/Washington
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## II. PROJECT BACKGROUND

### A. Country Setting

Peru, with a population of over 17 million, has the third largest land area in South America. However, since much of this land is not arable, the population density per arable square kilometer is 472. The Andean mountains cross the country from north to south, separating it into three distinct regions which differ from each other in flora, fauna, climate, and socio-cultural characteristics. The coastal region represents 11% of the total area, with approximately 46% of the population. The mountain and jungle regions represent 27% and 62% of the area and 44% and 10% of the population, respectively.

Peru's demographic growth shows increasing urbanization with a tendency for the population to concentrate in the Lima metropolitan area and a few other urban areas. From 1961 to 1972, the average urban growth rate was 5.6% a year while nationwide the growth rate was 2.9%. Thus, an ever-increasing percentage of the population is urban. In 1940, for example, 73% of the total population was rural and 27% was urban; in 1972, the rural-urban split was 47%-53%. Since that time, urban growth--particularly the growth of an outer urban ring of slums called pueblos juvenes--has continued to be dramatic, with services such as health, education, water, electricity, and transportation not keeping up with the significant urban migration.

### B. Current Status of Primary Health Care and Family Planning

Health problems in Peru have been exacerbated in recent years by rapid population growth and a national economy in crisis, characterized by declining GDP growth rates, a chronic fiscal deficit, accelerating rates of inflation, and decreasing real income. These factors plus maldistribution and ineffective use of public health resources have resulted in a health delivery system that is high-cost and inaccessible to the majority of the population. Thus, mortality rates have continued at high levels: the infant mortality is 120 deaths per 1,000; approximately one-half of all deaths in Peru occur among children under five years of age; and maternal mortality is 40 per 10,000 live births per year. Among children, two principal causes of death are infections and parasitic diseases, which can be prevented by vaccination and improved environmental sanitation; gastrointestinal and respiratory diseases are the major causes of illness and death in the entire population.

Faced with these serious health problems, the GOP has been unable to expand government health services quickly enough to keep pace with the rapid population growth that is occurring nationwide and especially in the cities. Both this population growth and the alarming rates of migration

to urban centers have overburdened the health, education, and other government service infrastructure, in addition to putting pressure on resources (food, energy, cultivable land, and water) and urban job creation. Rapidly increasing numbers of migrants settling in the pueblos jóvenes are not being adequately served by existing health facilities. Most of the services provided in the pueblos jóvenes are curative hospital services, such as emergency, maternity, and out-patient care, which in addition to being costly, reach only a fraction of the population. Little or no preventive care is normally available at the community level in pueblos jóvenes or rural areas.

Both public and private sector efforts to meet Peru's overwhelming health needs have proved inadequate. The Ministry of Health, with an infrastructure of 107 hospitals, 500 health centers, and 1200 health posts, is officially responsible for serving two-thirds of the entire population; in practice, the staffing levels, equipment, and supplies for these facilities vary greatly from region to region so that only a fraction of the poor receive even minimal health care. The Social Security Institute provides preventive and curative services to insured workers and their families, an additional 12% of the population; the Armed Forces cover their members (7% of the population); and the remaining 15% are served by private institutions. Most of these services are hospital-based and costly to both the user and the provider. Only a few public health facilities in Peru currently offer routine integrated health and family planning services, and even fewer of these focus on the community level using paraprofessionals. AID is currently providing \$7,150,000 in loan and grant support for the national rural primary health program, which emphasizes health delivery through health posts, community agents, and traditional midwives; this support, however, is designed to provide assistance to rural communities while marginal urban areas remain largely unattended.

The provision of family planning services has also been inadequate throughout the country. Because a high-level commitment was lacking in the past, the provision of family planning services has been sporadic. Opposition by the Catholic Church and past governments, as well as criticism in the press, has impeded the implementation of a comprehensive population policy coordinating public and private efforts nationwide. Private activities, though generally successful on a small scale, have had limited impact. The only entity in Peru with the mandate and the potential capacity to develop and implement a nationwide population policy is the MOH. However, due to the lack of commitment to family planning and the low priority traditionally accorded health care, the MOH has not received adequate technical, financial and administrative support to implement its health programs much less to embark upon a program to integrate family planning services into the ongoing system.

Lack of coordination of research and data collection has contributed to the inability of the GOP to implement its population policy.

Baseline data on fertility, migration, health, and demographic trends are needed to implement, as well as to evaluate, the effectiveness of the GOP's health and population programs. At present, the National Institute of Statistics (INE) is responsible for data collection and analysis, and does in fact carry out these functions, but generally not in response to specific needs enunciated by policy-making entities. Thus, while INE's technical competence is excellent, the data which it generates are not always useful for the purposes of policy-making. In addition, a number of private organizations and international agencies carry out research and data collection, but gaps in information often result because research efforts are not coordinated.

While some Peruvian officials had long expressed their concern for the public health and demographic consequences of Peru's rapid population growth, reluctance to take any concrete action reflected the belief that Peru possessed large areas of fertile, unsettled lands in the Amazon watershed and that the settlement of these lands and general economic and social development would eventually resolve the population problem. This stance was taken by the Peruvian government at the 1974 World Population Conference. In fact, the first phase of the military government (1968-74) adopted a decidedly pro-natalist position on family planning. In August 1976, however, the GOP, officially recognizing the population problem and reversing the previous policy of non-involvement in demographic matters, established population policy guidelines as part of a national development plan. While the document did not enumerate precise fertility reduction goals, it cited three objectives: the achievement of a "free and responsible" decision regarding paternity by each couple, the reduction of morbidity and mortality levels, and an improved geographical distribution of the population. (See Annex II Exhibit J for chronology of population policy changes.)

There was no concrete commitment to implementing this policy, however, until the present government assumed power in July 1980. Shortly thereafter, in a televised speech outlining the development program and priorities of the new government, Prime Minister Manuel Ulloa cited, for the first time, the GOP's decision to provide voluntary methods of fertility control as part of a nationwide maternal-child health program. This speech was subsequently followed by addresses by the Minister of Health as well as other high-level officials, re-emphasizing the GOP's new commitment to family planning. The government has thus recognized that a decline in fertility cannot be achieved without a specific nationwide program which includes family education and the availability of a range of family planning methods and that without a reduction in population growth, Peru's development efforts will suffer. As evidence of this commitment, the GOP recently published and distributed nationwide an updated population policy statement. (For the full text, see Annex III Exhibit B.) The AID Mission now has a unique opportunity to fortify this GOP commitment by responding to its request for assistance to implement its population policy.

### C. Project Strategy

The AID-supported health and population program in Peru is being implemented in stages in response to GOP priorities in the development of one comprehensive sector program. The proposed Project is an integral component of that sector program and will be essential to the achievement of GOP health and population goals. The strategy of the proposed Project is to support the GOP's initiative to strengthen primary health care in marginal urban areas, and to integrate family planning into the public and private health delivery systems.

Although initially contemplated for inclusion in the Mission's Primary Health Project, family planning activities could not form part of that project, due to the hesitancy of the former government to implement a nationwide family planning program. Moreover, the previous government emphasized the development of rural primary health infrastructure over that of marginal urban areas. Therefore, the emphasis of this new bilateral health and population loan/grant Project will be to respond to the priorities announced by the GOP in order to fill the gaps in the existing program and thereby assure integrated service delivery in both rural and marginal urban areas.

The three fundamental GOP goals for improving the health status of Peruvians are to reduce infant morbidity and mortality, protect maternal and child health, and reinforce the existing health infrastructure. The AID sector program focuses on overcoming the fiscal, technical, administrative, and managerial constraints which have prevented these goals from being achieved in the past.

Thus, the Mission is supporting three important activities. The first is primary health care, including the extension of basic health services, relying largely upon paraprofessional workers, and emphasizing preventive rather than curative care. These services are being directed primarily toward the maternal and child population. Second is the construction of potable water systems in rural communities, along with the provision of sanitary education and latrines. Third is the implementation of the GOP population policy.

Responding to the underutilization and/or lack of basic preventive health services in pueblos juvenes and building on the experience of the rural Primary Health Project (Extension of Integrated Primary Health), the Project will support a community-based health service delivery system in pueblos juvenes administered by promoters and traditional midwives. The Project will demonstrate the feasibility and cost effectiveness of providing preventive health care at this level in contrast to hospital-based curative services. Project activities under this component will include community education and self-help activities, such as basic

preventive health and sanitation, family planning, and responsible parenthood information; and simple, low-cost medicines, including oral rehydration salts, vitamins, and iron tablets.

In response to the lack of access to contraceptives nationwide, the proposed Project is designed to integrate a new service activity, family planning, into the current activities in primary health and environmental sanitation. The Project will build upon and complement the ongoing private sector activities, supported both by AID central funds and other donors, and is not designed to replace these activities.

By providing technical assistance in addition to financial resources, the Project will help to strengthen the institutional capacity of the MOH to implement its health and population programs effectively; it will support both public and private research activities in an effort to coordinate data collection and analysis for policy formulation at the national level.

#### D. USAID Assistance Strategy

##### 1. Relationship to Mission CDSS Strategy

The FY 1983 CDSS emphasizes the need for AID, in cooperation with other donors, to fill the gap between Peru's commitment to the poor and its still-weak fiscal position. The CDSS assistance strategy includes emphasis on social programs, concentrated in the sierra, and on urban basic human needs. Specifically with regard to social programs, the USAID goal is to support the expansion of government services using low-cost models for the delivery of health, family planning, education, and nutrition services to rural inhabitants of the nation's poorest sierra communities. In response to the severe problem of urban poverty in Peru, the Mission strategy is to provide basic social services and infrastructure, food assistance, and programs that foster a pattern of balanced urban-rural growth. By expanding coverage of the ongoing Primary Health Project and integrating family planning services into the health delivery system through the proposed Integrated Family Planning/Health Project, the Mission is assuring that basic health care is made available to the marginal urban population and that the serious problem of rapid population growth is addressed.

##### 2. Relationship to Current Mission Programs

The AID health sector program includes two major projects which address health sector needs. "Extension of Integrated Primary Health" (\$7,150,000) focuses on the development of a health delivery system using health paraprofessionals at the community level and includes the complementary support activities of training, supervision, community education, and information system required to institutionalize this new public health

model. The Project provides loan and grant support for a nationwide rural primary health program, including health post equipment, training for community agents and traditional midwives, medicines, community education, and simple environmental sanitation services. While Primary Health focuses major support on the community and health post levels in rural areas, the Integrated Health Family Planning Project will expand coverage to selected marginal urban areas and will reinforce the rural health center level, including clinical and community-level supervision, services, and referrals.

The second major component of the overall sector program is the "Rural Water Systems and Environmental Sanitation" Project (\$5,500,000) which uses loan and grant funds to provide integrated water systems and environmental sanitation--potable water, latrines, and sanitation education--to rural communities in up to six department of the sierra. Within the context of the MOH primary health program, project technicians in both primary health and environmental sanitation will design and implement integrated primary health services and water systems in designated communities. Thus, the activities of the Primary Health Project and those of the Environmental Sanitation Project complement and enhance each other.

Other components of the sector program include both bilateral grants and OPGs. "Sur Medio Maternal Child Health and Population" (\$1,800,000) finances a model integrated delivery system for primary health and family planning with a health and population grant. This project was intended as a demonstration program to foster the implementation of family planning services in Peru. (See summary evaluation of this project below.)

A \$790,000 OPG with CARE has, as one of its activities, the construction of 25 health posts in pueblos jovenes in the Lima area. Approximately \$4.0 million in Title I resources annually are programmed for this project. An OPG with the Instituto Marcelino (\$150,000) is building upon the successful family planning model of that Institute to extend services to two additional regions, Arequipa and Chiclayo. Smaller projects, funded by AID, other international donors, and local private organizations, have over the years, initiated a wide variety of innovative community-level delivery systems and/or model family planning population projects. For example, ALAFARPE (National Association of Pharmaceutical Laboratories) has coordinated community, government, and private enterprises to establish a social and health service program in four pueblos jovenes, operating from four health centers and providing community-based health services, including family planning. ADIFAM (Association for the Integrated Development of the Family), a private, non-profit Catholic organization, operates 20 clinics in the pueblos jovenes in the Lima area and in Chosica and provides community-based distribution of family planning services. (See Annex II Exhibit L for further information on other projects.) Thus, the conceptual and technical elements of the proposed Project have been implemented at the operational level, albeit using a smaller population base.

### 3. Lessons Learned from the Sur Medio Project

The proposed Project reflects current Mission strategy to consolidate AID efforts in primary health care, maternal/child health, and family planning in Peru. The design, as presented in this Project Paper, has been influenced by a number of major factors, including: (a) Mission and MOH management capacity; (b) current GOP strategies which place maternal/child and family planning under the general rubric of primary health; and (c) a careful analysis of past programs, to determine which program strategies and interventions have proven successful and which have not. In the last of these, Mission and GOP experience with the Sur Medio Maternal/Child Health and Population project (527-0224) was useful in arriving at the final design for the present Project.

The Mission recently completed an evaluation of the Sur Medio program, using the services of a health management consultant as well as Mission and MOH staff. The results are contained in the final evaluation report, copies of which are available in LAC/DP and LAC/DR. Annex II Exhibit H contains a summary of major findings.

The evaluation identified both strengths and weaknesses in the Sur Medio model. The Project was successful in expanding the delivery of maternal-child health and population services to rural areas previously not served or insufficiently served by the GOP. However, several problems adversely affected Project implementation: lack of effective central control over the Project; insufficient management and logistics system to implement the Project; and conflict between contract personnel and permanent MOH staff.

Under the proposed Project, implementation will be decentralized but one entity, MCHP, is responsible for the overall management of the Project. MCHP and AID will review and approve regional implementation plans and will monitor Project activities in the regions. As outlined in the Technical Analysis (IV.C.), the management and logistics system of the Primary Health Project will be used for this Project and additional technical assistance will be provided to improve the efficiency of the system. In addition, supervision will be carried out at frequent intervals to insure the proper functioning of the system.

### 4. Other Donor Activities

AID is currently the major international donor agency in primary health and family planning. A number of other major donors are, however, exploring the possibility of extending financial assistance to the GOP's primary health programs. Both the World Bank and Inter-American Development Bank are currently carrying out assessments which could lead to loans in 1982. In order to insure complementarity and donor consistency,

all major donors and potential donors are meeting on a regular basis. (See Annex II, Exhibit L for other donor listing.)

Other major international donor groups include the following:

a. Pan American Health Organization (PAHO) offers technical assistance in all specialty areas of public health and sanitation engineering and exerts considerable impact upon Ministry policy and program content.

b. United Nations Fund for Population Activities (UNFPA) supports five priority health regions in the delivery of maternal child health and family planning services including budget support for salaries, information, education and communication, training, equipment and medicines. UNFPA support for calendary year 1980 totalled \$499,000. The proposed AID project will complement UNFPA activities; AID will not work in hospitals and health centers designated for UN support. UNFPA financial support will probably continue at the same level during the life of the proposed AID-funded Project.

c. Inter-American Development Bank (IDB) has concentrated its efforts on potable water and sewage programs. In the fifteen-year period from 1960-1975, loans totalling \$9.5 million have been disbursed for rural water projects in communities of 500-2000 inhabitants. The IDB is currently considering a fourth potable water loan of \$6.5 million and is working with MOH to develop a program to support primary health activities, including hospital construction, in two departments.

d. World Bank (IBRD) has financed urban water services and is currently exploring the feasibility of providing a large health sector loan for facility construction in support of primary health. USAID and IBRD representatives are coordinating their project development plans to avoid duplication and assure complementarity of project inputs.

e. Governments of West Germany and Holland have provided health sector support and are coordinating their program planning with USAID to finance primary health activities, especially in the area of feeding programs and community development.

f. Church World Service, CARE, Catholic Relief Service and other private agencies fund smaller projects related to both food distribution, health care and potable water.

g. UNICEF is currently implementing an integrated program which includes primary health services as well as education and other activities in Lima and three other departments. The UNICEF project is carrying out basic primary health activities and training of paraprofessionals. However, the Project does not provide routine family planning services or basic medicines such as oral rehydration salts.

h. A number of AID centrally funded grantees, including Family Planning International Assistance (F.P.I.A.), Pathfinder Fund, International Project, John Hopkins University, and Development Associates, are providing family planning program support for private sector agencies and limited support to the public sector. As stated earlier, the Mission anticipates the continuation of these centrally funded activities. The proposed Project will complement, not replace, these important sources of support for family planning.

III. PROJECT DESCRIPTION

A. Project Goal and Purpose

The goal of the proposed Project is to assist the GOP to improve the health and well-being of the Peruvian poor.

The purpose of the Project is two-fold: 1) to strengthen basic primary health services in marginal urban areas and reinforce the service delivery capability of MOH health centers and 2) to expand and integrate family planning services into the public and private health sector and reinforce national population policy formulation and research analysis.

The proposed four and one-half year Project will provide \$4 million in loan funds, \$6.8 million in grant funds, and \$3.6 million in GOP counterpart funds. The Project builds upon the planning and implementation experience as well as the public health infrastructure of current AID programs--both Mission-funded and centrally funded--in primary health, maternal child health and family planning, and environmental sanitation. The Project will foster an integrated health and family planning delivery system by expanding primary health services, including family planning, into selected marginal urban areas and integrating family planning services into the existing MOH health care system for rural areas.

Health-focused activities include the strengthening of primary health services in marginal urban areas and the reinforcement of existing health centers. Approximately 200 rural health centers and 50 urban centers will receive equipment for basic primary health. In addition, the Project will finance training for professional and paraprofessionals in public health and management; provision of basic medicines; supervision and logistics management; and the training of urban health promoters who will distribute basic health supplies and refer patients to health centers or hospitals for further medical attention when necessary.

The population activities of the Project will promote the effort to institutionalize family planning by providing contraceptive services through the public health structure, including family planning equipment for the health centers mentioned above as well as a phased-in program of community-level delivery by paraprofessional promoters. The Project will provide family planning information and education through community-based activities and mass media promotion. It will also expand private sector family planning programs and will stimulate and coordinate national population policy and research analysis.

The proposed Project will be implemented through the Directorate of Maternal-Child Health and Population (MCHP) of the Ministry of Health. (See Table 1.) This unit within the MOH is also currently responsible for implementing the Mission's "Extension of Primary Health Care" Project. Building upon the experience gained under that Project, the proposed Project will expand and reinforce urban primary health services and will support a nationwide family planning effort. As in the previous project, both activities will be implemented through a decentralized, tiered referral system, beginning with a community-based health promoter and leading to regional hospitals. The Project will finance US and local technical assistance, in-country training, supervision, and evaluation to ensure that the different levels of the delivery system are equipped to provide the required services.

Given the existing health infrastructure and the outreach mechanism established under the Primary Health Project, the MOH can absorb the additional resources made available by this Project. Demand for new personnel for the Project will be minimal, with the exception of urban promoters who are volunteers. Additional training in family planning service delivery will permit health personnel already in place to expand their range of services to include distribution of contraceptives.

#### B. End-of-Project Status

At the end of the Project, the following conditions will indicate that the Project purpose has been achieved:

1. The MOH will be operating an integrated health/family planning delivery system in both rural and marginal urban areas, providing basic health care as well as family planning services to a large segment of the Peruvian population, including approximately 50% of the marginal urban population in the target areas.
2. Both public and private institutions will have increased their capacity to provide family planning services so that the prevalence of effective contraceptive methods will double from 15% to 30% among women at risk, who desire no more children. National population policy formulation and population research will be coordinated through the National Population Council.

#### C. Project Inputs

Project loan funds will be used to support urban primary health activities and will finance the purchase of equipment, vehicles, and basic medicines (oral rehydration salts, iron tablets, and vitamins) for health centers and for the strengthening of services in marginal urban areas. The loan will also finance the training of professionals and paraprofessionals, administration, information and education activities, and supervision of primary health paraprofessionals.



Grant funds will be used in support of family planning as well as policy formulation and research activities to provide equipment, contraceptives, and administrative support for the integration of family planning into the public and private sector health delivery systems. The grant will finance technical assistance, training for professionals and paraprofessionals, policy seminars, research, and evaluation within the MOH, IPSS, and INE. In addition, grant support will be provided for technical assistance, research, and evaluation for several private sector and semi-autonomous entities, including ASPEFAM, AMIDEP and the National Population Council.

The GOP will provide funds for salaries, transportation costs, equipment, materials, and supplies.

#### D. Project Outputs

At the end of the Project, the following outputs will have been produced:

1. 250 health centers will be fully equipped.
2. Use of community-level health and family planning services in pueblos juvenes will increase, with approximately 1,000,000 persons served each year.
3. Nationwide, approximately 700,000 persons will be using effective family planning methods. (See Project Coverage, Tables in the Technical Analysis.)
4. Basic medicines will have been provided to approximately 800,000 persons.
5. Approximately 1,080 professionals and 2,000 paraprofessionals will have been trained.
6. The information and education campaign will have reached about 7,000,000 persons.

#### E. Project Activities

1. Strengthening of Urban Primary Health Service Delivery and Reinforcement of Health Centers

Accessibility, availability of personnel and supplies, and quality and cost of care vary greatly in Peru's urban health facilities, ranging from highly specialized MOH hospitals and expensive private clinics to poorly staffed and undersupplied health centers. As explained in more

detail in the Social Soundness Analysis (IV.D), most pueblo joven dwellers cannot afford private health care and are generally not eligible for Social Security health benefits. Thus, two formal health service options are available: MOH hospitals and health centers.

MOH hospitals generally lack in-patient facilities and financial resources to provide adequate out-patient care. High rates of staff absenteeism, overcrowded wards, lack of equipment or malfunctioning equipment, and lack of supplies and medicines are common conditions in most hospitals. Yet, due largely to traditional reliance on the hospital pueblo joven dwellers, when they seek medical attention, tend to go to the hospital, oftentimes with illnesses that do not require hospitalization or hospital-based care. As a result, the current government has declared a state of emergency in the health sector and has asked for international donor assistance in order to improve hospital care, and to relieve pressure on the overburdened urban hospitals by strengthening health center capability to provide basic health services. However, many health centers lack sufficiently trained staff as well as adequate physical facilities, equipment, supplies, and supervision. In addition, the local population is often either unaware of the services being offered, or discouraged by the long waits and the poor quality of attention received. Consequently, they do not attend existing clinics and either forego medical attention or use the services of the traditional healer or local pharmacy.

The proposed Project, through this first component of strengthened primary health care and health center reinforcement, will undertake activities designed to change the current pattern of service underutilization and reliance on hospital services. The Project is designed to support urban primary health services in Arequipa, Chimbote, and parts of Lima by providing basic equipment and medicines and by funding extensive training for program managers and for paraprofessional promoters. The objective of this component is to create a reliable health care outreach and referral capacity in the pueblos jóvenes of these areas.

Volunteer urban health promoters, trained under the Project, will provide information on the health services to be offered in order to stimulate increased demand. These promoters will function somewhat as the promoter does under the Primary Health Project in rural settings, but with a more limited role. Due to the relative physical isolation, the rural promoter is obliged to take a more active role in the actual delivery of health care. In the urban setting where actual access to the health infrastructure is easier, the role of the urban promoter will be simplified to include only case identification and referral, health education, and distribution of family planning supplies and three basic medicines. The urban promoter will be primarily an extension agent for the health center, directing people to the center, and facilitating the distribution of a few specific supplies. Due to this limited role, large

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numbers of urban health promoters can be trained to provide services to the heavy population concentrations served by the participating marginal urban health centers.

To achieve the objectives of this component, \$4 million in loan funds will be provided for the following inputs:

a. Equipment and Vehicles (\$685,000)

Under the Project, 250 health centers will be provided with basic medical equipment for primary health to complement the minimal resources they already have. This loan-funded equipment will strengthen the service delivery component at health centers which provide professional clinical services and serve as the community referral point for medical care. In addition to basic equipment required in routine medical examinations, family planning equipment, such as IUD insertion kits, will be provided. (See Cost by Project Component and Equipment List, Annex II Exhibits E and F, for details.)

Educational equipment, such as simple slide projectors and other audiovisual aids, will be provided to promote integrated primary health and family planning activities. Low-cost radio equipment will be provided to five remaining hospital areas which currently have no radio access to their health facilities and regional offices. Minimum office equipment including calculators and typewriters will also be financed. In addition, the Project will provide 8 vehicles in selected hospital areas to facilitate supervisory and education activities as well as to reinforce community-level service delivery.

b. Training (\$480,000)

Pro-man administration and management is a priority training objective of this Project. The MOH has sponsored seminars, workshops, and courses in specific health services, e.g., tuberculosis, malaria, vaccinations, maternal and child health. However, due to less than optimal use of human and physical resources, lack of program and logistics control, and inadequate fiscal management, these programs of service delivery have been less effective and more costly than necessary. The training and technical assistance provided in the Project will focus upon one of the major weaknesses of the MOH bureaucracy, systems management and administration, in an effort to improve both the quality and cost-effectiveness of the service delivery infrastructure. The Project will provide up to 375 weeks of training in approximately 125 courses over a four-year period, to be carried out with the assistance of U.S. and local technical advisors. It will emphasize management by objectives and will include the use of a management information system for program, cost, and inventory data. For more detailed information on types of courses, see Annex II Exhibit E.

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The training component will also focus on improving the skills of the health personnel located in marginal urban areas, specifically in those areas not covered in the routine continuing education program. Professional staff will receive a basic orientation to integrated health and family planning; epidemiology of specific diseases which are common in urban settings; and seminars focusing on management and supervision, including program planning, logistics control, and financial management. Training for paraprofessional health workers will include basic information on public health, case identification and referral, and family planning.

c. Information Education, and Communication (\$500,000)

Project funds will be available for the development of health/family planning educational materials for use by urban health promoters and health center staff. These materials will be developed at the Ministerial level, with the participation of operational level staff. The major funding for health materials for rural areas is already included in the Primary Health Project. Building upon the successful mass media campaign of the AID-funded EX-IMPROMI project, the proposed project will fund radio and TV spots in support of health and population activities. Audio-visual equipment necessary to implement existing MOH equipment will be purchased with project funds.

d. Medicines (\$600,000)

Health promoters will distribute Project-financed iron tablets and multivitamins for pregnant and lactating women as well as oral rehydration salts for children, and, under a phased-in program, will distribute contraceptives. Particular attention will be given to the distribution and use of oral rehydration salts, coinciding with the current, well-publicized campaigns by the MOH to alert the general public to the effect and treatment of infectious gastrointestinal diseases in infants and children. Additional medicines will be provided by the GOP and distributed by professionals in the health centers.

e. Supervision (\$700,000)

Successful primary care delivery requires continuous supervision. An active and regular supervisory system will enhance program quality and facilitate an effective system for information collection and distribution of supplies. Support includes per diem and funds for gasoline to insure that supervision will be constant and effective, especially during the early stages of the Project. Also included under the supervision component are monetary incentives for doctors and nurses so as to encourage professionals to work in remote areas and to supervise promoter activities at the community level. The GOP will submit a plan detailing the use of these incentives to fulfill a Condition Precedent to disbursement of the funds for supervision. It is critical that, following completion of the Project, these supervisory costs be adequately supported by the MOH. In order to insure that this occurs, AID funds will be provided on a declining basis, so that by the end of the Project, the GOP will have assumed the full cost of supervision to the Project Agreement, the GOP will covenant to support supervisory activities once the Project ends.

f. Logistics System (\$395,000)

Building upon the logistics system initiated under the Primary Health Project, this Project will provide additional support to

improve the capacity of the MOH to distribute basic health equipment and medicines and to provide supervision and evaluation services. Project technical assistance will provide for a full-time management and logistics specialist at the central level. See the Technical Analysis (IV.C) for more detail on the logistics system.

g. Technical Assistance (\$680,000)

A major objective of the technical assistance component of the Project is to strengthen the institutional management and administrative capability of the MOH to implement this Project. As a result of this component, the MOH will have an improved capability to plan and execute future primary health programs.

Major donors have emphasized the need for technical assistance to improve the effectiveness of MOH health service delivery. They cite inadequate MOH institutional infrastructure and bureaucratic redtape as major reasons for the Ministry's inability to use resources effectively. Along with inadequate GOP support for the health sector (less than 4% of total GOP budget in recent years), these factors have prompted many international groups to focus their support in specific health regions or communities, while simultaneously working to strengthen central-level administration and coordination.

Prior AID technical assistance has supported decentralized regional programs in primary health, environmental sanitation, and family planning. At the same time, AID has worked to establish protocols for the national primary health plan, including system designs for program support, fiscal management, data collection, logistics and inventory control, supervision, training course design, and personnel requirements.

Under this Project, grant funds will be utilized to provide both long- and short-term technical assistance for a total of 148 months. The Mission envisions an institutional contract for U.S. and local technical advisors to provide both management assistance and support for a series of training courses at various levels within the health delivery system. Specifically, the Project will provide technical assistance to improve the institutional capability of the sector to use limited national and international resources more effectively. Under the technical assistance component, emphasis will be placed upon institution building, systematic problem-solving, and management controls, including the development of an adequate logistics and inventory control system. The long-term advisors will provide program, fiscal, and information management assistance and will assure Project continuity. Short-term advisors will provide specialized assistance at both the central and regional levels and will coordinate their activities with long-term advisors to assist them in supervision and follow-up in the field. Annex II Exhibit D outlines the major technical assistance requirements.

## 2. Integration and Expansion of Family Planning Services

The integration and expansion of family planning services into the ongoing health and population activities will be carried out by the MOH through its own outreach capacity, as well as through that of the Peruvian Social Security Institute and several private and quasi-private sector organizations. Within the MOH, the coordinating unit will be the Directorate of Maternal Child Health and Population. During the first year of the Project, primary health promoters at the community level in selected regions will be trained to provide family planning services. Promoters in 10 of the 17 health regions in Peru are being trained in basic health techniques under the Primary Health Loan. The proposed Project will support the additional training necessary to enable these promoters to provide family planning services as well.

As Project implementation begins, these promoters will participate in the family planning education and promotion campaign by distributing written materials on family planning, calling community meetings at the health post with the auxiliary and visiting doctor or nurse, and making referrals to the health post or center for the provision of family planning services. Initial distribution of contraceptive methods will take place at the health post or center, following consultation with the attendant doctor, nurse, or trained auxiliary. A community-based distribution system will gradually be implemented, such that by the end of the Project, oral contraceptives, condoms, and vaginal tablets will be supplied either by the auxiliary or the promoter. Health centers will also provide these methods as well as IUD insertion performed by doctors and nurses. At the hospital level, all methods will generally be available.

A fee structure will be developed for these services and will take into account supply and transportation costs and ability to pay. The formula for setting this fee will be established by the MOH in its operational plan to fulfill a Condition Precedent to disbursement. Money from the sale of contraceptives will be placed in a fund to be used to continue family planning services.

### a. Delivery of Family Planning Services through the MOH Public Health Infrastructure

Family planning will be introduced as a routine service in health centers and clinics in pueblos jovenes and in the primary health care network throughout the country. This network includes regional hospitals, health centers, health posts, and community-level promoters. AID will provide \$4,535,000 in grant funds to finance this activity.

Contraceptives will be provided with Project grant funds (\$4,000,000). The methods to be introduced will vary by the service level and type of health personnel available at each level. At the hospital level, oral con-

traceptives, IUDs, and direct contact methods will be available. Selected hospitals will have the capacity to carry out surgical methods. Health centers will also provide oral contraceptives, condoms, vaginal tablets, and IUDs. Health posts and, under a phased-in process, both urban and rural community-level promoters will supply oral contraceptives, condoms, and vaginal tablets, and will make referrals to health centers for additional services. Funds for supplies, training, equipment, and supervision will be provided to assure that the quality of care is maintained.

Training (\$660,000) will be provided to all staff handling contraceptive supplies and will include a basic orientation to family planning with specific information about each method. This information will include contraindications, possible complications, and determination of the need to refer patients to a higher level in the system. Training will also emphasize the administrative and managerial upgrading of personnel. Course content for these activities will include program planning and project management with additional focus on management of the logistics system. These courses will be aimed primarily at those responsible for actual program planning and delivery at each level, but will include briefings for other related health personnel on their roles in promoting family planning education and referral for services. The training will be carried out by trainers in participating institutions with the assistance of US and local technical advisors.

Equipment (\$285,000) Both urban and rural health centers will receive grant-funded family planning equipment, including minor surgery kits and IUD insertion kits. Project funds will equip or complement existing equipment in 200 rural health centers, 50 urban health centers, and 50 hospitals. Equipment for the latter includes minilap and combination minilap and vasectomy kits. (See Cost by Project Component and Equipment List, Annex II Exhibits E and F.)

Supervision activities are essential to insure the quality of care, continued staff training, technical monitoring of community services, support for information, education and communication activities; and distribution of supplies. These activities are particularly important in the proposed Project given the relative newness of family planning services and the MOH's inexperience in using community-level personnel for service delivery. Supervision will be carried out by the primary health supervisory personnel and funded under that component. Supervisors will monitor the initial activities of these paraprofessionals to see that referrals are properly made to the appropriate health referral facility. Supervisory functions will be emphasized at all levels providing family planning services. AID will finance per diem and transportation costs of health center professionals, including physicians, nurse-midwives, and nurses.

Logistics (\$85,000) Technical assistance is being provided under the Primary Health Project to implement the basic logistics systems for the

rural primary health care network. The proposed Project will provide additional technical assistance at the central level to augment the supply, distribution, and inventory control systems at the regional level. Additional resources will be made available for transportation, maintenance of vehicles, and travel and per diem for logistics system staff. Training in supply management will also be provided for all logistics system personnel.

Information, Education, and Communication. The Project will help to strengthen the capacity of the MOH to develop and disseminate educational and informational materials, particularly those related to family planning. Project funds will pay for educational materials and technical assistance to apply specific family planning delivery technologies developed under the Sur Medio Project and other family planning projects in the private sector. In addition, each participating health center will be provided with a small slide projector for use in the clinic and for community outreach work. Funds will be provided to develop television and radio campaigns introducing population education, general family planning information, and responsible parenthood/sex education themes.

b. Integration of Public and Private Institutions into the National Family Planning Network

The MOH will coordinate the population activities of various public and private entities which are currently working independently to provide family planning services. These activities will complement those of the MOH by expanding family planning services and training. Specific programs will be developed by the individual institutions and submitted to the MOH for approval to assure their consistency with overall GOP policies. Included in the operational plan for each institution will be a working agreement signed by the MOH and the participating institutions and describing the responsibilities of both entities. The MOH will also assist in the evaluation of these programs during the life of the Project. The participating institutions will be the Peruvian Social Security Institute, ASPEFAM, and several semi-autonomous organizations.

(1) The Peruvian Social Security Institute (IPSS)

Under the proposed Project, the Peruvian Social Security Institute will introduce family planning activities into its regular maternal and child health program. The IPSS and the MOH will enter into a working agreement which outlines the responsibilities of each entity. The four activities to be carried out by the IPSS are: services, information and education, training and supervision, and research. Up to US\$900,000 will be provided to finance this activity.

Family planning services will be offered in all IPSS establishments. Both temporary and permanent contraceptive methods will be

made available in accordance with the norms established by the IPSS Central Committee. Hospitals will offer clinical and surgical methods; polyclinics and health centers will offer all the clinical methods; and health posts will provide oral contraceptives, condoms, foam, and information on natural methods. Before these services are offered, personnel at all levels will be trained as appropriate in contraceptive techniques, surgical methods, program administration, and educational methodology.

With the support of this Project, about 20% of the total IPSS fertile female population at risk will receive services during the first year. This percentage will increase progressively to reach a 50% coverage of that population by the end of the fourth year, or approximately 103,000 women. (For a detailed examination of the Project coverage, see Technical Analysis.)

IPSS will provide the physical infrastructure, personnel, and supplies necessary for the implementation, supervision, and evaluation of the program. Project grant funds will pay for equipment, supplies, and training. Medical equipment for Social Security hospitals and health centers will include IUD insertion kits and minilap kits. Supplies financed by the Project will include oral contraceptives, condoms, foam, and IUDs.

Information and Education. The Project will also support family planning education and the dissemination of population information by IPSS establishments. Educational equipment will include film and slide projectors for use in both staff training and inpatient and outpatient client education. For educational purposes, the hospitals and health centers will receive films, slides, pamphlets, and other educational materials.

Training and Supervision. Project funds will train maternal child health and family planning staff of hospitals and health centers throughout the country. In addition, follow-up visits will determine the effectiveness of training activities in relation to service delivery, staff knowledge, attitudes toward contraception, and accuracy of information provided to the client population.

Several of the training courses will be held in Lima, including one for management personnel and another for health care providers, including doctors, nurses, and nurse-midwives. One representative from each IPSS region as well as a national IPSS program coordinator will participate in the five-day management course, which will emphasize program management rather than clinical instructions. Since physicians throughout the country will be trained in surgical procedures through the centrally funded AID/W International Project, this training will not be included in the present program. However, Project funds will support two-day mini-courses in Lima

for health providers who require refresher training in family planning techniques.

A team of health care providers from each region will also be trained in Lima for a period of two weeks. These teams will consist of a physician or facility director, nurse or nurse-midwife, and social worker. The training course will emphasize the administrative, medical, operational, statistical, and educational aspects of family planning program management with specific information for each type of health care provider. These regional teams will then return to their regions and train local personnel in family planning. Three persons from each hospital and polyclinic and one person from each medical center, sanitary post, and factory post will also be trained. Thus, a total of 220 persons will be trained outside of Lima.

An initial phase of supervision will insure that personnel are adhering to established norms and procedures in the delivery of family planning services. Follow-up evaluations will be carried out bi-annually to measure the performance of the personnel in achieving Project objectives. Quality of care and compliance with standards will be evaluated. In case of deficient performance, additional in-service training will be provided to reorient personnel.

Research. IPSS staff will undertake a series of research activities, including periodic quality control assessments; evaluations of the participation of the doctors, nurse-midwives, and nurses in the program, and assessment of the acceptability and continuation rate of each contraceptive method. This evaluation process will foster improved program data collection and management.

In addition, funds will be made available for an annual IPSS-sponsored population conference. This conference will provide a forum for any interested health providers to exchange ideas, interact with other conference participants, and learn about the most recent advances in the field of population and family planning. Since an entrance fee will be charged, program operational expenses will be covered and funds will be made available for transportation and per diem expenses of selected guest speakers.

(2) ASPEFAM

With this Project, ASPEFAM (Peruvian Association of Medical Schools) will expand and capitalize on its experience in delivering family planning services. The activities under the proposed Project will focus on three areas: service delivery, professional training, and program management. Up to \$260,000 has been earmarked to support this activity.

Grant support for service delivery will assist in the expansion of services in hospitals already in the ASPEFAM delivery system, including the Maternity Hospital of Lima, Belen Hospital of Trujillo, Goyeneche of Arequipa, and the Villarreal University Hospital in Lima. As a result of this expansion, an additional 3,000 women per month will receive services.

ASPEFAM will also provide professional training designed to improve the technical knowledge and ability of medical students and graduates in family planning service delivery, program management, and administration. Instructors from the university centers will provide on-site program development assistance and training to approximately one-third of the major area MOH hospital centers outside Lima. The others will be included in the ongoing MOH implementation schedule.

The third activity, program management, is designed to assist the MOH administrators to improve their supervisory, management information, and evaluation systems. Technical advisors from ASPEFAM will work with MOH hospital and clinic administrators to institutionalize improved operational systems for program management. Specific components include information retrieval, patient tracking system, quality-of-care assessments, and logistics control.

### (3) Semi-Autonomous Organizations

A minimum of \$175,000 will be made available with MOH approval to support the family planning activities of quasi-public authorities, such as CENTROMIN, as well as cooperative organizations, such as CECOAAP (Center of Agrarian Cooperatives for Sugar Production). Although these semi-autonomous organizations have, in many cases, already undertaken limited family planning activities, they have not received adequate funding to purchase the necessary equipment and supplies or to train their personnel in family planning techniques. The Project will help these organizations to develop their population policies and will provide funding for training, equipment, contraceptive supplies, technical assistance, and administrative support.

In conversations with Mission representatives, CECOAAP and other organizations have expressed a desire to participate in this activity and the MOH is also interested in encouraging the participation of these groups. The MOH will advise potential participants regarding the availability of support for their program. The MOH will solicit proposals and will submit to AID for approval proposals that it wishes to support under this Project component.

c. Support for Population Policy Formulation and Research Analysis

The family planning component also includes activities designed to foster population policy formulation and implementation as well as policy research. AID assistance will reinforce the GOP capability to collect and analyze ongoing population data, including census information, vital registration of births and deaths, surveys on contraceptive prevalence (such as the World Fertility Survey), and analysis and dissemination of population information as it relates to policy issues. The National Population Council, a policy-making body, and MCHP, the Project implementing agency, will carry out this activity. The Council will provide a public forum for discussion and debate on the issue of population and its impact on development.

In the past, AID and AID-supported grantees have worked with a variety of individuals and institutions to support population policy objectives by providing information, materials, conference assistance, training, and observation trips to encourage public and government awareness of population issues. Press releases, publications, television and radio interviews, and meetings with Church and public officials have brought the population debate to the public and fostered a change in attitudes regarding the acceptability and need for government support for family planning activities. Under the proposed Project, these efforts will be coordinated through one central institution, the National Population Council, the resulting policy will then be carried out by MCHP.

Three major Peruvian institutions involved in population research, policy, and demography will be supported under this Project-- The National Population Council, INE, and AMIDEP.

(1) The National Population Council

The National Population Council, established in November 1980, has been designated as the principal population policy-making body in Peru. It is responsible for coordinating all population research activities as well as for establishing population guidelines and policy at the national level. The Council is composed of representatives from the President's Office and the Prime Minister's Office as well as from the Ministries of Health, Education, Economy, Finance and Commerce, Housing, and Security; Joint Chiefs of the Armed Forces; Peruvian Social Security Institute; National Planning Institute; Peruvian Medical School; National University of Peru; and the Catholic Church.

Under the proposed Project, the Council will coordinate the establishment of technical norms for the national family planning program and the dissemination of research and policy publications,

management data reports, and other policy directives. Demographic data and policy research will be analyzed in the Council. From this research and analysis will emerge a national population policy which encompasses both public and private sector activities. In support of its activities the National Population Council will receive \$100,000 in Project grant funds.

(2) National Institute of Statistics

The National Institute of Statistics (INE) has four divisions (Census and Demographic Surveys, Social and Economic Indices, National Accounts and Data Processing), an Office for Technical Cooperation and Training, and ten regional offices. INE has been the major population policy research institute in Peru; it has implemented the field work for the AID-supported World Fertility Survey, conducted the Population and Economics Seminar Series, and is currently responsible for the Vital Registration Project (VISTIM).

Under this Project, INE will receive support for its population policy and research initiatives which are vital to the implementation of the GOP population policy and family planning program. The Project will include funding for the collection and analysis of baseline data on fertility, migration, health, and demographic trends needed to evaluate and analyze the effectiveness of the GOP's health and population programs. In addition, the demographic technical unit of INE will provide technical papers on population issues and problems which can be used by both the GOP planning offices and the newly formed Population Council to plan and implement policy directives. INE will receive \$120,000 to implement this component.

(3) AMIDEP

The Multidisciplinary Association for Population Research and Training, AMIDEP, is a private population policy research institute which will receive Project support for two years to continue its population policy conferences and seminars, publications, and population policy and research activities. AMIDEP is a private, non-profit organization, which was founded in May 1977, by a group of university professors in Lima and the regions. The objective of the Association is to promote research and training in the population field in Peru and the Andean Region. AMIDEP has increased its membership from nine founding members to thirty, all from universities in Lima, Arequipa, Ayacucho, Cajamarca, Cuzco and Trujillo. Since its founding, AMIDEP has concentrated its efforts on consolidating and promoting the Association, training through seminars and conferences, and promoting population policy and research activities. AMIDEP will receive up to \$100,000 in Project funds to carry out its activities.

#### IV. PROJECT ANALYSES

##### A. Financial Analysis

##### 1. Financial Plan

The total cost of this four and one-half year Project is estimated to be US\$14,400,000, of which up to US\$10,800,000 will be contributed by A.I.D. through a loan of US\$4,000,000 and a grant of US\$6,800,000. The GOP will finance 25% of the total cost (US\$3,600,000), with cash and in-kind contributions. Tables 2, 3, 4, and 5 show Sources and Applications of Funds, Requirements of Foreign Exchange and Local Currency, Expected Disbursements by Year, and Summary Budget by Project Component. Approximately 44% of total Project resources have been allocated to finance inputs for the strengthening of primary health in marginal urban areas and reinforcement of health centers; 56% has been assigned to integration of family planning.

Project loan and grant funds will finance the acquisition of medical and communication equipment, vehicles, medicines, and contraceptives and will also defray the costs of training, research, logistics and technical assistance. Approximately 50 work/months of foreign technical assistance and 140 work/months of local technical assistance will be required in the areas of fiscal management, logistics and inventory control, training and supervision, family planning service delivery, and health education. The cost of technical assistance per month has been estimated at US\$8,000 for US technical assistance and US\$2,000 for domestic advisors.

GOP funds will provide for the purchase of spare parts and maintenance for medical equipment and vehicles, as well as medicine and contraceptives, logistics and administrative support, and supervision. In-kind contributions will provide for vehicle and equipment maintenance, training, logistics and administrative support, information equipment and communication, supervision, and technical assistance support costs.

##### 2. Recurrence Costs

Peru is now entering into an economic recovery phase and, to a certain extent, the national budget has been freed from the harsh fiscal austerity of previous years. Increased allocations, in real terms, have occurred in 1981 and are expected to occur in the future, although the demand for funds for all sectors far exceeds the supply, at least for the present. Total budgetary allocations for the Ministry of Health (MOH) reflect the upward trend. Specifically, allocations to defray MOH operational costs have increased dramatically in 1980 and 1981 as compared to 1979. The percentage increments were 63% and 112%, respectively.

Table 6 shows the recurrent operational costs of the MOH with and without the major AID-financed health projects. The MOH budget does not include substantial health sector investments by each of the 13 regions which, while forming part of the MOH health system do not receive their operating budgets from the MOH. Thus, actual health expenditures are substantially higher than is indicated by the MOH budget alone. For the purposes of this analysis, the 1981 budgetary allocation of the MOH, amounting to US\$72,000,000, was extrapolated for the period 1982 to 1986 using a growth rate of 10% compounded annually. Given the substantial increases in the MOH operational budgets in the past two years (63% and 112%) and given the GOP commitment to increasing the social services budget (in part by reducing military expenditures as a percentage of total government expenditures), this 10% growth rate estimate is very conservative. Assuming that, in 1986, the GOP would provide an operational budget for the continuation of the Project equal to the total AID-GOP contribution in the final Project year, approximately \$2,370,000 (a reasonable assumption since some of the contraceptive supply will be replenished through the rotating fund and additional personnel will not generally be required even in areas of family planning service expansion), the additional GOP funds required to maintain Project activities of all three health sector Projects (Extension of Integrated Primary Health, Rural Water Systems and Environmental Sanitation, and the proposed Integrated Health/Family Planning) will represent only 2.2% of the entire MOH operating budget. Moreover, other international donors including the World Bank and IDB, have expressed their intentions to provide support for health sector activities, so it is likely that the MOH will not bear the full burden of these recurrent costs.

TABLE 2  
SOURCES AND APPLICATIONS OF FUNDS  
(US\$000)

Project Component/Investment Categories	A.I.D.		GOP	Total	Proj. Funds
	Loan	Grant			
<u>I. Strengthening of Primary Health in Marginal Urban Areas and Reinforcement of Health Centers</u>					44%
A. Equipment and Vehicles					
- Medical Equipment	685	-	400	1085	
- Education & Communication Equipment	20	-	30	50	
- Office Equipment	20	-	30	50	
- Vehicles & Maintenance Costs	100	-	100	200	
B. Medicines	600	-	500	1100	
C. Training	480	-	250	730	
D. Logistics & Administrative Support	395	-	300	695	
E. Information, Education & Communications	500	-	200	700	
F. Supervision	700	-	500	1200	
<u>II. Integration of Family Planning</u>					56%
A. Equipment					
- Medical	-	125	100	225	
- Education & Communication	-	160	50	210	
B. Contraceptives	-	4000	450	4450	
C. Training & Educational Materials	-	660	330	990	
D. Logistics & Administrative Support	-	85	100	185	
E. Research & Evaluation	-	480	90	570	
F. Technical Assistance/Support Costs	-	680	170	850	
Sub-Total	3500	6190	3600	13290	100%
Inflation & Contingencies (Average = 12%)	500	610	-	1110	
Total	4000	6800	3600	14400	

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AVAILABLE

TABLE 3

REQUIREMENTS OF FOREIGN EXCHANGE AND LOCAL CURRENCY  
(US\$000)

Project Component/Investment Categories	A. I. D.				GOP LC	TOTAL
	Loan		Grant			
	FX	LC	FX	LC		
<u>I. Strengthening of Primary Health in Marginal Urban Areas and Reinforcement of Health Centers</u>						
A. Equipment and Vehicles						
- Medical Equipment	685	-	-	-	400	1085
- Education & Communication Equipment	20	-	-	-	30	50
- Office Equipment	-	20	-	-	30	50
- Vehicles	100	-	-	-	100	200
B. Medicines	600	-	-	-	500	1100
C. Training	-	480	-	-	250	730
D. Logistics and Administrative Support	-	395	-	-	300	695
E. Information, Education & Communication	-	500	-	-	200	700
F. Supervision	-	700	-	-	500	1200
<u>II. Integration of Family Planning</u>						
A. Equipment						
- Medical	-	-	125	-	100	225
- Education & Communication	-	-	160	-	50	210
B. Contraceptives	-	-	4000	-	450	4450
C. Training & Educational Materials	-	-	-	660	330	990
D. Logistics and Administrative Support	-	-	-	85	100	185
E. Research & Evaluation	-	-	-	480	90	570
F. Technical Assistance/Support Costs	-	-	400	280	170	850
Sub-Total	1405	2095	4685	1505	3600	13290
Inflation & Contingencies (Average = 12%)	200	300	460	150	-	1110
Total	1605	2395	5145	1655	3600	14400

ASIAN DEVELOPMENT BANK

TABLE 4  
EXPECTED DISBURSEMENTS BY YEAR  
(US\$000)

Project Component	Yr. 1	Yr. 2	Yr. 3	Yr. 4	Total
<b>I. Strengthening of Primary Health in Marginal Urban Areas and Reinforcement of Health Centers</b>					
AID Loan: A. Equipment and Vehicles	825	--	--	--	825
B. Medicines	335	175	90		600
C. Training	120	120	120	120	480
D. Logistics & Administration	95	100	100	100	395
E. IEC	125	125	125	125	500
F. Supervision	200	200	195	105	700
Sub-total	1700	720	630	450	3500
<hr/>					
GOP: G. Equipment and Maintenance	100	100	180	180	560
H. Medicines	50	100	150	200	500
I. Training	25	75	80	70	250
J. Logistics & Administration	50	75	75	100	300
K. IEC	50	50	50	50	200
L. Supervision	25	50	175	250	500
Sub-total	300	450	710	850	2310
<hr/>					
<b>II. Integration of Family Planning</b>					
AID Grant: A. Equipment	285	--	--	--	285
B. Contraceptives	825	1105	1450	620	4000
C. Training & Educational Materials	165	165	165	165	660
D. Logistics & Administration	25	20	20	20	85
E. Research & Evaluation	120	120	120	120	480
F. Technical Assistance	180	200	200	100	680
Sub-total	1600	1610	1955	1025	6190
<hr/>					
GOP: G. Equipment	75	75	---	---	150
H. Contraceptives	25	70	155	200	450
I. Training & Educational Material	40	90	100	100	330
J. Logistics & Administration	20	25	25	30	100
K. Research & Evaluation	20	20	20	30	90
L. Technical Assistance Support Costs	40	40	40	50	170
Sub-Total	220	320	340	410	1290
<hr/>					
SUB-TOTAL	3820	3100	3635	2735	13290
<hr/>					
INFLATION & CONTINGENCIES	250	460	200	200	1110
<hr/>					
TOTAL	4070	3560	3835	2935	14400
<hr/>					

TABLE 5

SUMMARY BUDGET BY PROJECT COMPONENT  
(US\$000)

Project Component	A.I.D.		GOP	TOTAL
	Loan	Grant		
I. <u>Strengthening of Primary Health in Marginal Urban Areas and Reinforcement of Health Centers</u>	<u>3500</u>	-	<u>2310</u>	<u>5810</u>
A. Ministry of Health	3500	-		
II. <u>Integration of Family Planning</u>	-	<u>6190</u>	<u>1290</u>	<u>7480</u>
A. Ministry of Health	-	4535	1150	
B. Public and Private Institutions	-	1655	140	
1. IPSS	-	900		
2. ASPEFAM	-	260		
3. Semi-autonomous Organizations	-	175		
4. National Population Council	-	100		
5. INE	-	120		
6. AMIDEP	-	100		
Sub-Total	<u>3500</u>	<u>6190</u>	<u>3600</u>	<u>13290</u>
Contingency & Inflation (Average = 12%)	<u>500</u>	<u>610</u>		<u>1110</u>
TOTAL	<u>4000</u>	<u>6800</u>	<u>3600</u>	<u>14400</u>

TABLE 6

MOH - RECURRENT OPERATIONAL COSTS  
(Millions of Soles) \*

	Base Year 1981	1982	1983	1984	1985	1986
<u>Without Projects</u>						
MOH total operational costs	58800	64680	71148	78263	86089	94698
<u>With Projects</u>						
MOH additional operational costs:						
527-U-072	123	260	470	559	727	945
527-U-074	57	80	118	137	159	191
New Project	-	208	368	380	484	948**
Total AID Projects	180	548	956	1076	1370	2036
Percentage Increase due to AID Projects Operational Costs	0.31%	0.85%	1.34%	1.37%	1.59%	2.2%

(\*) S/ 400 Soles = US\$ 1.00

(\*\*) Assumes that recurrent costs in the first year after the PACD are equal to the AID-GOP contributions in year five of the Project.

## B. Institutional Analysis

The organizations which will have implementation responsibilities under the Project are the Ministry of Health, the Peruvian Social Security Institute, the National Population Council, ASPEFAM, INE, and AMIDEP. Maps, organizational charts, and supplemental organizational information appear in Annex II Exhibits B and C.

One of the objectives of this Project is to make the MOH primary health care system administratively feasible. The Project seeks to deal with, and provide assistance to, those systems or organizational units in the MOH which are involved in the operation of the primary health care system. In most instances, the Project will help to improve the administrative capabilities of a system or unit, and in a few, the Project will help establish the policy and procedural frameworks needed to enable a unit or system to take an active and effective part in extending primary health care and family planning services.

USAID/Peru is familiar with the ongoing operations of the other implementing agencies and has chosen to work with them based on their excellent track records. The Mission has supported and monitored centrally-funded assistance to both AMIDEP and ASPEFAM, and has worked closely with the demographic unit of INE. The IPSS has not received direct assistance from AID to date, but an in-depth analysis of IPSS was carried out during PP preparation, and the Mission is confident of its ability to carry out projected activities.

### 1. Ministry of Health

Approximately 3% of the GNP (down from 4.1% in 1964) is allocated to the MOH. Of this amount, 85% to 90% is used to cover personnel costs, leaving approximately 15% for program operations. The MOH is responsible for providing health care to approximately 68% of the total population, that portion which is uncovered by any other health insurance or medical program.

At the central level, the MOH is comprised of executive and managerial branches as well as technical offices. Central administrators, directed by the Minister and Vice-Minister, design the national health policies with the advice and national support of a variety of national health and medical advisory groups. The technical offices are responsible for the development and supervision of specific health programs and activities which correspond to national health priorities. These offices establish the national technical norms and procedures for the entire public health sector.

The technical office designated to implement the proposed Project is the Directorate of Maternal Child Health and Population (MCHP). Its main function is to establish norms and supervise the maternal and child health care and population activities throughout the country. Recently, responsibility for primary care in general has been added to MCHP's activities, so it is currently responsible for implementing the ongoing AID Project, "Extension of Integrated Primary Health", as well as other donor efforts. Responsibility for implementation, however, has been channeled to the regional level, so that, at the central level, MCHP

can carry out its normative and monitoring responsibilities. As the current Project is essentially an expansion of activities in already existing health delivery units, the additional workload can be absorbed without requiring significant personnel increases. It should be noted that a technical assistance management expert is presently working in the MCHP, and his principal objective is to help establish a management reporting system for control purposes. Two other MOH divisions will be involved in Project implementation, the Directorate General of Administration (DIGA), responsible for accounting, maintenance, and logistics; and the Directorate of Information, which stores and analyzes health data throughout the country.

Management of public health services is highly decentralized in the 17 health regions. (See Table 7.) Each regional office is staffed by a director and subdirector with various technical support personnel, and is responsible for the overall planning and management of public health services throughout the respective regions. The immediate administrative responsibility of the regions is not, in most cases, to the central level MOH, but rather to the local regional planning body, the ORDE. This structural arrangement automatically ensures a large degree of decentralization.

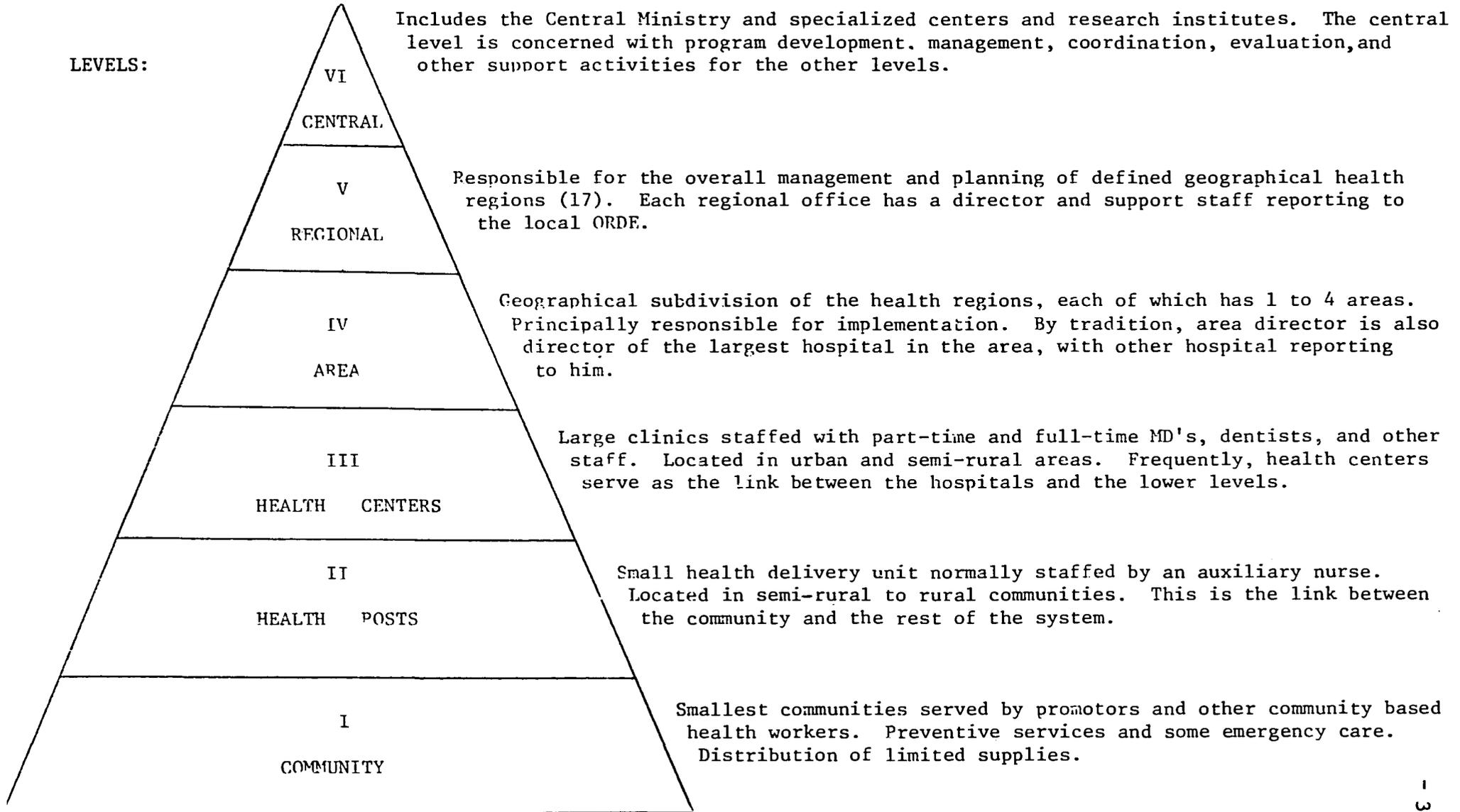
Each health region is further subdivided into one to four areas which are directly responsible for implementing regional and central programs and which have recently begun to participate in the planning process. Each area is headed by a director who is simultaneously the director of the largest hospital in the area, normally designated as the base hospital. The area director has full operative responsibility for all of the health delivery units in the area as well as the area hospital. In addition, he gives support to the regional director.

The area level is the highest level of actual service delivery. The service delivery units consist primarily of the MCH hospitals which provide the specialized curative care for the area. Relatively little preventive care actually occurs in the hospitals, although at present, most family planning in the country is carried out through the hospitals. Indeed, one of the objectives of this Project is to facilitate the delivery of family planning services to the other tiers in the hierarchy.

In terms of public health, the first critical level of the health delivery system is level III, the health center, of which there are about 500 in the country. These centers are relatively large clinics situated in urban and peripherally urban areas serving reasonably large population concentrations, frequently 20,000 - 50,000 people. They are staffed by a full- or part-time doctor, one or more nurses or nurse-midwives, and several auxiliary staff, including nurses, statisticians, laboratory technicians, and others. In some cases, dental services are

PUBLIC HEALTH CARE DELIVERY SYSTEM: Ministry of Health and Social Security

LEVELS:



The primary focus of the health center is to provide curative services to the immediately surrounding population. Family planning services are being initiated at the health center level, with methods limited to whatever the training of staff permits. Some outreach is carried out, at times in conjunction with PL 480 Title II programs which are frequently administered by staff of the centers.

The centers themselves are not always well-equipped, limiting the effectiveness of staff. Although a laboratory technician may be present, for example, the laboratory facilities and supplies are often inadequate. No equipment was provided to this level under the Primary Health Project, and complementary equipment will be essential to attract clientele to the centers where the family planning services will be distributed. For this reason, basic health equipment has been included in this Project.

Level III health centers serve as the direct supervisory and supply link with the level II health posts. In part, inadequate supervision in the past was due to lack of transportation, but equally important was the lack of emphasis on carrying out this aspect of the work. Under the Project, a normative change, placing more emphasis on supervision, will be stimulated from the central level. This change will be critical to assuring an exchange of information, material and psychological support for the lower delivery levels, and continuing provision of family planning and other supplies.

Level II health posts are generally situated in rural areas in towns of 500-2000 population. They are simply equipped and staffed by an auxiliary nurse or sanitarian. The training of this person is basic, about six months in duration, but he/she is capable of carrying out simple curative procedures, some emergency care, and health education. A primary channel for dissemination of family planning information and supplies will be through the health post level. The auxiliary will also be responsible for supervising promoters at the community level, and in many cases acting as the supply link.

The lowest and most pervasive level of the delivery system will be the community level. The primary provider at this level will be the promoter, a local inhabitant, trained in basic public health. Care at this level will consist of a few simple procedures, distribution of some basic drugs and family planning supplies, referrals, and some health education.

A major problem which currently confronts the MOH in its efforts to extend primary health to rural areas is the lack of qualified personnel who are willing to work outside of the major urban areas. The "Secigrista" program, which compels graduating students in health fields

(medicine, nursing, and dental students who have completed all course work) to spend one year working in either rural or marginal urban areas, has, to some extent, alleviated this problem, but there is little evidence that the program is working to attract qualified personnel to these areas on a permanent basis. The pattern appears to be that the Secigrista spends one year serving in his/her designated area, then returns to the urban atmosphere which has traditionally attracted medical personnel.

The MOH plans to experiment with new methods of attracting personnel to peripheral areas, by offering incentives--which increase according to the amount of time spent in rural or marginal urban areas--to those personnel who are willing to serve up to five years outside of the urban centers. Although not yet fully defined, these incentives will include salary supplements, low interest or no interest loans to purchase equipment needed for private practices, and scholarships for studies outside of Peru leading to specialization for those spending a full five years in a rural or pueblo joven environment. Under this long-range plan, the MOH is attempting to bring qualified medical personnel to the health center level on an "as needed" basis. In fulfillment of a Condition Precedent to disbursement under the supervision component, the MOH will submit for AID approval a staffing plan for all levels of Project activities and a format for agreements between the MOH and the supervisory personnel serving in remote areas and receiving salary supplements. AID will provide up to \$700,000 in loan funds for supervision activities, including incentives to attract doctors and nurses to serve at the community level.

At present, in the urban and marginal urban areas, many of the delivery points, mainly level III health centers, are underutilized. By improving the quality of services and making the public aware of those services, utilization and, hence, the general state of health will improve.

## 2. Peruvian Social Security Institute

The Peruvian Institute of Social Security (IPSS) is composed of a central management office, which dictates policy, and eight regional executive offices, which are responsible for developing and implementing health programs in their respective geographical areas. Within the central level, there are seven General Directorate support offices, of which two will be directly involved in the IPSS family planning program: the Directorate General of Training and the Directorate General of Health Care Services. The IPSS has approximately 19,500 employees of which 31.3% are professional, 6.5% are technicians, 35.4% are health auxiliaries, and 26.6% provide administrative and maintenance support. These human resources are distributed among the eight IPSS Health Regions, with about 64% in Lima and the remaining 36% throughout the rest of the country.

Health care services are delivered to IPSS beneficiaries through a multi-level system as shown in Table 7. The Social Security

Institute has a total of 18 hospitals, 17 medical centers, 6 polyclinics, 40 sanitary posts and 91 factory posts distributed throughout the eight IPSS Health Regions. The most specialized care is provided at the national hospital level. Each national hospital has a minimum of 800 beds as well as the most advanced and specialized equipment in the IPSS System. Less specialized hospitals include the central hospital with at least 400 beds, the regional hospitals with at least 150 beds, and zonal hospital with at least 80 beds. At the present time, three new hospitals in Cuzco, Huancayo, and Pucallpa are under construction and scheduled for completion in the next few years. In addition, a 100-bed obstetrical hospital for Lima as well as two hospitals in the northern region are in the planning stages.

Outpatient care is provided in a number of different facilities, including polyclinics, medical centers, factory health posts, and sanitary posts. Polyclinics offer a complete range of speciality services on an outpatient basis in urban areas. Medical centers are much smaller facilities which offer general medical care. The factory post offers first aid as well as follow-up care at the factory site while the sanitary post provides simple medicine administered by a nurse's aid.

As of January 1, 1980 (D.L. 22482), Social Security benefits were made available not only to the insured employee but to this entire family, with childhood benefits extending to the age of eighteen. Implementation plans for servicing this additional population group are currently underway, but due to severely limited resources as well as facility constraints, it will be some time until these added health care benefits are made available. Health services are available to the IPSS population at any Social Security facility, or at any facility contracted by the IPSS (Ministry of Health, Air Force, mining companies, and private clinics). If the IPSS beneficiary wishes to visit his own private physician or receive private health care services in a non-contracted facility, the IPSS will reimburse a small portion of the cost.

IPSS Family Planning Experience. The IPSS has not formally initiated a nationwide family planning program, but it does offer a pilot program in Lima at two facilities, Hospital No. 1 and Hospital No. 2. Both hospitals employ ob/gyn physicians, nurses, nurse-midwives and social workers and have received initial supplies of contraceptives from the Pathfinder Fund. The IPSS has also been actively involved in organizing educational activities. In August 1979, it introduced a course on responsible parenthood and, in September, sponsored the First IPSS Conference on Health and Population.

The proposed AID Project is designed to support the IPSS in its efforts to provide family planning services and training programs throughout the Social Security System. All Social Security hospitals, as well as all outpatient facilities, including factory and sanitary posts, will be involved in this program.

Because the Social Security population is economically active and tends to be better educated, the potential for the widespread acceptance of its family planning program is high. It is important to note that similar programs have been successfully instituted in other Latin American countries such as Mexico. Furthermore, the existing IPSS infrastructure provides a low-cost distribution system for allocation of family planning resources.

Project Implementation. The IPSS Directorate of Training and of Health Care Services will be jointly responsible for coordinating, directing, controlling, and evaluating the Project. Implementation will be coordinated by the management of each IPSS region, while operations will be carried out by IPSS hospitals, health centers, posts, and factories.

The program will be introduced progressively into all IPSS facilities, beginning with the two national hospitals in Lima. During the second stage, all hospitals nationwide will offer family planning services. Finally, all outpatient facilities will introduce services. Supplies will be stored in the central IPSS warehouse and distributed throughout the IPSS regions to all hospitals and outpatient facilities. The first shipment should be sufficient for two years and thereafter supplies will be reordered as needed.

### 3. National Population Council

The National Population Council was established in November 1980, as the principal organization responsible for promoting, coordinating, and regulating the population policy activities of the public and private sectors; for promoting and carrying out research on population; and for disseminating scientific knowledge and statistical information related to population. The organization, whose creation was one of the central recommendations of the National Population Conference organized by AMIDEP in Tarma in mid-1979, is dependent upon the office of the Prime Minister. Represented on the Council are all government ministries, as well as the Social Security Institute, the Armed Forces, the National Institute of Planning, the Medical Society, the Peruvian Universities, and the Catholic Church.

One of the major functions of the Council is to support the implementation of the 1976 "Population Policy Guidelines for Peru", the GOP strategy for an integrated family planning program. The Council will be the official GOP representative in the Government's relations with foreign or international organizations which are involved in population policy activities. It will analyze technical norms, management data reports, and other policy and program directives, and disseminate research and policy publications. The Council will have as its primary function that of

promoting coordinated and effective national action in response to the serious demographic problems facing the country.

Project Implementation. The National Population Council will direct data collection and research efforts and will use the resulting studies to establish national population policy. Working closely with MCHP, the Council will also oversee policy implementation. In addition, it will coordinate research efforts by the various institutions involved in population activities in order to disseminate this information.

#### 4. ASPEFAM

The Peruvian Association of Medical Schools (ASPEFAM), a private, non-profit organization, was founded in January 1964. Membership in the Association includes the University medical programs at San Marcos, Federico Villarreal, Cayetano Heredia, Arequipa, Ica, Trujillo, and the School of Public Health. ASPEFAM serves as a technical and financial resource to each of the participating medical faculties and supports teaching, services, and research programs related to the medical and public health curricula of the various institutions.

ASPEFAM is governed by a general assembly of delegates from the six medical schools. The Assembly sets policy and handles administrative issues. The ASPEFAM Executive Council reports directly to the Assembly and is responsible for directing the operations of the Association, while the Executive Director coordinates and oversees the daily operations of the organization. Advisory services are provided by a Consulting Council as well as an Advisory Committee.

Support from the Pan American Federation of Associations of Medical Schools (FEPAFEM) and the International Population Council has enabled ASPEFAM to develop population and family planning curricula in the medical schools through the integration into the academic program of courses in demography, maternal and child health, and family planning. ASPEFAM has also expanded the libraries, created nursing and midwifery training programs, and produced audio-visual teaching aids.

Project Implementation. The central office of ASPEFAM will coordinate the Project activities of the medical faculties. These activities will focus on applied operational research. ASPEFAM will maintain contact with MCHP as well as with the teaching institutions and area hospitals where the ASPEFAM program activities will be implemented.

During the development of the operational plan, the design team will be composed of representatives from both institutions (MOH and ASPEFAM) and will include both central- and regional-level participants. The Obstetrics and Gynecology departments of the University-affiliated hospitals will administer the training and the technical assistance. The

training participants and service providers include the hospital ob/gyn staff, physicians, nurse-midwives, and nurses from the designated area hospitals and participating health centers.

5. INE

The National Institute of Statistics (INE) is the governing body of the National Statistical System, which has sectorial units in various ministries. The Institute has four divisions (Census and Demographic Surveys, Social and Economic Indices, National Accounts, and Data Processing), an Office for Technical Cooperation and Training, and ten regional offices. INE receives both GOP and international donor support for its population programs. The most important ones are the Seminars on Population and Economics and the Vital Registration Project (VISTIM).

To date, the Population and Economics seminars have been carried out in the major regions of the country. The seminars have been organized for approximately forty high-level government officials, in collaboration with regional development and planning entities. The contents of the seminar include: planning for social and economic development, population analysis as a planning instrument, demographic factors in social and economic planning, and Peru's population policy and service programs.

The goal of the VISTIM Project is to develop a totally new vital registration system for Peru and it is supported by the National Center for Health Statistics (NCHS) as a part of the VISTIM Program to improve vital registration systems in developing countries throughout the world. With the help of VISTIM, in collaboration with UNDP-Lima, INE has obtained a medium-sized computer and additional data-entry facilities and, as a result, is self-sufficient in data management, not only in vital statistics, but in its other statistical activities as well.

INE is now producing annual vital statistics (including detailed tabulations with estimates of coverage) for the first time. Previously, the birth and death data were only published in the annual report of general statistics. The annual report on birth statistics for 1975-76 is ready for publication, and the 1977 report will be ready shortly. Death statistics were published during 1980.

A draft Law, now under consideration in the National Planning Institute, will establish within INE a national vital registration system reflecting the innovations and reforms developed under the VISTIM project. INE will also be responsible for the execution of the Health and Contraceptive Prevalence Survey under a tripartite contract with the MOH and the Westinghouse Corporation and will implement the Rapid Group Demographic Analysis in Peru.

Project Implementation. INE will be responsible for collecting demographic data to be used by the National Population Council in the formulation of population policy and its director will be a member of the Council. Within its central headquarters, INE will establish a technical unit to implement its program research and policy analyses. The multidisciplinary professional staff will coordinate its research activities with both the Population Council and the private sector research groups, including AMIDEP.

#### 6. AMIDEP

The Multidisciplinary Association for Population Research and Training (AMIDEP) is a private, non-profit organization, founded in May 1977, by a national group of university professors. The objective of the Association is to promote population research and training in Peru and the Andean Region.

The AMIDEP program is administered through an Assembly, a Board of Directors and an Executive Committee. The Assembly, composed of all members, is responsible for modifying the by-laws and electing the Board of Directors. The Board of Directors defines policy for the Association, admits new members, and approves research projects. The functions of the Executive Committee are to promote research activities to assure the quality of the Association's publications, to secure financial support for their activities, and to coordinate the teaching program.

The major objectives of AMIDEP are to promote population research, foster population policy development and implementation, and to stimulate the coordination of population-related research, service, and policy analysis. Since its formation, AMIDEP has been considered as an active national institution and is well-respected for the quality of its research and policy activities. At present, AMIDEP has a total number of forty-five members, thirty in Lima and the rest outside the capital. By profession, they are economists, physicians, demographers, anthropologists, psychologists, sociologists, and professors. AMIDEP initially received funds from G.E. TEMPO and is now supported by Battelle and the Ford Foundation.

Since November 1977, AMIDEP has organized a variety of activities including conferences, workshops, seminars, courses, lectures and research. AMIDEP sponsored the National Population Conference, held in Tarma in June 1979. GOP officials, university professors, politicians church clergy, and laymen attended this conference and addressed eight of the most important population problems in Peru. The five-day meeting brought nationwide attention to the population issue and was influential in promoting the establishment of the National Population Council.

In June 1980, AMIDEP held a workshop on public policies and their effect on population. The main objectives of this workshop were to assess whether public policies adequately addressed the population problems of the country; to sensitize GOP policy-makers to the impact of their sector policies on population and development issues; and to promote an exchange of ideas and foster a better understanding of Peruvian population problems among politicians, officials, and researchers. The Seminar included thirty persons, twenty of them experts in population. The others were delegates from the newly elected Government, including two Ministers and two Senators.

AMIDEP has organized several postgraduate population seminars and research courses. The seminars, held in Lima and the provinces, dealt with topics such as the interrelationship between population and economic development, studies about fertility determinants in Peru, social analysis on women and development, employment and population, internal migrations, and social demography. The research courses, held in Arequipa, Ayacucho, Cuzco, Cajamarca, Huánuco, Piura, and Puno, have stimulated interest in the study of population problems in these universities. Three of them -- Arequipa, Cuzco and Cajamarca have established centers for interdisciplinary research in population.

In addition, AMIDEP has prepared research projects on population and publishes a population newsletter which is distributed to 2,000 people in leadership positions in Peru. AMIDEP has sponsored some twenty lectures on population, one of which was given at the Center for Higher Education of the Armed Forces (CAEM) and another at a conference of Peruvian priests and nuns in January 1980. Finally, the organization has compiled information on population with emphasis on data for Peru and the Andean region.

Project Implementation. AMIDEP will expand its program of population policy advocacy, analysis, and research, using its existing organizational structure and its formal and informal relationships with other research groups and academic institutions. The same procedures will be used for research design and review by members of both the executive staff and the board of AMIDEP. Under the Project, AMIDEP will expand the public dissemination of population information and research by increasing the number of affiliated members, advisors, and population specialists working within AMIDEP.

C. Technical Analysis

1. Adequacy of Outreach/Delivery System

One out of every three persons in Peru resides in rural areas with little access to health care facilities. Likewise, the need for services is considerable in the ever-increasing urban population, especially in the marginal areas of the coastal cities. The GOP is presently taking action to reach out to both the underserved urban and rural populations to deliver health care services, including family planning.

Project activities to be carried out by the various executing agencies should mutually reinforce the effort to achieve the Project purpose. As a result of the Project, low-income groups, including adolescents and men, will be provided with increasingly easy access to high quality family planning services. Small, widely dispersed rural settlements, many of which normally do not have a resident physician and possess only a rudimentary pharmacy, will be served.

The principal means of extending services to the vast, underserved populations in a reasonably rapid and cost-effective manner has been through the training of various types of community-based outreach workers, and the inclusion and upgrading of existing traditional practitioners and midwives into the national health care system. This approach has demonstrated success in a number of Latin American settings, and is currently being developed in Peru with assistance from the Primary Health Project.

These community health workers, or promoters, are generally responsible for representing the health interests in their communities. They act as a point of reference, provide emergency care and treatment for certain common illnesses, and are responsible for dispensing a limited stock of drugs. The distribution of family planning materials along with other pharmaceuticals is both logical and feasible.

The training of these outreach workers represents a compromise: normally, with limited basic education, the information they are able to absorb and subsequently disseminate is limited. As unpaid health workers, they cannot leave their primary source of income, usually agriculture, to undergo extensive training. Moreover, funds are not normally available to support extensive training. Thus, training should be relatively short and consist of basics.

Promoters have been trained from time to time in Peru during the past twenty years. Most of that training was carried out in an ad hoc fashion by doctors and nurses doing resident fieldwork. In the

absence of an established primary health system, complete with functional norms and a related training curricula, the training was basically community health education. With recent attempts to create an integral primary health system, efforts to define the functions of promoters, the selection criteria, and hence the requisite training curricula, have commenced.

As relatively few promoters have been trained to date, the model is still in its development stage, and modifications in terms of selection, functions, and training may still be expected. Nevertheless curricula have been developed under existing projects, and model programs have been implemented in departments such as Puno and in other similar projects throughout the world. The basics of population, human reproduction, and family planning can easily be incorporated into the training of these community health workers. The initial level will not lead to true expertise, given the limitations mentioned above, but will provide for the basic knowledge necessary for promoters to carry out their responsibility of disseminating family planning information and supplies.

The normal cycle of continuous in-service education will provide both additional knowledge and incentive for carrying out community-level service delivery. In the case of urban promoters, whose responsibilities are limited in comparison with their rural counterparts, training will focus on some very basic health concepts as well as family planning. In no case will the promoters be providing services without adequate training: contraindications of family planning methods will be stressed, and the more sophisticated techniques, such as IUD-insertion, will be performed by personnel specially trained in those procedures. To support the ability of these community workers to carry the family planning message to their communities, considerable backup will be provided, including supervision by trained personnel and distribution of prepared family planning information.

Under the Sur Medio Project, a series of training manuals for promoters have been developed, including one for family planning. The family planning manual may be used nationwide, possibly in an adapted and abridged format for actual presentation in the communities.

The community-based distribution (CBD) system which will be gradually implemented by means of promoters has been tested in numerous settings. While CBD models vary from place to place, several characteristics have been found to be common to successful programs: establishment of a pricing system which makes the contraceptives affordable to the clients; dissemination techniques which reach the clients in their communities; efficient systems of resupply; distribution of simple indigenous education and information materials; and a continuous program supervision and evaluation.

As noted above, the logistics, supervision, and evaluation of an effective family planning component will be greatly enhanced by incorporating that component into the overall primary care package, thus creating access to the various support mechanisms currently being developed. The promoters will reach the clients in their communities, and through the use of family planning materials subsidized through this Project, the population will be afforded economic as well as physical access to the services. In short, all of the requirements for a successful community-based distribution system either exist at the present time or will be implemented.

Estimated coverage under the Project is summarized in Tables 8, 9 and 10.

## 2. Proposed Contraceptive Technologies

The Project will emphasize contraceptive methods which will make appropriate contraceptive technology available to a greater proportion of the target group.

### a. Female sterilization

The Project will seek to make simpler techniques of voluntary sterilization more widely available to meet the existing backlog of requests and the increased demand expected to be generated by the Project. If the proportion of women who stated in the World Fertility Survey that they did not want any more children is taken as one index of the demand for sterilization, then it is clear that there is a significant unsatisfied demand for this method of contraception.

Voluntary sterilization will continue to be available exclusively at hospitals. The Project will provide the sterilization equipment required and training for some personnel so that laparoscopy and mini-laparotomy can be performed on a widespread basis, replacing the more common -- as well as more costly and more time-consuming -- tubal ligation procedure. Simplification of the female sterilization procedure will make it possible to perform a greater number of sterilizations reducing the demand on operating facilities and personnel.<sup>1</sup>

### b. Wider variety of reversible methods

Secondly, the Project will offer greater variety of effective, reversible contraceptive methods. Currently, the most widely known and available methods in Peru are oral contraceptives and female sterilization. However, with negative characteristics assigned by many women to the pill, and sterilization appropriate only for those women who definitely desire no additional pregnancies, the availability of methods

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1. The Project will finance training of medical doctors in sterilization techniques, as well as equipment, but will not finance sterilization procedures per se. The GOP does not currently, and will not under this Project, offer any monetary or in-kind of incentives for persons seeking sterilization as a family planning option.

TABLE 8

PROJECT COVERAGE

(in thousands)

	<u>1982</u>	<u>1983</u>	<u>1984/85</u>	
Total Population	18,278.5	18,790.3	19,314.8	
Women of Fertile Age (15-49 years)	4,252.3	4,390.9	4,534.3	
Women at Risk (65.8% of the Women of Fertile Age)	2,798.0	2,889.2	2,983.6	
Women who want no more children (61.4% of the women at risk)	1,718	1,774	1,832	
Coverage <u>1/</u>	<u>Percentage</u> <u>2/</u>	28%	39%	50%
	<u>Number</u>	481	692	916
MOH	(66%)	317	457	605
Social Security Institute	(12%)	58	83	110
Armed Forces	( 7%)	34	48	64
Private and Others	(15%)	72	104	137
Total Coverage:	100%			

Notes

1/ The coverage is calculated on the following basis:  
According to Peruvian Fertility Survey, 17% of the women who want no more children are already using effective methods. Therefore, the first year the program will continue to provide methods to these women, and expand coverage to include an additional 11% of the women who state that they want no more children, but who are not currently using effective methods.

2/ Coverage: Percentage of women who want no more children.

Sources: Peru's World Fertility Survey, 1977-78 and ONE's Demographic Projections.

TABLE 9

CONTRACEPTIVE USERS : NUMBER OF UNITS AND TOTAL COST  
(in thousands).

	1982	1983	1984/85	Inventory	Total Cost
<u>ORAL CONTRACEPTIVES</u>					
No. of users	133	191.4	253.4		
No. of units	1,596	2,296.8	3,040.8		
Estimated cost (\$000)	\$ 319.2	459.4	608.2	\$ 300	\$1,686.8
<u>IUD</u>					
- Lippes Loops					
No. of users	152	218.7	289.6		
No. of units	153.5	73.4	78		
Estimated cost (\$000)	\$ 46.1	22	23.4	\$ 12	\$ 103.5
- Copper T's					
No. of users	38	54.7	72.5		
No. of units	41.8	18.4	19.6		
Estimated cost (\$000)	\$ 41.8	18.4	19.6	\$ 10	\$ 89.8
<u>Condoms</u>					
No. of users	19	27.3	36.2		
No. of units	1,900	2,730	3,620		
Estimated cost (\$000)	\$ 85	122.8	162.9	\$ 80	\$ 450.7
<u>Surgical</u>					
No. of users	7.6	11	14.5		
Estimated cost (\$000)	\$ 152	220	290	\$ 145	\$ 807
<u>Neosampon and Foam</u>					
No. of users	30.2	43.8	57.9		
No. of units	90.6	131.4	173.7		
Estimated cost (\$000)	\$ 181.2	262.8	347.4	\$ 70.8	\$ 862.2
<hr/>					
TOTAL COST (\$000)	\$ 825.3	1,105.4	1,451.5	\$ 617.8	\$4,000
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TABLE 10

ESTIMATED PROJECT CONTRACEPTIVE USERS BY METHODS AND BY YEARS  
(in thousands)

	Percent of all methods	1982	1983	1984/85
Total Population (users)		379.8	546.9	724.1
Oral contraceptives	35%	133	191.4	253.4
IUD's				
- Lippes Loops	40%	152	218.7	289.6
- Copper T's	10%	38	54.7	72.5
Condoms	5%	19	27.3	36.2
Surgical	2%	7.6	11	14.5
Others	8%	30.2	43.8	57.9

TABLE 10-a

ESTIMATED PROJECT COVERAGE (MEDICINES)

1. Oral Rehydration Salts		
Total Number of doses (envelops)		2,000,000
Number envelops per treatment (ave.)		3.3
Number of users		600,000
2. Iron Tablets		
Total number of tablets		9,000,000
Number of tablets per treatment(ave.)		
Number of users(high risk pregnancy & malnourished mothers)		100,000
3. Multivitamins		
Total number of tablets		4,500,000
Number of tablets per treatment(ave.)		45
Number of users(malnourished mothers & children)		100,000

ESTIMATED MEDICINE USERS, BY YEAR OF PROJECT

	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
Oral Rehydration	150,000	150,000	150,000	150,000
Iron Tablets	20,000	20,000	30,000	30,000
Multivitamins	20,000	20,000	30,000	30,000

such as the IUD, the diaphragm, spermicides, and condoms offers additional options to women whose concern is postponing or spacing pregnancies. These alternatives are especially desirable in the case of adolescents, particularly those who, not yet having entered a stable relationship, will nonetheless want protection for their sexual contacts. With the exception of the IUD, these methods can be readily distributed without medical supervision, making contraception more accessible to this group. Health personnel, including promoters, will be instructed in the use and prescription of these methods as part of the training in family planning they will receive under the Project, and promotion and explanation of these methods directed towards the target population will be effected through the Project's training and technical assistance component.

c. Male contraception

Finally, the Project will offer contraceptive technology with a new emphasis on male contraception. Unfortunately, there are few reliable data on male contraception in Peru. Despite the lack of prevalence data on men, informal queries of physicians and nurses indicate that there is interest on the part of men in using contraception and private pharmacies, essentially the only source of condom supplies independent of the MOH, sell a large volume of condoms--but at high prices. The strategy of making condoms widely available at low cost offers a simple, effective, and low-cost means of preventing unwanted pregnancy.

The more significant technical issue in male contraception involves (a) increasing the availability of the vasectomy which is now limited by a lack of adequate operating facilities, equipment, and trained personnel, and (b) increasing its adoption which is inhibited by ignorance and psychological and other concerns about male sterilization. These constraints will be addressed during Project implementation through AID assistance to provide adequately equipped operating facilities, better trained personnel, and vasectomy kits.

In conclusion, while there are a number of technical feasibility issues involved in the Project, Project activities have been designed to take these issues into account, and funds are provided for a wide variety of supporting inputs which should help to guarantee the technical feasibility of the Project.

3. Institutional Experience

As discussed in the Institutional Analysis (IV.B), all of the organizations involved in this Project have had experience in family planning. Certain aspects of their overall delivery systems, such as logistics, are weak but are being improved.

#### 4. Logistics System

One of the significant problems which has affected the development of family planning programs elsewhere has been the inability to plan the procurement of and to distribute supplies in an orderly and timely fashion to service delivery points. Although an administrative hierarchy for government services exists, responsibilities for management and service delivery at each level have not been defined in the majority of regions, and therefore the supply linkages are weak. The absence of an adequate administrative infrastructure also weakens supervisory and evaluation efforts in all aspects of service delivery. These activities are critical to estimating and promoting demand for family planning services, as well as insuring quality services.

The strategy for improvement of the logistics system will include three basic components:

- The establishment of administrative hierarchies in each of the regions, with general supervisory responsibilities defined for each level.
- The design and implementation of a nationwide logistics systems capable of ordering, receiving, storing, distributing, and controlling supplies, including contraceptive supplies.
- The design and implementation of an information component capable of reporting utilization patterns of contraceptive materials for control and planning purposes.

##### a. Establishment of Administrative Hierarchies

Successful completion of this activity will be crucial to the establishment of an adequate logistics system; in most cases, the supervisory linkages between service delivery points will also serve as the channels for supplies distribution and control. These linkages will also form the basis for the information system required to project contraceptive material demand.

Each health region will examine its own administrative structure in terms of geographical proximity, span of control, and existing and/or projected transportation capabilities, and will adopt a realistic and suitable administrative structure for providing support at each level in the areas of supervision, logistics, supplies, evaluation, and specifically defined service delivery components such as vector control, tuberculosis control, etc. The responsibilities for each hierarchical level will be clearly defined. This process has already begun in some of the regions.

b. Design of the Logistics System

A general blueprint for a workable logistics system was designed under the Extension of Integrated Primary Health Project (527-0209). This blueprint is described in a manual entitled, "Normative Guide for Logistics in the Primary Health Plan." It includes a general description of procedures for the entire supply system, encompassing purchasing, storage and inventory control, distribution, related information retrieval, and a description of the functioning of a rotating drug fund.

Each of the health regions will establish a logistics system based on this general model. Technical assistance is now being provided through the Primary Health Project to assist the regions in adapting the system to their own requirements. In the process, certain refinements in the general model based on experience are anticipated.

Rather than establish parallel supply systems, the regions will store and distribute contraceptive materials along with all other drugs and supplies. Thus, family planning delivery will be integrated into the overall package of service delivery at each delivery point.

Under this Project, vehicles will be provided for the selected health regions to facilitate service delivery, supervision, and information flow. To insure proper vehicle maintenance, technical assistance will be provided to complement the maintenance assistance begun under the Primary Health Project.

c. Design and Implementation of the Information Components

The manual described above also lays out a series of formats for information retrieval, each serving defined managerial requirements. The minimal logistical information components will be:

- Personnel Record Card
- Patient Register
- Community Drug Requisition
- Supervisor's Checklist
- Supervisor's Monthly Report

Use of these forms is described in detail in the manual.

One basic objective of the information system is to limit the work involved at the lower administrative levels, while still providing the information required for planning and control purposes. Again, adaptation of the basic design in each region will be carried out according to the design of its administrative infrastructure, and technical assistance will be provided to facilitate successful implementation.

d. Other Institutions

Under this Project, the other primary distributor of family planning supplies will be the Social Security Institute (IPSS). As previously described, IPSS has its own administrative structure which varies from region to region, but which generally consists of three to four levels, extending in most cases to the health post level. The logistical problems faced by IPSS are similar to those experienced by the MOH with the exception that the system is considerably smaller and does not include the community level.

The experience of the MOH in developing its infrastructure and logistical system will be carried over to the Social Security system. Specifically, the general system design and the manual mentioned above will be made available to the IPSS. This technology transfer should be relatively easy as the objectives of a logistics system and the procedures involved in successful functioning are generally the same. Implementation will in fact be greatly simplified by the smaller size of the system and the absence of the promoter level. Technical assistance will be provided either through the Project or through Institute funds to help in the adaptation and implementation process.

Training for operative personnel in logistics planning and control is contemplated under the Primary Health Project. One of the consistent problems of the MOH has been high attrition among trained staff most of whom enter into the IPSS system where the pay is better and job security is higher. In this case, the inevitable movement of staff will enhance the transfer of technology and experience between the two systems.

The other private institutions involved in the Project will focus primarily on research activities and, in the absence of extensive health delivery networks, will not experience the same logistical obstacles faced by the MOH and the IPSS. Most materials will be used in one or more sites with few of the accompanying problems of large systems. Edited versions of supply manuals will be provided in an effort to enhance necessary functions such as inventory control.

5. Family Planning as a Strategy for Limiting Fertility

Of the four variables making the greatest contribution to changes in fertility -- age at marriage, lactation, induced abortion, and contraception -- the latter has been shown to be the most effective in reducing fertility. The gap between the desired family size and actual fertility performance in Peru was highlighted in the World Fertility Survey in which a large proportion of women stated that they did not want any more children. The Project will augment the services already provided in Peru in order to respond to the unmet demand for all methods, by providing oral

contraceptives, IUDs, foams, and tablets. Surgical methods will be available as well, but will be restricted to the hospital level.

None of the male/female contraceptive technologies to be provided under this Project is new to Peru. Oral contraceptives and condoms are readily available through the commercial sector, black market street sales, and some clinical and community-level activities in the MOH and private sector. The IUD, previously available only through the public sector and organized private programs, became legally available to the private physicians in 1980 when commercial importation was legalized. Foams and jellies are widely available as are condoms, including locally produced lines.

#### 6. Opposition to Family Planning

While the present government has made it clear, on several opportunities, that it intends to go forward with an accelerated program which will offer family planning services to couples desiring to space their children or limit family size, there are organized groups in Peru -- specifically, certain elements within the Catholic Church, certain political groups, and some doctors -- who actively oppose this decision. While these groups have been relatively quiet in recent months, limiting themselves to occasional newspaper attacks on the GOP's family planning policy, no one within the government doubts that a well-orchestrated anti-family planning campaign undertaken by either the Church or leftist political groups could seriously hinder the GOP's efforts. Recognizing the potential consequences of an all-out attack by either the Church or organized political groups, the MOH has adopted a policy of moving as quickly as possible in the area of family planning, expanding services with a minimum of publicity, on the theory that once services are in place, it will be extremely difficult to take them away, no matter how vocal or organized the attempt, because they fulfill a need.

In keeping with this "low profile" position, the MOH has rejected, for the time being, a program in commercial retail sales (CRS) for Peru, feeling that it would raise the visibility of family planning and encourage organized opposition. However, since CRS strategies have proved effective in distributing contraceptives in many areas, the MOH will reexamine CRS options in the future once the basic GOP infrastructure is in place and demand for services increases.

Simultaneously, the GOP is trying to breach the differences of opinion with the Catholic Church by including it, wherever possible, within MOH-sponsored programs. For this reason, support of the National Population Council, which has a member designated by the Church, is important. Church-approved methods of family planning will be included in basic

curricula given to nurse-midwives and promoters, and clergy are encouraged to participate in local health committees, which provide the community support to local health facilities.

D. Social Soundness Analysis

1. Primary Health Activities

a. The Impact of Urbanization

Urbanization in Peru has three principal features: movement to coastal areas, increased concentrations of population in the larger cities, and the overwhelming primacy of Lima. In the period 1961-1972, the most recent intercensal period, Peru's total population grew at a rate of 2.9% per annum with rural population growing at 0.7% and urban population at 5.6%. Urbanization trends suggest that, by 1990, 18 million of Peru's projected 27.2 million will reside in cities, that Lima will have doubled its population, and that the poor inner city areas and pueblos jovenes will have to absorb the bulk of the projected increases in population.

The urbanization process has been fed by permanent rural sector emigrants. There is sufficient evidence to make the following statements about the migratory process:

(1) The direction has been from rural to urban areas although a portion of this occurs in two or more stages, going first from rural to small urban centers and from these to larger urban centers.

(2) The largest flow of migrants has been from the sierra region to the coastal region and over two-thirds of this movement has been to Lima.

(3) By 1972 emigrants from the sierra accounted for almost two-fifths of Lima's population. Similar trends are noted in major secondary cities such as Chiclayo, Trujillo, and Chimbote on the north coast and Arequipa and Tacna in the south.

Common observation and various studies indicate that the massive migration outpaces the industrialization process and that an increasingly large share of urban labor is employed in low productivity service activities, resulting in high levels of low-income employment in urban areas.

b. Existing Urban Health Facilities

Existing health facilities in major urban areas vary widely with respect to geographic dispersion, availability of essential services and medicines, availability of medical personnel, and cost of services. Lima presents a panorama of health care facilities that represents the extreme in contrasts -- with highly specialized MOH hospitals and expensive and prestigious private clinics existing only a

few kilometers from poorly managed and relatively unstocked health centers in the peripheral pueblos juvenes. In Lima, as in other urban centers, the average marginal urban dweller is generally not given much of a choice when it comes to obtaining health services. The high costs associated with private health care, including both professional and laboratory fees, as well as time and transport costs, preclude this alternative for that segment of the population existing on precariously low incomes.<sup>1/</sup>

Marginal urban dwellers are also, for the most part, excluded from Social Security benefits. To qualify for these benefits, employees must be actively working in the "modern" sector - i.e., factories, offices, government entities, etc. Domestic workers, while eligible, are very rarely signed up, since most middle to upper socio-economic class employers do not encourage Social Security participation.

The two viable alternatives<sup>2/</sup> for the vast majority of marginal urban dwellers are the health centers, located in their own communities, or specialized MOH hospitals generally located in the inner urban area convenient to "modern" sector employment and middle and upper socio-economic class housing. Each of these has its own distinct set of problems, described below:

(1) MOH hospitals: The MOH operates and maintains a series of hospitals throughout the country. In Lima, there are a series of "specialized" hospitals (neoplastic diseases, childrens' hospital, mental illness, etc.), as well as a major hospital for each of Lima's hospital regions. In major urban areas outside of Lima, there is usually only one regional hospital, serving the entire non-insured population. Each hospital has a full-time staff and offers both in-patient and out-patient care. The major problems, inherited by the present government and currently the subject of a National Health Emergency Plan, include: lack of even minimal in-patient facilities, such as sheets, blankets, sterilizers, boilers, X-ray equipment, incubators, etc.; insufficient medical staff, including doctors, nurses and technicians, to oversee operations; and insufficient resources to adequately attend the burgeoning out-patient population.

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<sup>1/</sup> A private pediatric consultation in a clinic located in a middle class area of Lima, for example, costs approximately \$8.00. Round trip transportation from the Villa El Salvador pueblo joven complex, south of Lima, would cost an additional \$1.20 per person, and the entire trip plus consultation would take about four hours, representing about \$2.00 in lost income.

<sup>2/</sup> There are a very few low cost health facilities located in pueblos juvenes run by local or international FVOs; while health care is considered excellent, coverage is too minimal to consider as a true alternative.

While the MOH has labored intensively to bring about needed changes in the government-run hospital facilities, even the most optimistic GOP observers concede that it will take at least five years to bring hospital care to even minimally acceptable levels, and even then only with major international donor assistance or long-term credit.

(2) Community-Level Health Centers: In theory the health center is the lowest rung on the health-delivery pyramid where professional medical care is available. In fact, even this is problematic, because physical facilities are poor and over-crowded, pharmaceutical stocks are inadequate, and basic equipment is frequently non-existent or out-of-service (including sterilizers, dental equipment refrigeration facilities, and laboratory equipment). Outside of Lima the situation is even more dismal, since communications through the geographical hierarchy (center to area hospital to health region to the MOH in Lima) are slow and replacement of a single piece of equipment may take up to two years.

The result of this situation is that the great majority of marginal urban dwellers have simply lost confidence in the local health center. The combination of long waits, marginal services, and lack of medicines have led to a mounting frustration and concomitant decision to bypass the health center level and go directly to the nearest hospital (where frustrations remain high, but competent medical attention is ultimately available) or to simply forego modern attention altogether. The result has thus been, first, an artificial overloading of the hospitals system, and, second, an underutilization of the health center system.

c. Benefit Incidence: Primary Health

The strengthening of ongoing primary health activities in major urban areas will have a number of major benefits.

First, by focussing on providing a full range of preventive health services combined with reinforcing community education programs, the social barriers to marginal urban client acceptance will be lowered. The majority of adult pueblo joven residents are migrants from the sierra, where limited physical and financial access to adequate health facilities has been the traditional pattern. Long distances to provincial capitals, where professional medical assistance is available, combined with the high costs associated with such trips, made preventive health care an unaffordable luxury prior to migration, and once migration occurs the tradition patterns are difficult to break. In such areas, the concept of seeking health assistance in cases other than severe illness is simply not an accepted custom, and even in an urban setting, there is resistance. The Project strategy of upgrading health centers so that

needed services will be available and affordable to this largely migrant population will thus be accompanied by an intensive program of community education which, in turn, will be reinforced by mass media campaigns.

Second, Project components designed to strengthen primary health services in marginal urban areas will reinforce family planning objectives. By providing health care services and well-baby clinical care as well as assuring maternal protection through pregnancy delivery, and into the first year after birth, couples will receive positive reinforcement in their decisions to space or limit their families. Demographic patterns clearly show a high correlation between health service availability, reduction in infant mortality, and contraception.

Third, urban health centers are generally located in geographically discrete neighborhoods, and MOH policy is to create public support of health activities by actively involving the community in its operations and outreach activities through "health committees." The committee then works with the community in determining priorities, such as promotion of school nutrition, construction of community latrines, or bringing pressure on local authorities for construction of basic health-related infrastructure. The health center then becomes an important community resource for a wide variety of activities which affect the population it serves.

## 2. Family Planning

The proposed integration of health and family planning in Peru has taken account of the widespread acceptability of the delivery of family planning services through the existing integrated health infrastructure of the MOH and Social Security. This model follows the experience of past AID support in Latin America for family planning, particularly during the nascent stage of development of a country's family planning program. The Project focuses on (1) the expansion and integration of family planning services into the primary health and private sector activities already underway; and (2) the coordination of national population policy and research analysis. Two key factors in understanding the proposed Project from a socio-cultural standpoint are: (1) that family planning is an accepted technology for which there is a large unmet demand; and (2) that integrating family planning within primary health care can improve and increase the impact of both services.

In the AID Population Task Force Report issued in June 1980, Peru appears among those priority countries worldwide which have an annual population increase of 400,000 or more. From the findings of that report, Peru now emerges as a country in which a voluntary family program should meet with positive results, due both to the great need for services which exists and to the positive government commitment

toward family planning under the Belaunde administration.

The 1977-79 World Fertility Study<sup>1/</sup> carried out in Peru showed that knowledge of fertility control measures was high, with 82% of ever-married women having heard of some contraceptive methods. Yet the same study showed that usage of modern methods was low because of the lack of widespread availability of modern contraceptives: 49% of ever-married women had used a method at some time, but only 23% had ever used an effective method. There is a clear demand for services in the public and private sectors, and limited service delivery systems to date in both sectors have met with a high level of acceptance.

a. Estimate of Unmet Need

As discussed above, knowledge of contraceptives does not necessarily promote their use. In Peru, the proportion of women who are at risk, but not currently using any method of contraception is an outstanding 59% (See Table 11). Eighty-five percent of those using contraception are not using an efficient method. There is also a very high unmet need of 27% for women at risk who do not want more children. Those at the upper end of the age spectrum might benefit from voluntary sterilization services, if available. (See Table 12).

The estimate of unmet demand for contraception is that 27% of the women "at risk" desire some contraception and 50% of the women "at risk" desire efficient or modern methods. The substantial unmet demand in Peru suggests that it is feasible to reduce fertility levels by increasing the availability of services, especially in rural and marginal urban areas and in areas where the average educational level is low. Additional emphasis should be placed upon increasing the accessibility of efficient methods to women who do not want more children.

Although knowledge of contraceptive methods is fairly high, it should be noted that this knowledge is often both incomplete and inaccurate. The greatest number of women have familiarity with oral contraceptives (63%), injection (61%), female sterilization (59%). Only half of the women reported knowing about the IUD. Male sterilization is recognized by the fewest women, only 19%. Knowledge of all methods is less than in other countries in Latin America.

<sup>1/</sup> Recent sources, mostly of Peruvian authorship, were consulted in undertaking this analysis. The primary data source on fertility knowledge, practice, and unmet demand was the World Fertility Survey carried out by INE in 1977-78, Peruvian Population Problems, a major report of AMIDEP, Lima 1980 (410 p.), and "Diagnosis of the Social and Economic Situation of the Peruvian Woman," CEPD, Lima 1975.

TABLE 11

PERCENTAGE OF EXPOSED WOMEN - ESTIMATES OF UNMET NEED

<u>TYPE</u>	<u>PERCENT</u>
1. Exposed women	
a. Not using any method	59%
b. Not using efficient method	85%
2. All exposed women who want no more children	
a. Not using any method	27%
b. Not using efficient method	50%

SOURCE: World Fertility Survey  
First Country Reports,  
Tables 5.2.3 and 5.2.3.B

b. Current Use of Contraception

As indicated in Table 13, Peru has a relatively low level of contraceptive use when compared to other countries, especially other Latin American countries. According to the World Fertility Survey, the following percentages of exposed women\* in Peru are current users of some form of contraception:

Total	41.2%
Current age	
15-19	24%
20-24	38
25-29	46
30-34	50
35-39	42
40-44	39
45-49	31

\*Sample = 3,851 women

c. Current Services

At present, family planning services cover only a small portion of the Peruvian population. Of the total number of women at risk, only 330,471 or 14% are currently using effective methods of contraception, according to the World Fertility Survey. Thus, a full 85% of the female population at risk is not reached with family planning services by the existing health structure. It is estimated that of those 330,471 women using effective methods, approximately 80% or 264,376 are currently receiving contraceptives through commercial and street sales and private medical facilities. Approximately 10%, or 33,047 women, are receiving services in organized private sector programs including ADIFAM, Hospital Loayza, Instituto Marcelino, ALAFARPE and others. An additional 10% are receiving services from the public health infrastructure of the Ministry of Health, Social Security Institute and the Armed Forces.

d. Benefit Incidence: Family Planning

Potential benefits, of a successful population program which results in progressive reductions in family size as well as in the overall population growth rate are numerous.

First, major health benefits will be fostered by this Project. (1) Fewer pregnancies, accompanied by increased spacing between births, will reduce the incidence of complications during pregnancy that often result in adverse health effects for both the mother and the fetus. (2) With increased spacing between pregnancies, low-income mothers will have a longer period in which to breastfeed their infants, a distinct

TABLE 12

KNOWLEDGE OF CONTRACEPTIVE METHODS:  
PERCENTAGE OF EVERY MARRIED WOMEN WHO HAVE EVER HEARD  
OF SPECIFIC METHODS, PERU, 1969 AND 1977-1978

<u>METHOD</u>	<u>ENAF (1977-78)*</u>	<u>PECFAL (1969)**</u>
Any method	82	36
Pill	63	28
Injection	61	6
Female Sterilization	59	13
Rhythm	55	16
IUD	49	5
Douche	47	14
Condom	40	15
Withdrawal	40	8
Diaphragm Spermicides	31	8
Male Sterilization	19	4
Other	11	3

SOURCE: World Fertility Survey of Peru 1977-1978

\* Table 4.1 and 4.2

\*\* Table 4.2 (Comparative Survey of Fertility in  
Latin America, 1969)

TABLE 13

PERCENTAGE OF CURRENTLY MARRIED WOMEN AGE 15-44 USING CONTRACEPTION BY METHOD,  
SELECTED AREAS IN LATIN AMERICA AND THE UNITED STATES OF AMERICA

Current Use and Method	United States (1976)	Sao Paulo State, Brazil (1978)	Costa Rica (1978)	Panama* (1976)	Mexico (1978)	Paraguay (1977)	Peru (77-78)	El Salvador (1975)
<u>Currently Using</u>	<u>67.8</u>	<u>63.9</u>	<u>63.9</u>	<u>53.9</u>	<u>41.0</u>	<u>25.7</u>	<u>25.4</u>	<u>21.8</u>
Orals	22.3	27.8	23.2	17.0	14.0	10.1	4.2	7.4
Sterilization	19.3	16.1	14.6	21.6	7.0	2.9	2.7	9.8
IUD	6.1	0.4	5.1	3.7	7.0	3.4	1.4	2.0
Condom	7.2	6.6	8.4	1.2	1.0	1.8	1.1	0.6
Other Methods	12.9	13.0	12.6	10.4	12.0	7.4	16.0	2.0
<u>Not Currently Using</u>	<u>32.2</u>	<u>36.1</u>	<u>36.1</u>	<u>46.1</u>	<u>59.0</u>	<u>74.3</u>	<u>74.6</u>	<u>78.2</u>
Number of Women (in sample)	8,611	1,880	2,037	2,723	2,663	1,208	5,076	1,351
Reported or Estimated Crude Birth Rate (per 1,000 population)	14.8	23.9	29.8	30.8	38.0	46.0	42.0	43.0

\* Includes only women 20-49. It is estimated that 47% of currently married women age 15-44 were currently using contraception.

SOURCE: Morris, Leo "The Use of Contraceptive Prevalence Surveys to Evaluate the Family Planning Program in El Salvador and Other Countries in Latin America". Paper presented at EIS Conference, Atlanta, Georgia, 1979.

advantage especially in low-income target areas where parents cannot afford to purchase food supplements of the same nutritional value as maternal milk. (3) Improved infant nutrition as well as birth of fewer children due to increased spacing will have a positive impact on family nutrition in general. One result should be a decline in the incidence of second and third-degree malnutrition in children under five years old.

Second, a variety of economic and social benefits will result from family planning: (1) Low-income families, as a result of having fewer children, will be able to enjoy a higher standard of living (2) By the year 2000, fewer workers than currently estimated should be entering the workforce. (3) Yearly savings to the GOP in social and welfare programs (e.g. health and education services, subsidies) should be significant. (4) Crowding should be significantly lower, especially in low-income urban areas where existing housing is more adequate for smaller families. (5) Many children, who might otherwise lack the financial means to complete their academic/vocational training, should be able to continue with their schooling.

Finally, family planning has a high and positive impact on the role of women. With fewer pregnancies and increased spacing between pregnancies, adverse effects on maternal health can be significantly reduced. Freedom from childbearing and the ability to space and plan numbers of births will also free target group women to devote more time to roles other than those of wife and mother. In particular, a significant number of women living in low-income urban areas, many of whom are heads of household, will be able to work in full-time, salaried jobs. Finally, as wives and mothers, women with fewer children should also have the time to be more effective in these roles as well as pursue other social and economic opportunities.

With a fertility rate in Peru of 6.4 children per woman, the potential impact of a well-organized, nationwide family planning program is great. The number of pregnancies a woman has, her age, the interval between pregnancies, and socio-economic conditions are primary determinants of the health impact of childbearing. Maternal and infant mortality and morbidity are higher among adolescent mothers and women in their thirties and older. With the delivery of a fourth child, the incidence of maternal death, stillbirth, and infant mortality also rises and increases with each subsequent delivery. A reduced number of pregnancies and greater spacing of births improves the nutritional status of women, as well as the health of her offspring. Finally, abortion complications are also one of the leading causes of death among women of reproductive age<sup>1/</sup>. Clearly, the general health of women would

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<sup>1/</sup> See Complications of Abortion in Developing Countries, Population Reports, July, 1980.

improve dramatically if family planning measures were more widely available and used, especially since at present only 22.1% of Peruvian women receive pre-natal care, only 26% receive medical attention at the time of birth, and only 6.6% receive post-natal care.

Access to family planning services also offers psychological security for women to the extent that they may perceive themselves as having more control over their lives. The economic benefits should not be under emphasized either, since the family can be limited to the number of children that are desired and that can be supported. Finally, limiting the size of the family may offer opportunities for women to seek employment outside the home or for educational advancement. By drawing women outside their homes and families, education may bring about changes in self-image, further developing independent values and aspirations.

A substantial number of women (36%) practice both modern and less effective methods of contraception, even though they would like to have more children--and thus are using contraceptives for the purpose of spacing their children.

Despite the opposition of the Velasco Government to all efforts to provide either family planning information or services, the knowledge acquired by Peruvian women during that period was relatively high. In 1969, only 36% of the married females had some knowledge of specific contraceptive methods. This percentage rose to 82% by 1977-78, when the World Fertility Study was completed. This increase can only be explained by the significant motivation and interest of the women themselves to search for information to reduce their own fertility even through the inefficient means available at that time.

## E. Economic Analysis

### 1. Benefits of Improved Health Care

Health care is a basic human need, one which until very recently has been effectively denied to a significant portion of Peru's lowest economic strata population. Traditionally in Peru, health care has been almost exclusively associated with the modern urban sector; the high cost of establishing adequate health infrastructure in outlying rural areas, combined with a reluctance on the part of trained professionals to leave the conveniences of the major cities, has resulted in a concentration of medical facilities in a handful of urban areas leaving a majority of the population either unserved or drastically underserved.

The present government, cognizant of the developmental implications of extending adequate health services to these unserved and underserved areas, has embarked upon an ambitious program of primary health coverage. The long-range economic benefits which will accrue as a

result of such coverage cannot be quantified with any degree of precision, but there exists a substantial body of evidence that suggests a strong correlation between improved health care in developing countries and productivity.<sup>1/</sup> Productivity, measured in terms of increased work units as a result of better human health and longer lives, is, however, only one of the economic benefits which results from investments in this sector. There are also significant savings which accrue to society:

-- By focussing on preventative and non-institutional health care, costs associated with institutional curative care will be lowered (macro-economic, or societal, saving); similar levels of improved health will be achieved at lower cost.

-- Improved health is associated with increased nutrient absorptive capacity, as well as a reduced incidence of intestinal parasites; the combined effect is equivalent to a larger supply of food (macro-economic, or societal, saving).

-- Decreased family expenditures result from time and transportation costs saved as a consequence of peripherally located primary health services (micro-economic, or family, savings)

-- Fewer work days are lost as a result of worker illness or family illness requiring principal wage-earners to be absent (micro-economic, or family, savings).

The above list is, of course, not inclusive, but rather represents some of the quantifiable benefits which improved peripheral health care provides. (See Annex II Exhibit G for health and population sector data and Annex II Exhibit K for demographic, economic and socio-cultural data.)

## 2. Benefits of Family Planning

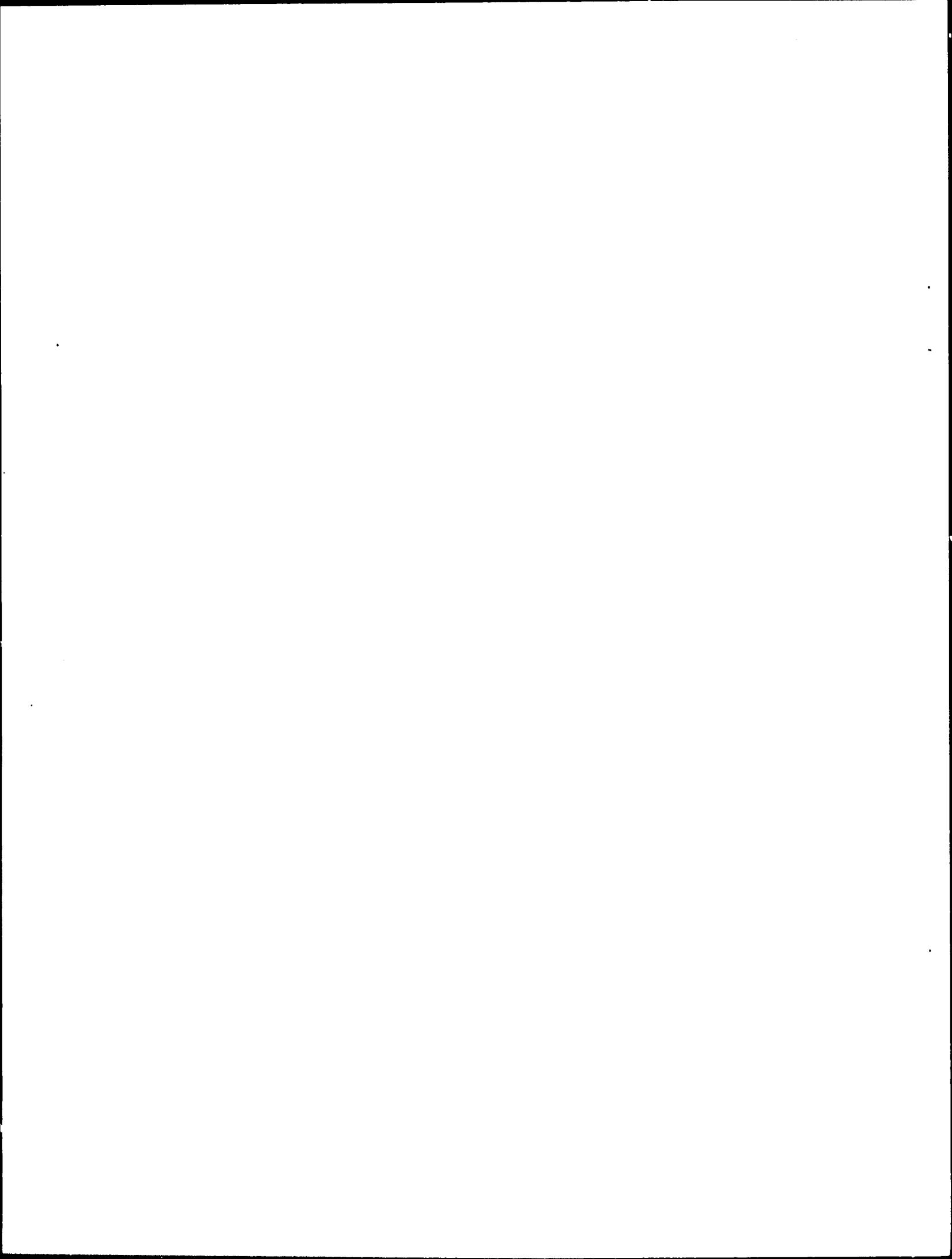
The Population Policy Guidelines, approved by the GOP in August 1976, discussed Peru's population problem in terms of two basic economic factors: production and employment.

### a. Production

The annual growth rate in national product was estimated at approximately 5.7% for the period from 1950 to 1962; this

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<sup>1/</sup> See U.S. World Development Agenda 1977, which compares data on per capita income, infant mortality and life expectancy for all developing countries.



only result in further deterioration of the quality of life in Peru. The proposed Project is an important first step in responding to the GOP's increasing concern of equating population growth with the country's economic potential.

C. Cost Effectiveness of Primary Health Approach

The proposed Project will result in measureable savings to users of the primary health system. At present, as outlined in the social soundness analysis, there are few options open to the poor in terms of securing health care, and until such time that adequate services are extended to rural and marginal urban areas these existing options are costly, both in terms of cash outlay and time expended. An average health consultation, in either a State-run facility or in a private clinic, will generally have a real user cost of from US \$4 to US \$12, as shown in the following table:

Type Facility	<u>1/</u> Consultation Fee (Median)	Time Expended	Lost Income (at 50¢/hr.)	Transportation Costs	Total
MOH Hospital	.50	6 hrs.	\$3.00	\$1.20	\$4.70
Clinic "A"	2.80	2 hrs.	\$1.00	.60	\$4.40
Clinic "B"	5.00	3 hrs.	\$1.50	.80	\$7.30
Clinic "C"	8.00	4 hrs.	\$2.00	\$1.20	\$11.20

The "average" cost of a consultation, excluding medication, is thus about \$6.90 -- the approximate amount of money needed to feed a family of six for one day, in a typical marginal urban pueblo joven.

The primary health system supported by the present Project is designed to increase coverage as well as reduce user costs. While the real costs to users differ from region to region, the following figures are representative (figures in US \$):

Region Facility	Consultation Fee (Median)	Time Expended	Lost Income (at 50¢/hr.)	Transportation Costs	Total
Ica: Health Center (semi-urban)	.25	1 hr.	.50	.50	1.25
Ica: Health Center (semi-rural)	.25	30 min.	.25	.25	.75
Lima: Health Center (urban)	1.00	1 hr.	.50	.50	2.00
Lima: Health Post (semi-urban)	.50	30 min.	.25	.25	1.00
Trujillo: Health Center (urban)	.50	1 hr.	.50	.25	1.25
Trujillo: Health Post (rural)	.25	1 hr.	.50	.25	1.00

1/ Clinics "A", "B", & "C" reflect the actual consultation fee scales at three Lima facilities; "A" is located in Comas, a largely pueblo joven area to the north of Lima; "B" is located in the center of Lima; "C" is located in San Isidro, a largely upper class suburb to the south of Lima. While all these figures are from the Lima Metropolitan area, they are not atypical of health care costs in other urban areas. Level of subsidy is higher in MOH facilities.  
2/ MOH estimates.

Using the above figures, we can calculate the "average" cost of a typical health consultation to be \$1.20, or a savings of approximately \$5.70 per beneficiary when compared to the existing formal health care system.

The project proposes extending primary health assistance to an estimated 250 health centers, with an intended target group of beneficiaries of over a million persons per year. Total yearly user savings as a result of strengthening the primary health systems, will be on the magnitude of US\$5.7 million.

In addition to user savings, the Project is also cost effective from the point of view of societal allocation of resources. If the GOP is to achieve its nationwide health objectives over the next five years, there are three basic alternative courses of action which it can follow: (1) a massive upgrading and expansion of existing "formal" facilities, including MOH hospitals and private sector clinics; (2) immediately embarking upon an ambitious program of relocating medical personnel out of Lima and other major urban areas into the sierra and jungle; or (3) following the primary health model as outlined in the current national plans for health improvement. While it is not possible, given available data, to precisely quantify the costs associated with the first two alternatives, we can estimate the magnitudes to be close to one billion dollars in the first case, and at least US\$30 million in the second alternative over a five year period. These figures have been calculated on the following basis:

Alternative 1: Upgrading/Expanding Existing Formal Facilities.1/

---Construction of five new hospitals in Lima (240 beds) @ \$80 million each	\$400,000,000
---Construction of 20 regional hospitals (80 beds) in currently unserved areas @ \$20 million each	400,000,000
---Construction of 150 Community Health Centers @ \$500,000 each	75,000,000
---Annual maintenance/operation costs for all new facilities: \$20 million a year for 5 years	<u>100,000,000</u>
	\$975,000,000

Alternative 2: Relocation of Medical Personnel

---200 medical personnel @ \$20,000/yr. for five years	\$20,000,000
---Transport costs	3,000,000
---Separate maintenance for families: \$5,000 x 200 x 5	5,000,000
---Upgrading 200 health centers @ \$10,000 ea. (new equipment)	<u>2,000,000</u>
	\$30,000,000

1/ Based on MOH figures for planned expansion.

The first alternative is clearly beyond the GOP's capacity to mobilize financial resources, and the second represents little more than a costly interim measure. At the same time, neither shows any guarantee that it would promote a system designed to reach down to the community level where health problems can be treated--and prevented--in a cost-effective manner.

The GOP's decision to promote primary health, then, is obviously based in large part upon the very finite resources that it is capable of mobilizing--but, also it is a positive response to health care needs within Peru.

In terms of the population component, the Mission feels that the proposed technology represents a proven cost-efficient way. A commercial retail sales program has been rejected at this time, as discussed in the social analysis section.

#### F. Environmental Impact

An Initial Environmental Examination was carried out during preparation of the PID and a negative determination was recommended by the Mission Director. The IEE was reviewed and approved by the LAC Bureau's Environmental Advisor on January 30, 1981. A copy of the IEE is attached as Annex I Exhibit F.

V. IMPLEMENTATION

A. Project Schedule

The Project will be implemented over a four and one-half year period. (See Project Implementation Schedule, Table 14 and First Year Implementation Plan, Table 15.) Project negotiations and signing will take place in July 1981 and Conditions Precedent will be met by December 1981. This period will be used by the Ministry for the purpose of Project planning and for the procurement of commodities and technical assistance needed for initial Project implementation, in addition to meeting CPs. Project activities will begin in January 1982 and continue through December 1985.

Primary Conditions Precedent will be met by September 1981, at which time the MOH will submit to AID a list of commodities to be procured for the first year of Project activities. These will be ordered so as to be able to start training and the delivery of services as soon after January 1982 as possible. Shortly, after the primary Conditions are met, the secondary Conditions Precedent will be fulfilled. To meet the secondary Conditions, each of the participating institutions will develop a time-phased operational plan for the life of the Project. This plan will be submitted to the MOH for review and then forwarded by the Ministry to USAID for approval. Initial Project-funded short-term technical assistance may be used to assist the institutions in the preparation of these plans, once initial Conditions Precedent have been met. The plans will provide detailed information for the first year, including a quarterly schedule of activities; a detailed financial plan a plan for supervision of Project activities at regional and community levels, with projected personnel requirements; and a local purchase procurement plan. Information for subsequent years will be more general with plans being updated on a yearly basis. The plans will be reviewed by USAID and the MOH each year, and approved by the Mission prior to beginning disbursements for each Project year.

During the first year of Project activities, primary health services will be expanded to approximately 25% of the estimated target population of one million, located in pueblos jovenes of Arequipa, Lima and Chimbote. Much of the training and foreign procurement of equipment and medicines will take place in the first two years of the Project. A total of 250 health centers will receive equipment and 500 promoters will be trained. Family planning services will be initiated through the rural primary health care delivery system in 17 health regions. In each of the three succeeding years of the Project, 250,000 additional persons in pueblos jovenes will receive community level health services and an additional 500 promoters will be trained. Family planning activities will be gradually expanded each year in each of the health regions.

## B. Disbursement Procedures

Of the \$10,800,000 grant and loan amount, \$6,750,000 is budgeted for the foreign currency cost of technical assistance and procurement of equipment and materials as shown in Table 3 of the Financial Analysis. Grant funds in the amount of \$1,608,000 will be obligated in FY-81 in order to fund initial requirements in technical assistance, contraceptive supplies, training, supervision and research. Additional grant funds will be required in each subsequent fiscal year, as detailed in Table 4 of the Financial Analysis, for the purchase of contraceptive supplies and support of training and supervision activities. Loan funds will also be disbursed in each subsequent year.

For local currency costs (\$4,050,000), AID will make disbursements directly to each institution with prior approval of both the institution's yearly operational plans and budgets by AID and the MOH. Disbursements will be made on an advance basis with liquidation of previous advances required prior to the issuance of a subsequent advance. This procedure has been used under the Integrated Primary Health and the Rural Water Systems Projects and has proved successful. Exact details of the advance and liquidation procedures will be worked out with personnel of the MOH and other participating institutions after the signing of the Agreement, and will be subsequently confirmed in Implementation Letter N° 1.

## C. Procurement and Contracting Procedures

### 1. Procurement and Contracting Mode

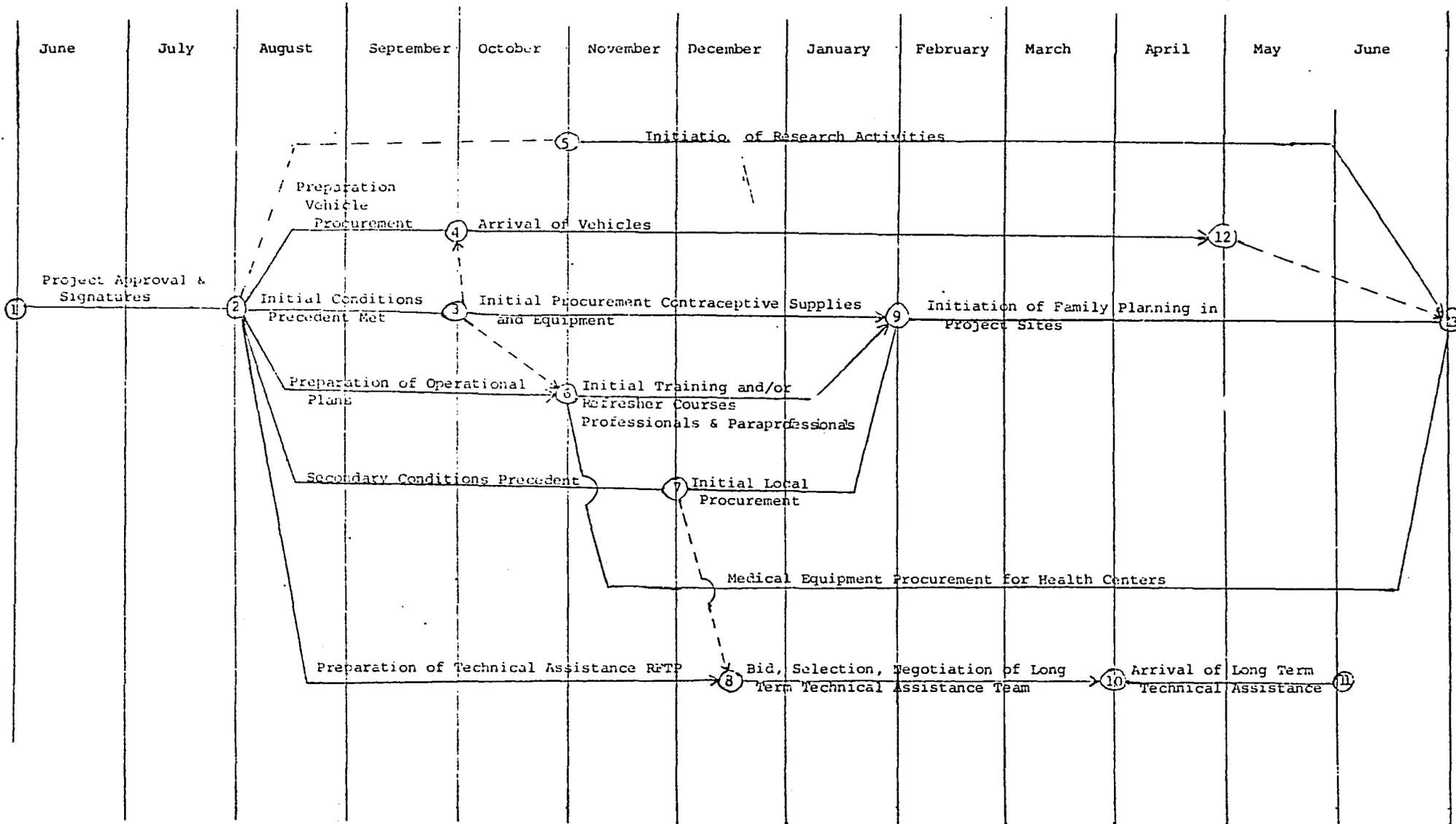
Under the previous two health sector projects financed by AID, Mission procurement mode has been utilized. This decision was made based on the limited staff resources which the Ministry had to implement the Projects and the lack of foreign procurement experience in obtaining large amounts of medical supplies, equipment and foreign technical assistance. During the implementation of the Integrated Primary Health Project, project-funded technical assistance was available to assist the Ministry in developing a detailed logistics plan for the distribution and control of the commodities provided under the Project. This plan also served as a basis for the logistics requirements under the Rural Water Systems Project.

While this assistance has been helpful in providing the MOH with the beginnings of a workable logistics system, it has also highlighted the limited staff resources and institutional capability of the Ministry to carry out local and international procurement for both commodities and technical assistance. Given these limitations and the large volume (both in dollar amount and the number of pieces) of supplies to be procured, the Mission believes that an exception to the country contracting policy as set forth in PD 68 is justified.

PROJECT IMPLEMENTATION SCHEDULE

PROJECT ACTIVITY	1981	1982	1983	1984	1985
	JFMAMJJASOND	JFMAMJJASOND	JFMAMJJASOND	JFMAMJJASOND	JFMAMJJASOND
1. Project Approval	x				
2. Project Signed	x				
3. Initial Conditions Precedent Met	x				
4. Preparation of Operational Plans	---				
5. Coordination/Orientation Seminar	--				
6. Preparation of Vehicle Procurement	--				
7. Vehicle Procurement	-----				
8. Secondary Conditions Precedent Met	x				
9. Initial Procurement of Contraceptive Supplies & Equipment	-----				
10. Subsequent Procurement of Contraceptives & Equipment		-----			
11. Local Procurement		-----	-----	-----	-----
12. Medical Equipment Procurement		-----			
13. Drug Procurement		-----	-----	-----	
14. Initiation of Family Planning Services at Project Sites		-----			
15. Research		-----	-----	-----	-----
16. Evaluation & Monitoring		--	-	-	---
17. Project Assistance Completion Date					x

TABLE 15  
FIRST YEAR IMPLEMENTATION PLAN



addition, with regard to the contraceptive supplies and equipment, extensive AID experience and existing contractual arrangements with U.S. suppliers will greatly facilitate procurement of these items. Since the rapid availability of these commodities will be critical to assuring a favorable Project impact, all procurement of foreign currency purchased goods and services will be performed by USAID. During the implementation of this and the other Mission-funded projects with the MOH, the Mission will continue to work with MOH staff to develop the contracting capabilities required for the Ministry to administer the procurement required for projects of this type. By the end of this Project, the MOH will have the institutional capability to carry out international procurement for the types and quantities of the commodities required to continue a national family planning program.

## 2. Procurement Plan

The sources and origin of grant-financed goods under the Project will be the United States and Peru. The nationality of suppliers of grant-financed goods and services under the Project will be the United States or Peru. The source and origin of loan-financed goods under the Project will be countries included in AID Geographic Code 941 or Peru. The nationality of suppliers of loan-financed goods and services under the Project will be countries included in AID Geographic Code 941 or Peru.

Project-funded technical assistance will be obtained through one or more institutional contracts. Standard AID contracting procedures will be utilized. Procurement of medicines, vehicles, equipment and commodities will also follow standard AID procurement procedures. Off-shore procurement will be carried out by AID. Local procurement will be effected by the Ministry utilizing procedures acceptable to AID.

A waiver is being requested for procurement of a locally produced oral rehydration salts in order to speed procurement and delivery as well as to support local production. Until recently, the MOH was unable to interest any local pharmaceutical manufacturer in producing this item, and the lack of local production capability hindered Ministry programs which were aimed at reducing the effects of infant dehydration as a result of diarrheal disease. Now that locally produced supplies are available, the MOH has begun a national campaign to combat this important health problem and the Mission wishes to support the MOH effort.

Procurement of vehicles, medical equipment, and medicines and contraceptives will be effected as soon as the Conditions Precedent have been met. Local procurement as well as additional procurement of contraceptives will take place each year.

D. USAID Monitoring Requirements

The USAID Project committee will monitor this Project and will have the following responsibilities:

1. Project Management

The Project Manager will be assigned from the Mission's Health, Education, and Nutrition Office. The Project Manager will work closely with the MOH General Directorate of Maternal-Child Health and Population, representatives of other participating agencies, and technical advisors to ensure that the provisions of the AID Project Agreement and Implementation Letters are met. The Project Manager will be assisted by the Mission Project Committee and will work closely with the Project Manager of the Primary Health Loan so as to assure complementary implementation and close coordination of both Mission-funded projects.

2. Joint Reviews

Joint reviews, undertaken by AID and GOP representatives, will be held periodically and will be an essential feature of Project implementation.

3. Evaluation

The Mission Evaluation Officer will coordinate periodic evaluations.

4. Disbursement

The Mission Controller will review disbursement requests and disbursements to ensure conformity with AID regulations and adequate financial control.

5. Additional Mission offices, such as Development Resources, the Executive Office and the Regional Legal Adviser, will be called upon as appropriate.

MCHP will submit to AID the following reports to assist the Mission in monitoring the Project:

1. A quarterly report of activities and counterpart expenditures completed as well as projections for the following quarter.

2. An annual implementation plan, including a projection of Project activities for the coming year and an annual operating budget with GOP counterpart allocation and AID local currency requirements.

### E. Evaluation Plan

In addition to periodic reviews and continual monitoring, two major evaluations will be undertaken. Approximately one year after Project implementation activities begin or when it is considered technically feasible by representatives of the institutions involved and/or AID, a comprehensive evaluation will be undertaken. The evaluation will:

1. Summarize and review the monitoring activities of the institutions involved and examine data collection management.

2. Assess overall Project management and supervision with emphasis on the logistics/support system, e.g., the distribution of basic health equipment, medicines, family planning, commodities, and other inputs. If problems are detected, the evaluation will recommend specific steps to remedy the identified problems.

3. Analyze technical assistance provided under the Project and make recommendations if necessary.

4. Assess integration of public and private institutions participating in Project activities.

The final evaluation, to be undertaken shortly before Project completion, will concentrate on Project impact.

The evaluation will determine the attainment of Project goals and purpose as described in Sections III, A and B of the PP and in the Project Logical Framework (Annex II Exhibit 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 Peru has both the financial capability and human resources capability to effectively maintain and utilize the proposed Project: INTEGRATED HEALTH/FAMILY PLANNING.

  
\_\_\_\_\_  
Leonard Yaeger, Director  
USAID/Peru



MINISTERIO DE SALUD

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# BEST AVAILABLE DOCUMENT

Lima,

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Señor  
LEONARD YAEGER  
Director de la Agencia para  
el Desarrollo Internacional  
C I U D A D

Estimado Señor Yaeger :

Tengo el agrado de dirigirme a Ud. en relación a nuestro Proyecto "Extensión de Cobertura de Servicios de Salud Integral Materno - Infantil", con el propósito de solicitar oficialmente a la Agencia para el Desarrollo Internacional - AID de los Estados Unidos de Norte América, el otorgamiento de un préstamo de US\$ 4'000,000 en las condiciones más favorables que concede AID, así como también una donación de US\$ 6'800,000. La contrapartida nacional para este monto ascenderá a US\$3'600,000.

Los fondos del préstamo solicitado serán utilizados para brindar apoyo a la expansión de servicios de salud primaria en las áreas marginales urbanas, y los fondos de la donación se utilizarán para apoyar la política del Gobierno Peruano de proveer servicios de planificación familiar, a fin de que las personas puedan implementar su decisión voluntaria e informada sobre la dimensión de su familia.

Hago propicia la oportunidad para expresar a Ud. Señor Director, mi mayor consideración.

Atentamente,

Uiel Ormaiz

DRAFT PROJECT AUTHORIZATION

Name of Country: Peru  
Name of Project: Integrated Health/Family Planning  
Number of Loan: 527-U-076

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Integrated Health/Family Planning Project for Peru involving planned obligations of not to exceed \$4,000,000 in Loan funds and \$6,800,000 in grant funds over a 4 1/2 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 (1) strengthening basic primary health services in marginal urban areas and reinforcing the service delivery capabilities of the health centers of the Peruvian Ministry of Health and (2) expanding and integrating family planning services in Peru into the public and private health sector and reinforcing national population policy formulation and research analysis.

3. The Project Agreement(s) which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with

AID regulations and Delegations of Authority, 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.

4. a. Interest Rate and Terms of Repayment

The Cooperating Country shall repay the loan to A.I.D. in U.S. Dollars within twenty-five (25) years from the date of first disbursement of the Loan, including a grace period of not to exceed ten (10) years. The Cooperating Country 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 10 (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 of Origin of Goods and Services (Loan)

Goods and services, except for ocean shipping, financed by A.I.D. under the Loan 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 Peru or countries included in A.I.D. Geographic Code 941.

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

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

d. Conditions Precedent to Disbursement

(1) Condition Precedent to Initial Disbursement (Loan and Grant)

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, the Cooperating Country shall furnish, in form and substance satisfactory to A.I.D., evidence that a Project Representative has been officially designated by the Ministry of Health.

(2) Condition Precedent to Disbursement for the Activities of Any Implementing Organization Under the Project, Except the Ministry of Health (Loan and Grant)

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement for the activities of any Implementing Organization under the Project, the Cooperating Country shall furnish, in form and substance satisfactory to A.I.D. an agreement between that Ministry of Health and such Implementing Organization describing the mutual responsibilities of the Ministry of Health and the Implementing Organization under the Project.

(3) Condition Precedent to Disbursement for Project Activities other than Initial Technical Assistance Activities (Loan and Grant )

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, to finance any project activities other than such technical assistance as necessary for the first year of project activities, the Cooperating Country and each Implementing Organization shall furnish, in form and substance satisfactory to A.I.D. an Operational Plan for Family Planning and Primary Health. Each Operational Plan shall include a Staffing Plan, a Supervision Plan and a Technical Assistance Plan, a Procurement and Distribution Plan, a Financial Plan, and a Training Plan. The Staffing Plan should describe the personnel to be provided by the MOH and each participating institution at each level of activity, as well as the name and qualifications of the individuals holding such positions and evidence that they have been assigned to the position. The Supervision Plan should describe the institutional and financial arrangements made by the MOH and each participating institution to assure adequate levels of supervision during Project implementation. In addition, the MOH plan should describe the system under which incentives for health professionals assigned to rural areas will be paid. A copy of the agreement to be entered into between the MOH and each health professional should be included for AID approval. The Operational Plan of the Ministry of Health may be submitted in parts, by health regions. Disbursement may be made for activities in a given health region or for a given Implementing Organization once the Operational Plan for that region or Implementing Organization has been approved by A.I.D.

(4) Condition Precedent to Disbursement for Project Activities in Each Project Subsequent to the First Project Year

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, for any project activities in each Project Year subsequent to the First Project Year, the Cooperating Country and each Implementing Organization shall furnish, in form and substance satisfactory to A.I.D., an Operational Plan for such year. Each Operational Plan shall include a Staffing Plan a Supervision Plan a Technical Assistance Plan, a Procurement and Distribution Plan, a Financial Plan, and a Training Plan. Operational Plans shall reflect the recommendations of the annual evaluations conducted under the Project prior to the beginning of each subsequent Project Year. The Operational Plan of the Ministry of Health may be submitted in parts, by health region. Disbursement may be made for activities in a given region or for a given Implementing Organization once the Operational Plan for that region or organization has been approved by A.I.D.

Covenants

- (1) Peru shall covenant that it will establish a community distribution system for health and family planning services.
- (2) Peru shall covenant that it will carry out Project activities in accordance with relevant United States legislation on family planning, as from time to time may be explained in Project Implementation Letters. In accordance with the preceding, Peru covenants that no Project activities or funds shall support the performance of abortions as a method of family planning or the

motivation of coercion of any person to practice abortions, nor the performance of involuntary sterilizations as a method of family planning or the coercion or provision of any financial incentive to any person to undergo sterilizations.

(3) Peru shall covenant that it will continue to provide sufficient annual budget allocations following completion of A.I.D. financing so as to assure continuity of the Project activities, including maintenance of Project funded equipment; supervision by health personnel of the activities which were funded under the Project; and incentives paid to health personnel assigned to rural areas for the life of the Project.

The following waivers to A.I.D. regulations are hereby approved. The rule that A.I.D.-financed pharmaceuticals must be of U.S. source is hereby waived to permit the procurement in Peru of oral rehydration salts.

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## 5C(1) - COUNTRY CHECKLIST

Listed below are, first, statutory criteria applicable generally to FAA funds, and then criteria applicable to individual fund sources: Development Assistance and Economic Support Fund.

### A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FAA Sec. 116. Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? Yes
  
2. FAA Sec. 481. Has it been determined that the government of a recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the United States unlawfully? No
  
3. FAA Sec. 620(b). If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement? Yes
  
4. FAA Sec. 620(c). If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government? No
  
5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? No

A.

6. FAA Sec. 620(a), 620(f); FY 79 App. Act, Sec. 108, 114 and 606. Is recipient country a Communist country? Will assistance be provided to the Socialist Republic of Vietnam, Cambodia, Laos, Cuba, Uganda, Mozambique, or Angola? No
7. FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression? No
8. FAA Sec. 620 (j). Has the country permitted or failed to take adequate measures to prevent the damage or destruction, by mob action, of U.S. property? No
9. FAA Sec. 620(l). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, inconvertibility or confiscation, has the AID Administrator within the past year considered denying assistance to such government for this reason? Yes
10. FAA Sec. 620(o); Fishermen's Protective Act of 1967, as amended, Sec. 5. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters:
- a. has any deduction required by the Fishermen's Protective Act been made? No
- b. has complete denial of assistance been considered by AID Administrator? Yes
11. FAA Sec. 620; FY 79 App. Act, Sec. 603. (a) Is the government of the recipient country in default for more than 6 months on interest or principal of any AID loan to the country? (b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act appropriates funds? No
12. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget which is for military expenditures, the amount of foreign exchange spent on military equipment and the Yes, as reported in annual report on implementation of Sec. 620(s)

111

B.1.

b. FAA Sec. 104(d)(1). If appropriate, is this development (including Sahel) activity designed to build motivation for smaller families through modification of economic and social conditions supportive of the desire for large families in programs such as education in and out of school, nutrition, disease control, maternal and child health services, agricultural production, rural development, and assistance to urban poor?

Yes

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2. Economic Support Fund Country Criteria

a. FAA Sec. 502B. Has the country engaged in a consistent pattern of gross violations of internationally recognized human rights?

N.A.

b. FAA Sec. 533(b). Will assistance under the Southern Africa program be provided to Mozambique, Angola, Tanzania, or Zambia? If so, has President determined (and reported to the Congress) that such assistance will further U.S. foreign policy interests?

N.A.

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

N.A.

d. FY 79 App. Act, Sec. 113. Will assistance be provided for the purpose of aiding directly the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?

N.A.

e. FAA Sec. 620B. Will security supporting assistance be furnished to Argentina after September 30, 1978?

N.A.

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. 65J (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)?

A notification will be sent to the Congress concerning this project.

Yes.

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?

Yes

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?

N.A.

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?

N.A.

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.

In theory, if its purpose were only to distribute commodities, the Project might be executed as part of a regional or multilateral project. However, the Project seeks to have more impact than mere distribution of commodities by attempting to help Peru develop its population policy and extending an outreach effort in health and family planning services tied in to a prior bilateral Mission loan.

A.

7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise)

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

12. FY 79 App. Act Sec. 608. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar, or competing commodity?

Much of the goods and services under the Project will be purchased from private U.S. sources

Peru will provide counterpart to meet the cost of many services required by the Project. Local goods and services will be paid for with local currency.

No

Yes

N.A.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b); 111; 113; 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained

The Project will promote the participation of women in the national economy of Peru and improve their status by giving them greater control over family planning

B.1.a.

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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. 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.)

(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;

(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.

(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;

(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

(i) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(ii) to help alleviate energy problems;

(iii) research into, and evaluation of economic development processes and techniques;

(iv) reconstruction after natural or manmade disaster;

The Project is designed explicitly to emphasize low cost, integrated delivery systems for health 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, and community distribution systems.

8.1.b.(4).

(v) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

(vi) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

c. [107] Is appropriate effort placed on use of appropriate technology? Yes

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)? Yes

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to the Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"? N.A.

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental and political processes essential to self-government.

There is tremendous demand in Peru for the services to be provided by the Project. An essential component of the Project is the involvement of Peruvian leaders in family planning policy.

g. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase or productive capacities and self-sustaining economic growth?

Yes, by helping to limit excessive population growth

2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan, including reasonableness of repayment prospects.

In the Mission's judgement, Peru has the capacity to repay the loan. Based upon events of the past few years, Peru ability and will to repay the loan make it reasonable to expect repayment.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

N.A.

AID HANDBOOK 3, App 5C(2)	TRANS. MEMO NO. 3:32	EFFECTIVE DATE June 7, 1979	PAGE NO. 5C(2)-5
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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?

N.A.

ANNEX I  
Exhibit D  
Page 9 of 12

5C(3) - STANDARD ITEM CHECKLIST

Listed below are statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

- |   |   |
|---|---|
| 1. <u>FAA Sec. 602</u> . Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed?  | Such arrangements will be written into the Loan/Grant Agreement |
| 2. <u>FAA Sec. 604(a)</u> . Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him?  | Yes   |
| 3. <u>FAA Sec. 604(d)</u> . If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the United States on commodities financed?  | N.A.  |
| 4. <u>FAA Sec. 604(e)</u> . If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity?  | N.A.  |
| 5. <u>FAA Sec. 608(a)</u> . Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items?   | Yes   |
| 6. <u>FAA Sec. 603</u> . (a) Compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates. | Compliance will be required in the Loan/Grant Agreement         |
| 7. <u>FAA Sec. 621</u> . If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the  | Yes.  |

PAGE NO. 5C(3)-2	EFFECTIVE DATE June 7, 1979	TRANS. MEMO NO. 3:32	AID HANDBOOK 3, App 5C(3)
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ANNEX I  
Exhibit D  
Page 11 of 12

A.7.

facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

8. International Air Transport, Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available?

Yes

9. FY 79 App. Act Sec. 105. Does the contract for procurement contain a provision authorizing the termination of such contract for the convenience of the United States?

Contracts to which this provision is applicable will contain such a provision.

B. Construction

1. FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest?

N.A.

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

N.A.

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the United States not exceed \$100 million?

N.A.

C. Other Restrictions

1. FAA Sec. 122 (e). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?

Yes

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

N.A.

3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-bloc countries, contrary to the best interests of the United States?

Yes, the Loan/Grant Agreement will contain this restriction.

4. FAA Sec. 636(i). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the United States, or guaranty of such transaction?

Yes, this restriction will be incorporated in the Loan/Agreement.

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5. Will arrangements preclude use of financing:

a. FAA Sec. 104(f). To pay for performance of abortions or to motivate or coerce persons to practice abortions, to pay for performance of involuntary sterilization, or to coerce or provide financial incentive to any person to undergo sterilization?

Yes, the Loan/Grant Agreement will reflect this restriction.

b. FAA Sec. 620(g). To compensate owners for expropriated nationalized property?

Yes

c. FAA Sec. 660. To finance police training or other law enforcement assistance, except for narcotics programs?

Yes

d. FAA Sec. 662. For CIA activities?

Yes

e. FY 79 App. Act Sec. 104. To pay pensions etc., for military personnel?

Yes

f. FY 79 App. Act Sec. 106. To pay U.N. assessments?

Yes

g. FY 79 App. Act Sec. 107. To carry out provisions of FAA sections 209(d) and 251(h)? (Transfer of FAA funds to multilateral organizations for lending.)

Yes

h. FY 79 App. Act Sec. 112. To finance the export of nuclear equipment, fuel, or technology or to train foreign nations in nuclear fields?

Yes

i. FY 79 App. Act Sec. 601. To be used for publicity on propaganda purposes within United States not authorized by the Congress?

Yes

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ING BUDGET CONSTRAINTS, CAN SUPPORT, AT A MINIMUM, THE PROJECT'S RECURRENT COSTS. THE MISSION SHOULD CONSIDER REQUIRING INCREASING GOP COUNTERPART CONTRIBUTIONS FOR THESE COSTS EACH YEAR DURING THE PROJECT SO THAT BY THE LAST YEAR COUNTERPART IS FINANCING ALL THE RECURRENT COSTS OF THE SYSTEM. DURING INTENSIVE REVIEW THE MISSION SHOULD ALSO EXAMINE EACH PROJECT COMPONENT, E.G. MOBILE HEALTH UNITS, TO INSURE IT IS THE MOST COST EFFECTIVE MEANS TO DELIVER HEALTH/FAMILY PLANNING CARE IN VIEW OF MOH RESOURCE CONSTRAINTS. WE NOTE THE FINANCIAL ANALYSIS PLANNED UNDER THE PRIMARY HEALTH PROJECT WOULD BE VERY USEFUL IN IDENTIFYING BUDGETARY TRENDS IN THE MOH AND FOR CARRYING OUT THE RECURRENT COST ANALYSIS. IN THE FINANCIAL PLAN, WE WERE CONCERNED WITH THE LEVEL OF FUNDS BUDGETED FOR THE IEC COMPONENT AND FOR INFLATION AND CONTINGENCIES GIVEN THE CONTINUING HIGH INFLATION RATES IN PERU AND IN THE U.S. THE MISSION SHOULD ALSO EXAMINE THE NEED TO INCLUDE FUNDS FOR THE BILATERAL COMPONENT OF A COMMERCIAL RETAIL SALES PROGRAM.

See Technical  
Analysis.

C. EXPERIENCE TO DATE:

THE BACKGROUND SECTION OF THE PP SHOULD SUMMARIZE THE RESULTS OF THE IN-DEPTH EVALUATION OF THE SUR MEDIO PROJECT SCHEDULED FOR FEBRUARY, 1981, AS WELL AS ANY IMPORTANT LESSONS LEARNED FROM INITIAL IMPLEMENTATION ACTIVITIES FUNDED UNDER THE PRIMARY HEALTH PROJECT. ANY PROBLEMS ARISING FROM THE DELIVERY OF CONTRACEPTIVES BY COMMUNITY AGENTS OR MIDWIVES SHOULD BE DISCUSSED

See Project  
Background &  
Annex II  
Exhibit H

D. TARGET GROUP:

THE PP SHOULD INCLUDE A COMPREHENSIVE DESCRIPTION OF THE CHARACTERISTICS OF THE CLIENT POPULATION TO BE SERVED

UNDER THE PROJECT INCLUDING A DISCUSSION OF THE MIX OF CONTRACEPTIVES TO BE USED. ALL THE BENEFICIARIES SHOULD BE ENUMERATED, INCLUDING MEN. FURTHERMORE, RECENT DATA WHICH SUPPORTS THE DEMAND FOR FAMILY PLANNING SERVICES SHOULD BE CITED IN THE PP.

See Social  
Soundness  
Analysis.

E. IMPLEMENTATION ARRANGEMENTS:

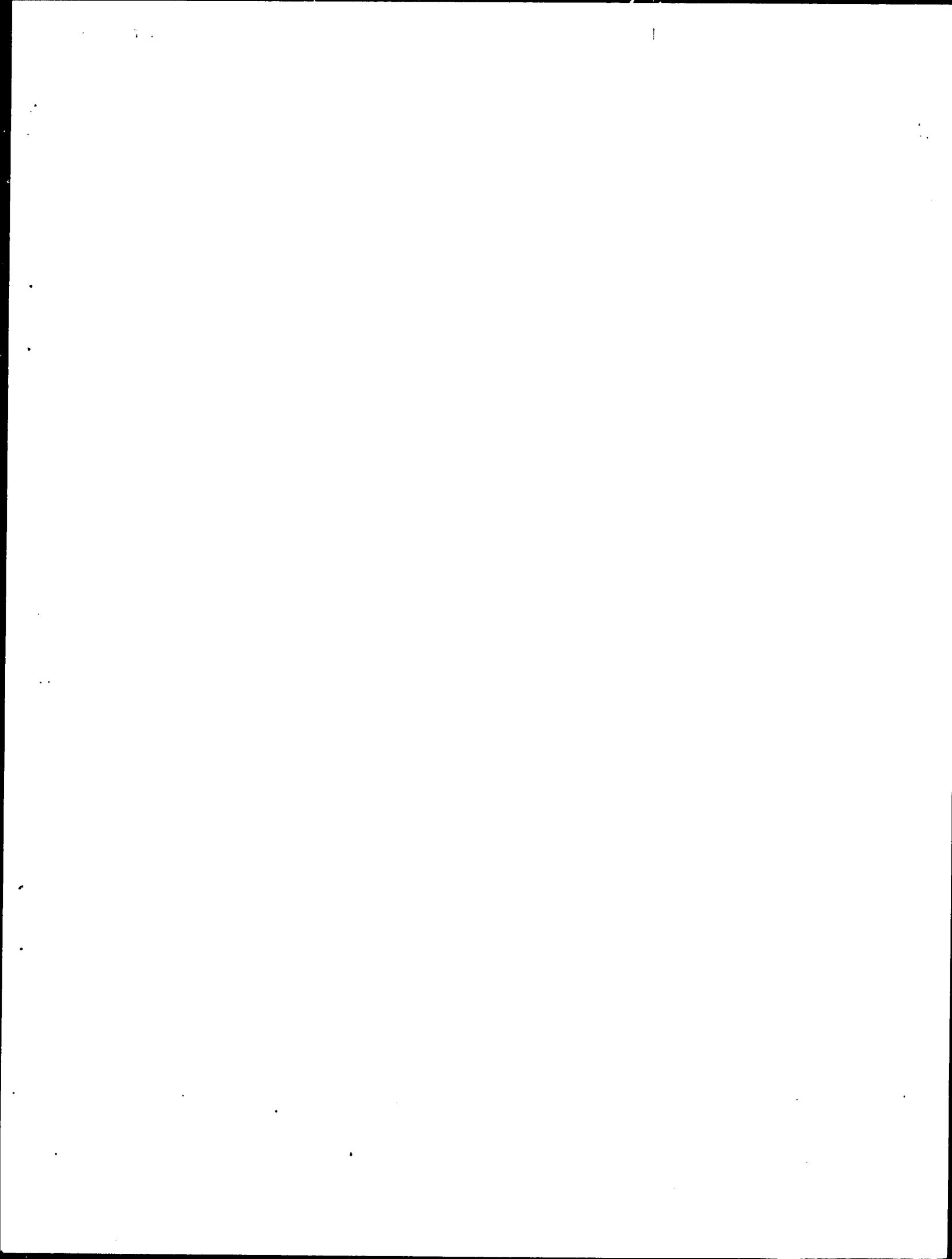
THE RELATIONSHIP OF THE MOH TO THE PRIVATE SECTOR AGENCIES SHOULD BE CLEARLY DESCRIBED IN THE PP AND THE PROCEDURES TO BE USED FOR APPROVING OPERATING PLANS AND FOR PAYMENTS TO THE PRIVATE ORGANIZATIONS SHOULD BE DELINEATED. BECAUSE OF THE LARGE NUMBER OF COMMODITIES TO BE PROCURED, I.E. CONTRACEPTIVES, MEDICINES, AND EQUIPMENT, A DETAILED TIME-PHASED PROCUREMENT PLAN SHOULD BE INCLUDED IN THE PP

See Institu-  
tional Analy-  
sis & Imple-  
mentation Plan

3. A NEGATIVE DETERMINATION FOR THE IEE HAS BEEN APPROVED FOR THE PROJECT BY THE BUREAU'S ENVIRONMENTAL ADVISOR.

HAIG

UNCLASSIFIED



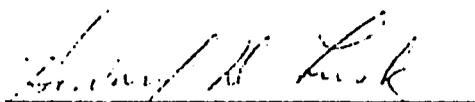
INITIAL ENVIRONMENTAL EXAMINATION

Project Location: Peru  
Project Title: Integrated Family Planning/Health  
Project Number:  
Funding: First FY:  
Life of Project:  
IEE Prepared by: Enrique Schroth USAID/Peru  
Acting Environmental Coordinator

The USAID/Peru project committee for the Integrated Family Planning/Health Project has undertaken a complete Initial Environmental 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 Integrated Family Planning/Health Project and concur in the Threshold Decision recommendation for a Negative Determination.

  
Howard D. Lusk, Acting 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 Integrated Family Planning/Health, I approve the Threshold Decision for a Negative Determination.

\_\_\_\_\_  
Assistant Administrator  
for Latin America

PROJECT: INTEGRATED FAMILY PLANNING/HEALTH

Project N°527-0230

Attachment to Annex  
Initial Environmental  
Examination (IEE)

IMPACT IDENTIFICATION AND EVALUATION FORM

Impact Identification  
and 1/  
Evaluation

Impact Areas and Sub-areas

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 ----- | N    |
| 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

IMPACT IDENTIFICATION AND EVALUATION FORM

C. ATMOSPHERIC

- 1. Air addtives \_\_\_\_\_ N \_\_\_\_\_
- 2. Air pollution \_\_\_\_\_ N \_\_\_\_\_
- 3. Noise pollution \_\_\_\_\_ N \_\_\_\_\_
- 4. Other factors \_\_\_\_\_  
\_\_\_\_\_

D. NATURAL RESOURCES

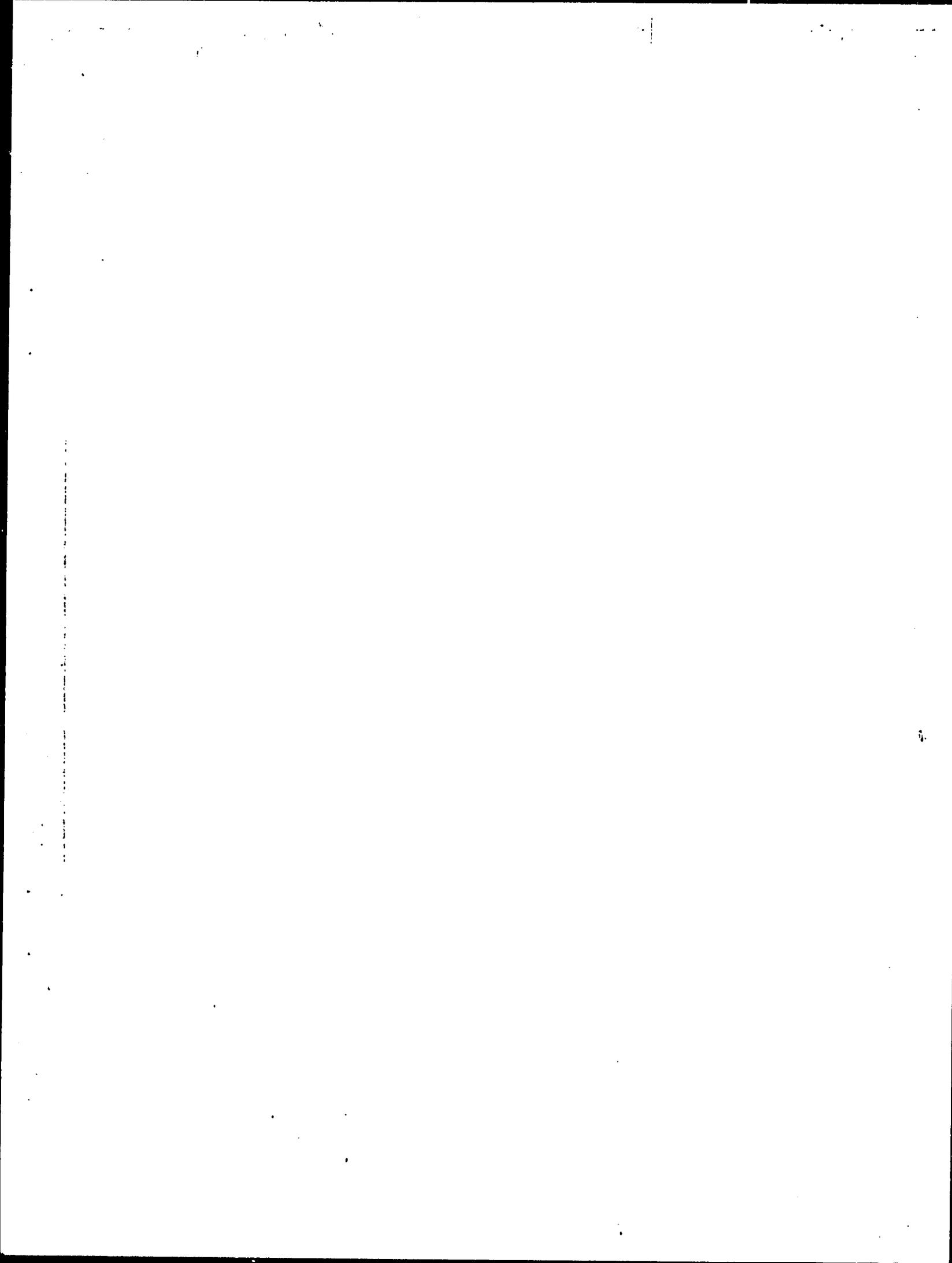
- 1. Diversion, altered use of water \_\_\_\_\_ N \_\_\_\_\_
- 2. Irreversible, inefficient commitments \_\_\_\_\_ N \_\_\_\_\_
- 3. Other factors \_\_\_\_\_  
\_\_\_\_\_

E. CULTURAL

- 1. Altering physical symbols \_\_\_\_\_ .. \_\_\_\_\_
- 2. Dilution of cultural traditions \_\_\_\_\_ N \_\_\_\_\_
- 3. Other factors \_\_\_\_\_  
\_\_\_\_\_

F. SOCIOECONOMIC

- 1. Changes in economic/employment patterns \_\_\_\_\_ L \_\_\_\_\_
- 2. Changes in population \_\_\_\_\_ L \_\_\_\_\_
- 3. Changes in cultural patterns \_\_\_\_\_ L \_\_\_\_\_
- 4. Other factors \_\_\_\_\_  
\_\_\_\_\_



V. 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 marginal urban areas and integrate family planning services into the health service system.

Project funds will be used to provide training to health professionals and workers, to purchase minimal equipment, materials and basic medicines for health centers, to purchase mobile vans for public health community level programs and to develop health data collection and logistics systems. 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 and family planning services 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.

# BEST AVAILABLE DOCUMENT

ANNEX II  
EXHIBIT A

PROJECT DESIGN SUMMARY

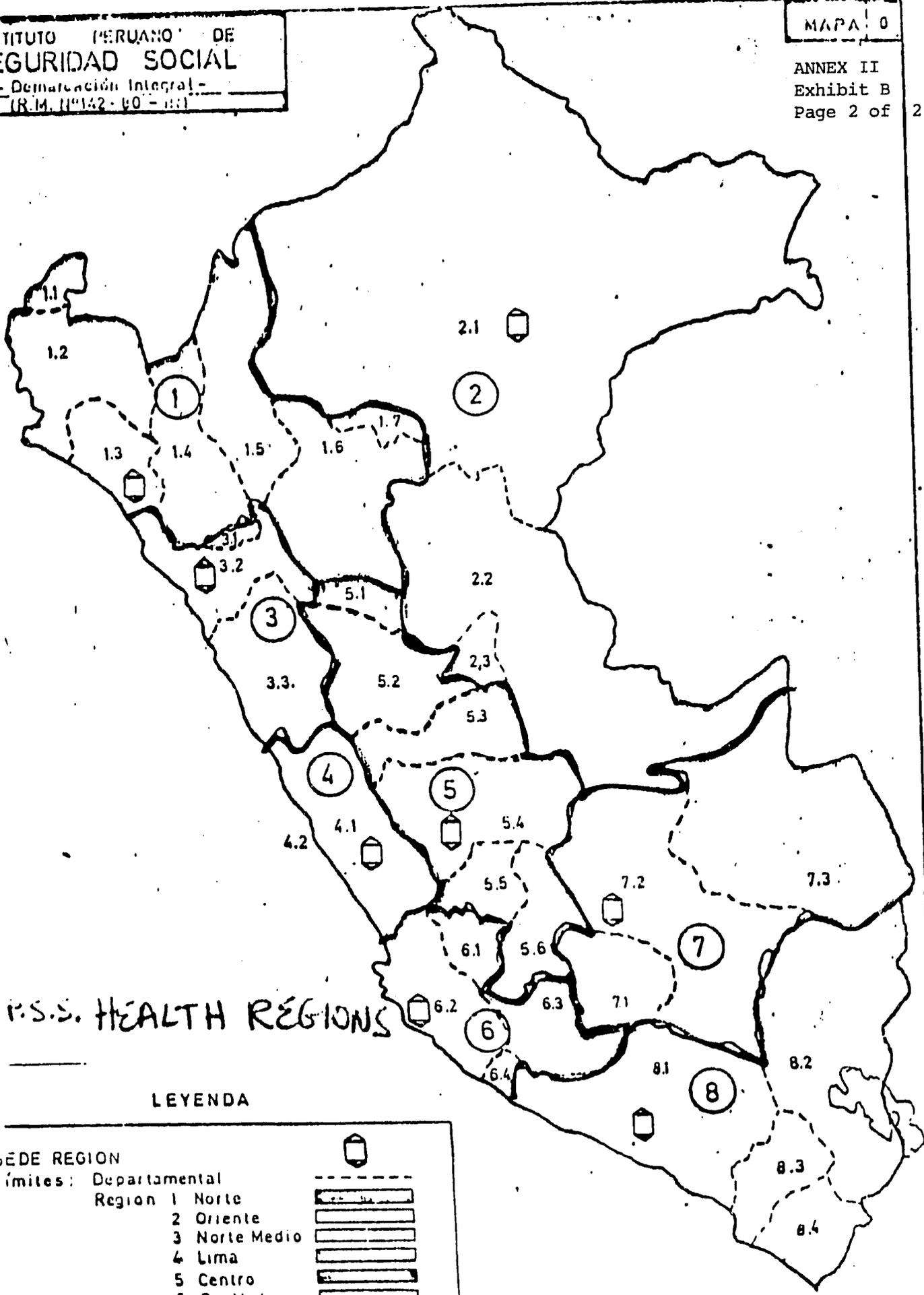
LOGICAL FRAMEWORK

Life Project:  
From FY 81 to FY 84  
Total U.S. Funding \$10,800,000  
Date Prepared: 15/4/81

Project Title & Number: Integrated Health/Family Planning

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes health and well-being of Peruvian poor improved.</p>	<p>Measures of Goal Achievement: Infant mortality reduced to 90 deaths per 1000 by 1990. Maternal mortality rate reduced to 30 per 10,000 by 1990.</p>	<p>National health and contraceptive prevalence surveys.</p>	<p>Assumptions for achieving goal targets: Government of Peru will continue support of health services to rural and marginal urban areas. Government of Peru will continue to implement its family planning program.</p>
<p>Project Purpose: 1. Basic primary health services in marginal urban areas strengthened and service delivery capability of MOH health centers reinforced. 2. Family planning services expanded and integrated into the public and private health sector and national population policy formulation and research analysis reinforced.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status. 1. 50% of marginal urban area population will have access to primary health and family planning services. 2. Among women at risk, prevalence of effective contraceptive methods will double from 15% to 30%.</p>	<p>National health and contraceptive prevalence surveys. Policy statements issued by National Population Council.</p>	<p>Assumptions for achieving purpose: Community participation components of existing health programs will continue to foster community involvement in health activities. Peruvian women will accept and use effective family planning methods. National Population Council takes the lead and plays an active role in policy formulation.</p>
<p>Outputs: 1. Health centers fully equipped. 2. Use of community-level health and family planning services by <u>pueblo joven</u> dwellers increased. 3. Number of persons using effective family planning methods increased. 4. Basic medicines provided. 5. Professionals trained. 6. Paraprofessionals trained. 7. Persons receiving family planning and health information via community education and mass media.</p>	<p>Magnitude of Outputs: 1. 250 2. 1,000,000 each year  3. 700,000  4. 800,000 5. 1,800 6. 2,000 7. 7,000,000</p>	<p>End-of-project evaluation report.</p>	<p>Assumptions for achieving outputs: Commodities are ordered and arrive in a timely manner.</p>
<p>Inputs: I. AID a. Equipment b. Medicines c. Training d. Information/Education/Communication e. Logistics System Support f. Supervision g. Technical Assistance, Studies h. Research and Evaluation i. Contingencies and Inflation     Sub-Total  II. GCP a. Equipment and Maintenance b. Medicines c. Training d. Information/Education/Communication e. Logistics and Administrative Support f. Supervision g. Technical Assistance h. Research and Evaluation     Sub-Total</p>	<p>Implementation Target (Type &amp; Quantity)(US\$000) I. a.      LOAN           GRANT           TOTAL    a.      825           285           1,110    b.      600           4,000          4,600    c.      480           660           1,140    d.      500           -              500    e.      395           85            480    f.      700           -              700    g.      -             580           680    h.      -             480           480    i.      500           610           1,110    Sub-Total   4,900       6,500       10,500  II. a.      710 b.      950 c.      520 d.      200 e.      400 f.      500 g.      170 h.      90 Sub-Total   3,600</p>	<p>AID disbursement records, GCP records.</p>	<p>Assumptions for providing inputs:</p>





I.P.S.S. HEALTH REGIONS

LEYENDA

SEDE REGION

límites: Departamental

- Region 1 Norte
- 2 Oriente
- 3 Norte Medio
- 4 Lima
- 5 Centro
- 6 Sur Medio
- 7 Sur Oriente
- 8 Sur

JGM (Abril 1980)

ANNEX II

EXHIBIT C

ORGANIZATIONAL INFORMATION

- C.1 Ministry of Health
- C.2 Peruvian Institute of Social Security
- C.3 National Population Council
- C.4 ASPEFAM
- C.5 National Institute of Statistics



MOH PHYSICIANS  
1979

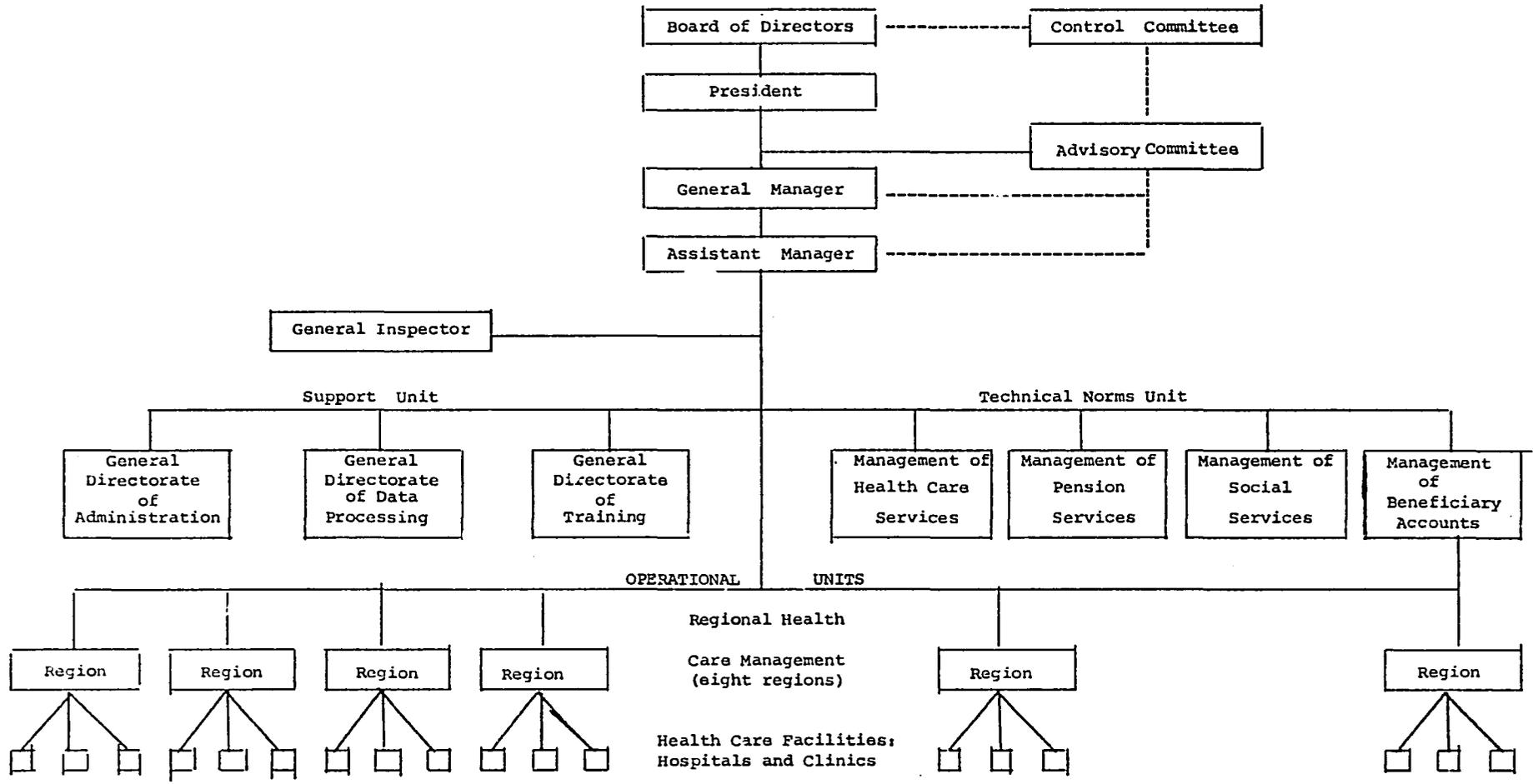
DEPARTMENTS	TOTAL No.OF PHYSICIANS	NUMBER OF INHABITANTS PER PHYSICIAN	RATIO OF PHYSICIANS PER 10,000 INHABIT.
Peru	10,246 (1)	1,687	5.9
Amazonas	19	15,347	0.65
Ancash	178	4,962	2.00
Apurimac	21	15,984	0.62
Arequipa	526	1,320	7.58
Ayacucho	42	12,577	0.79
Cajamarca	81	13,476	0.74
Callao	312	1,354	7.38
Cuzco	149	5,662	1.76
Huancavelica	24	15,434	0.64
Huánuco	73	6,802	1.47
Ica	255	1,830	5.45
Junín	196	4,457	2.24
La Libertad	498	1,958	5.11
Lambayeque	272	2,532	3.95
Lima (Provincia)	216	1,530	0.53
Lima Metropolitana	6,588	693	14.42
Loreto	131	5,011	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

DEPARTMENTS	TOTAL NO. OF PHYSICIANS	NUMBER OF INHABITANTS PER PHYSICIAN	RATIO OF PHYSICIANS PER 10,000 INHABIT.
San Martin	45	6,440	1.55
Tacna	94	1,345	7.44
Tumbes	43	2,235	4.47
No Ubicados	861	-----	----

(\* Source: Colegio Médico del Perú

(1) Does not include 861 physicians whose location is unknown

PERUVIAN SOCIAL SECURITY SYSTEM ORGANIZATIONAL CHART



I.P.S.S. Health Care Service System

Level

I. National Hospital	-800 + beds -Specialization of Services -Diagnosis and treatment -Hospitalization and Outpatient care -Ancillary Services -Preventive and Promotional -Family Planning
II. Central Hospital	-400 + beds -Less Specialized services -Diagnosis and treatment -Hospitalization and Outpatient care -Ancillary Services -Preventive and Promotional -Family Planning
III. Regional Hospital	-150 + beds -Same as Central Hospital
IV. Zonal Hospital	-80 + beds -Only general specialities available -Same as Central Hospital
V. Polyclinic	-Outpatient services -Basic Ancillary services -18 to 80 physicians -All specialties available
VI. Medical Center	-Outpatient Services -Minimal ancillary services -1 to 2 physicians -General Practitioner only -Referral
VII. Factory Post	-First Aid -Follow-up and referral -1 Physician with assistant
VIII. Sanitary Post	-First Aid and simple medicine -Nurses Aid -Referral -Rural Areas

INFRASTRUCTURE AND TERRITORIAL JURRISTITION OF THE I.P.S.S.

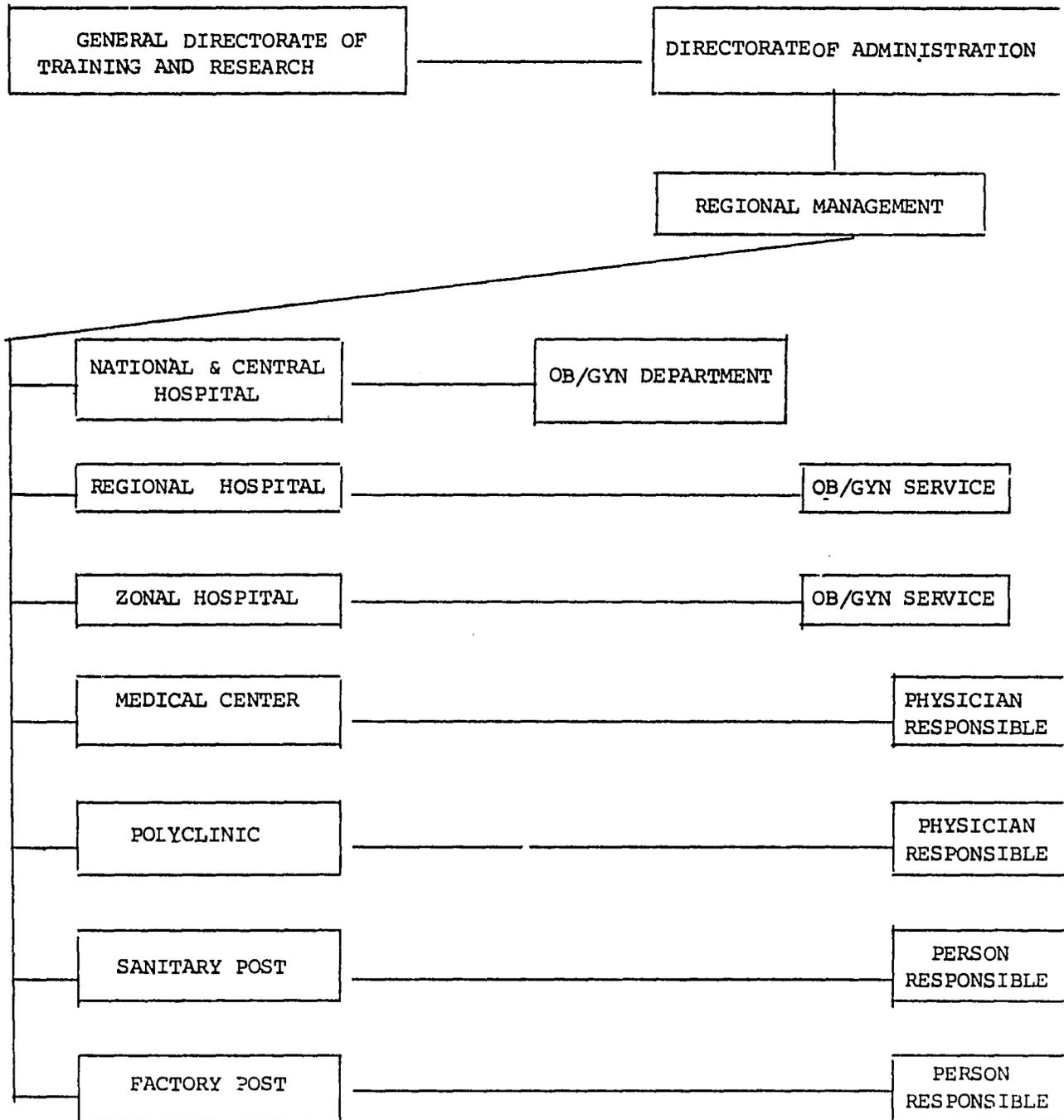
Region	Territorial Jurisdiction	Hosp.	Medical Center	Policlinic	Sanitary Post	Factory Post
North	Tumbes Piura Lambayeque Cajamarca except Prov. Cajabamba Amazonas San Martín, excep. the Dist. Uchiza & Tocache Loreto, only the Dist. Yurimaguas & Balsa Pto.	2	3		4	7
East	Loreto, except the Dist. Yurimaguas & Balsa Pto. Ucayali Huánuco, only the Dist. Honoría & Pto. Inca			2	3	-
Mid North	Cajamarca, only Prov. Cajabamba La Libertad Ancash	3	3		4	1
Lima	Lima Callao	6	1	3	8	65
Central	San Martín, only the Dist.. Tocache & Uchiza Huánuco, except the Dist. Honoría & Pto. Inca Pasco Junín Huancavelica, except Prov. Castrovirreyna Ayacucho, except Prov. Lucanas & Parinacochas	3	-	-	2	5
Mid South	Huancavelica, except Prov. Castrovirreyna Ica Ayacucho, only Prov. Lucanas & Parinacochas Arequipa, only the Dist. Acari, Bella Unión & Lomas	2	-	1	3	2
South East	Apurímac Cuzco Madre de Dios	-	3	-	6	2
South	Arequipa, except the Dist. Acari, Bella Unión & Lomas Puno Moquegua Tacna	2	7	-	10	9
	<b>TOTALES;</b>	<b>18</b>	<b>17</b>	<b>6</b>	<b>40</b>	<b>91</b>

I.P.S.S. HUMAN RESOURCES

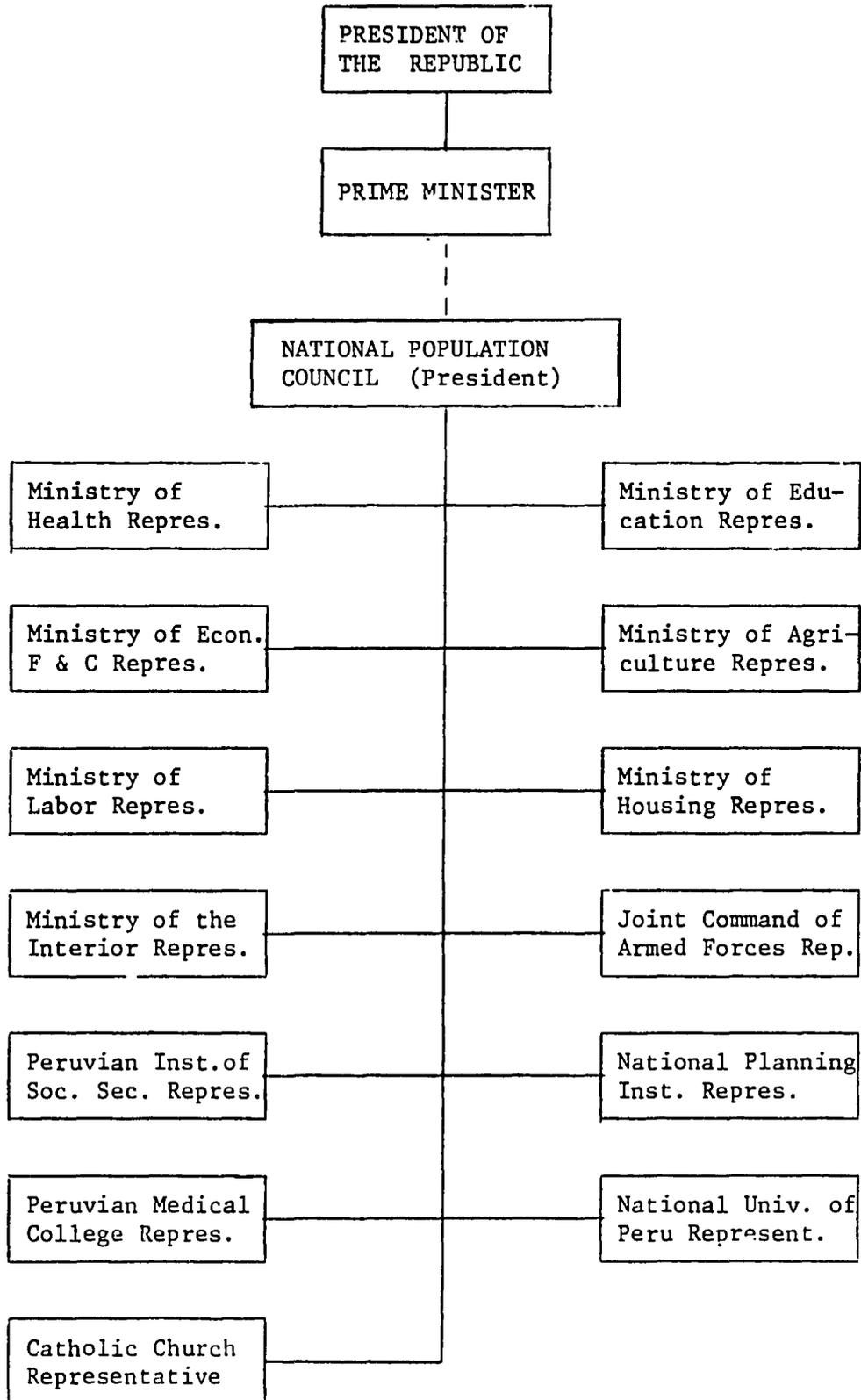
REGIONS		LIMA	NORTH & MID NORTH	SOUTH & MID SOUTH	CENTRAL	EAST	SOUTH EAST	TOTAL	
LEVELS									
<b>I</b>	<b>PROFESSIONAL</b>								
	1. Physician Directors	42	20	11	11	04	-	88	0.4%
	Physician Assistants	1619	455	293	116	19	29	2531	12.9%
	<b>TOTAL PHYSICIANS</b>	<b>1661</b>	<b>475</b>	<b>304</b>	<b>127</b>	<b>23</b>	<b>29</b>	<b>2619</b>	<b>13.4%</b>
	2. Dentists	117	43	33	18	7	4	222	1.1%
	3. Nurses	1638	427	244	101	1	11	2422	12.3%
	4. Nurse Mid-wives	255	38	22	6	-	-	321	1.6%
	5. Social Workers	78	23	11	7	3	-	122	0.6%
	6. Pharmacists	74	19	08	09	01	-	111	0.5%
	7. Dieticians	117	39	09	11	-	-	173	0.8%
	8. Psychologists	12	02	01	-	-	-	15	0.0%
	9. Accountants	33	18	08	09	01	01	70	0.3%
	10. Engineers	04	02	-	-	-	-	06	0.0%
	11. Others	29	05	06	03	-	-	43	0.2%
	<b>TOTAL PROFESSIONALS</b>	<b>4015</b>	<b>1091</b>	<b>646</b>	<b>391</b>	<b>36</b>	<b>45</b>	<b>6124</b>	<b>31.3%</b>
<b>II</b>	<b>TECHNICIANS</b>								
	1. Tech. Laboratory	186	41	11	09	02	03	252	1.2%
	2. Tech. X-Ray	112	17	07	05	-	03	144	0.7%
	3. Tech. Rehabilitation	96	30	04	10	-	-	140	0.7%
	4. Tech. Statistics	17	06	04	03	-	-	30	0.1%
	5. Tech. Maintenance	160	75	70	38	04	11	358	1.8%
	6. Others	321	19	10	09	02	-	261	1.8%
	<b>TOTAL TECHNICIANS</b>	<b>892</b>	<b>188</b>	<b>106</b>	<b>74</b>	<b>08</b>	<b>17</b>	<b>1285</b>	<b>6.5%</b>
<b>III</b>	<b>ASSISTANTS</b>								
	1. Nurses Aid	2469	775	398	141	16	57	3856	19.7%
	2. Laboratory Assistant	141	54	35	14	04	-	248	1.2%
	3. X-Ray Assistant	69	20	27	04	-	-	120	0.6%
	4. Statistics Assistant	43	07	06	02	01	-	59	0.3%
	5. Pharmacy Assistant	217	02	45	12	10	01	347	1.7%
	6. Rehabilitation Assistant	47	09	06	02	-	-	64	0.3%
	7. Others	1468	410	191	117	39	03	2228	11.4%
	<b>TOTAL ASSISTANTS</b>	<b>4454</b>	<b>1337</b>	<b>708</b>	<b>292</b>	<b>70</b>	<b>61</b>	<b>6922</b>	<b>35.4%</b>
<b>IV</b>	<b>ADMINISTRATIVE SUPPORT</b>								
	1. Accounting	383	93	57	51	03	-	587	3.0%
	2. Supplies	231	93	45	37	04	-	410	2.1%
	3. Personnel	175	38	20	31	01	-	265	1.3%
	4. Others	1002	227	208	91	16	14	1558	7.9%
	<b>TOTAL ADMINISTRATIVE SUPPORT</b>	<b>4454</b>	<b>451</b>	<b>330</b>	<b>210</b>	<b>24</b>	<b>14</b>	<b>2820</b>	<b>14.4%</b>
<b>V</b>	<b>PERSONNEL</b>								
	Maintenance	1791	436	312	193	08	18	2394	12.2%
	<b>ALL EMPLOYEES</b>	<b>12579</b>	<b>3503</b>	<b>2102</b>	<b>1060</b>	<b>146</b>	<b>155</b>	<b>19545</b>	<b>100</b>

NOTE: The geographical division of IPSS into 8 regions is recent, therefore, there is no separate information available for the 2 new regions that were added.

FLOW OF CONTRACEPTIVE SUPPLIES -- IPSS



ORGANIZATIONAL CHART - NATIONAL POPULATION COUNCIL



November 21, 1980 - "EL PERUANO"

YESTERDAY THE GOVERNMENT ESTABLISHED THE NATIONAL  
POPULATION COUNCIL

Supreme Decree No. 049-80-PCM

The President of the Republic

Considering:

The Supreme Decree No.244/64-DGS which is dated December 4, 1964 established the Center for Population and Development Studies. The principle objectives of this center are to serve as coordinating agency to study and investigate population growth, collect and disseminate all information related to population and development, evaluate the population problems in the country and study the requirements for feasibility of establishing a population policy at the national level.

The Supreme Decree No.00625-76-SA dated August 31, 1976 provided guidelines for the establishment of a Population Policy in order to focus the population policy toward an integral view of the population problem and to promote development and national security objectives. The policy will have a multisectorial approach as the essential element for its implementation.

Thus for this purpose, it is necessary to establish an organism which provides both technical orientation, and coordinates and reviews all actions to be developed at the national level in the field of population:

With the approval of the Council of Ministers, the President decrees:

Article 1.- The National Population Council is to be established as the central and ruling organism to promote, coordinate and direct the population activities to be carried out by the Public Sector agencies, as well as those actions performed by individuals from the private sector, promoting and executing to that end, research and studies on population in the country,

disseminating the scientific findings and statistical information related to population dynamics.

The National Population Council will be the official representative of the Peruvian Government when dealing with foreign or international delegations regarding population issues.

Article 2.- The National Population Council will report directly to the President of the Council of Ministers and consist of a representative of the President of the Republic who will preside over all meetings, and representatives from the following Ministries and agencies:

Ministry of Health, whose representative will act as Vice-President

Ministry of Education

Ministry of Economy and Finance

Ministry of Agriculture and Food

Ministry of Labor

Ministry of Housing

The Joint Command of the Armed Forces

Ministry of Interior

Peruvian Institute of Social Security

National Planning Institute

Peruvian Medical College

Peruvian University

Peruvian Catholic Church

The President of the Council will be assigned by Supreme Resolution and all other representatives will be named by Resolution of the appropriate Ministry or by agreement of the Board of Directors. Their functions will be ad-honorem for a period of two renewable years.

Article 3.- The National Population Council will have an Executive Office in order to provide administrative support and to coordinate the fulfillment of the Council disposition and agreements.

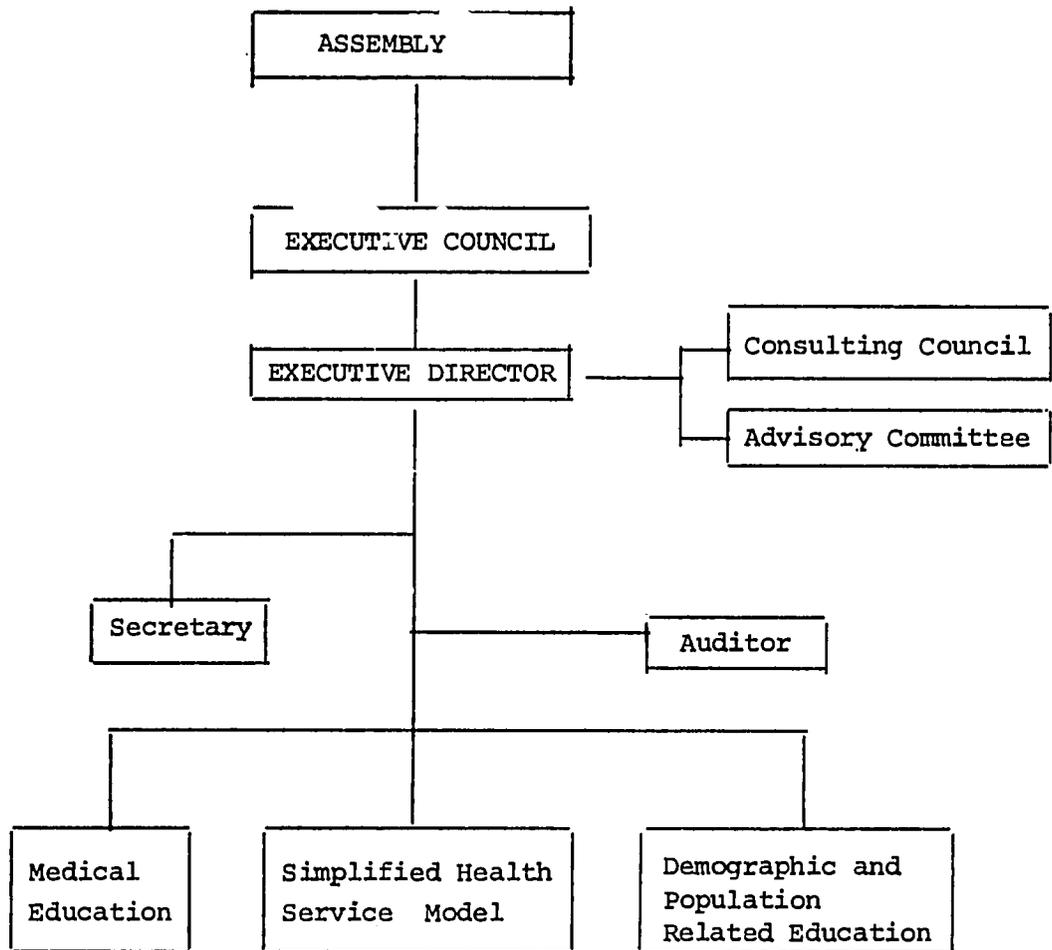
Article 4.- The National Population Council will be substituted for the Center for Population and Development Studies in all agreements contracts and commitments entered into or being negotiated.

Article 5.- Within a 90 day period from the establishment of the Council, a by-laws proposal will be submitted to the President of the Council of Ministers which will be approved by Supreme Resolution.

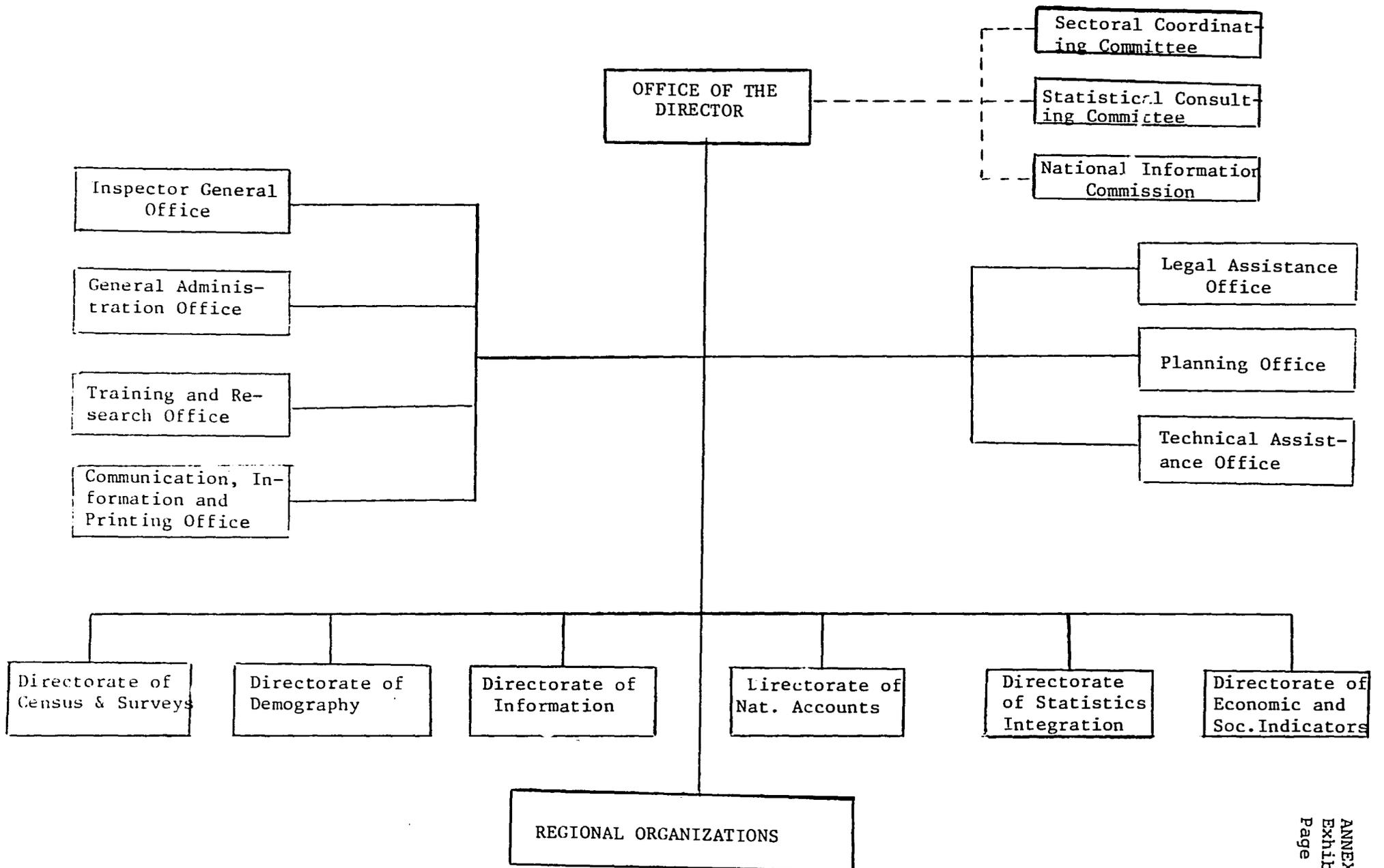
Article 6.- S.D. No. 244/64 dated December 4, 1964 creating the Center for Population and Development Studies will be terminated. All personnel, financial resources, materials, and goods will be transferred to the National Population Council.

Article 7.- This Supreme Decree will be signed by the President of the Council of Ministers.

ASPEFAM ORGANIZATIONAL CHART



ORGANIZATIONAL CHART - NATIONAL INSTITUTE OF STATISTICS



INE, March 1981

TECHNICAL ASSISTANCE PLAN

<u>MINISTRY OF HEALTH:</u> <u>Type of Assistance</u>	<u>Total No. of Months</u>	<u>FOREIGN ADVISORS*</u>		<u>NATIONAL ADVISORS</u>		<u>Total Cost</u>
		<u>No. of Months</u>	<u>Cost per Month</u>	<u>No. of Months</u>	<u>Cost per Month</u>	
Fiscal Management	36	6	\$10,000	30	\$1500	\$105,000
Management Information System/Evaluation	18	6	\$10,000	12	\$1500	\$ 78,000
Logistics and Inventory Control	33	9	\$10,000	24	\$1500	\$125,000
Training and Supervision	28	4	\$10,000	24	\$1500	\$ 76,000
Family Planning Service Delivery and Education	28	4	\$10,000	24	\$1500	\$ 76,000
		29	at \$10,000	114	at \$1500	\$460,000
<hr/>						
<u>IPSS: Health Planner</u> (Local technical assistance: 40 months at \$1500/mo)						\$ 60,000
<u>Semi-Autonomous Organizations:</u> Short term local technical assistance, up to 40 mos. at \$1500/mo.						60,000
<u>ASPEFAM:</u> Local Technical Assistance (approximately 13 work mos. at \$1500/mo.)						20,000
<u>National Population Council:</u> Technical Advisor (8 mos. Foreign Advisors at \$10,000/mo)						80,000
<hr/>						
TOTAL						\$680,000

\* It is planned that one long-term foreign advisor will provide<sup>21</sup> months of assistance covering several of these areas under an institutional contract for all foreign and local technical assistance.

COST BY PROJECT ELEMENT

	<u>Loan</u>	<u>Grant</u>
I. <u>Ministry of Health</u>	<u>\$3,500,000</u>	<u>\$4,535,000</u>
A. Equipment and Vehicles *	<u>\$420,000</u>	<u>\$196,000</u>
1. Medical Equipment		
a. Medical sets for health centers (250 at \$2,500 each)	\$625,000	
b. Minor surgery kits, 250 for health centers and 50 for hospitals (300 at \$200 each)	60,000	
c. IUD kits for 250 health centers and 50 hospitals (300 at \$120 each)		36,000
d. Mini-lap kits for hospitals (50 at \$300 each)		15,000
e. Minilap and vasectomy kits for hospitals (50 at \$400 each)		20,000
2. Education and Communication Equipment		
a. Slide projectors for 250 health centers (250 at \$500 each)		125,000
b. Radio units for hospitals areas (5 at \$4,000)	20,000	
3. Office Equipment		
a. Typewriters 3 at \$1,000 each)	3,000	
b. Calculators (25 at \$200 each)	5,000	
c. Card and file systems (20 at \$350)	7,000	
d. Other	5,000	
4. Vehicles (8 at \$12,500)	100,000	

(\* ) Includes transportation costs.

	<u>Loan</u>	<u>Grant</u>
<b>B. Medicines and Contraceptives</b>	<b>\$ 600,000</b>	<b>\$3,319,000</b>
1. Medicines (2,000,000 oral rehydration salts envelopes; 9,000,000 iron tablets, and 4,500,000 multivitamins)	600,000	
2. Contraceptives (6,951,500 oral contraceptive cycles; 9,712,500 condoms; 193,333 Lippes Loops IUDs, and 60,200 Copper Ts IUDs)		3,319,000
<b>C. Training</b>	<b>480,000</b>	<b>220,000</b>
1. Integrated Maternal-Child Health and Family Planning for nurses and midwives (10 five-week courses at a cost of \$8,000 each) -30 participants per course -330 total number trained		80,000
2. Integrated Maternal-Child Health and Family Planning for health auxiliaries (30 two-week courses at \$3,000 each) -20 participants per course -600 total number trained		90,000
3. Integrated Maternal-Child Health and Family Planning for Neighborhood Health Advocates (100 three-week courses at \$2,000 each) -20 participants per course -2,000 total number trained	200,000	
4. Epidemiology for Health Center Directors (25 five-day courses at \$1,600 each) -20 participants per course -500 total number trained	40,000	
5. Mass Media Communications Course for Educators (10 two-week courses at \$3,000 each) -15 participants per course -150 total number trained		30,000
6. Logistic/Management Course (10 two-week courses at \$2,000 each) -15 participants per course -150 total number trained		20,000
7. Management/Administration (20 three-week courses at \$3,000 each) -15 participants per course -300 total number trained	60,000	

	<u>Loan</u>	<u>Grant</u>
8. Training in Supervision (20 two-week courses at \$3,000 each) -15 participants per course -300 total number trained	60,000	
9. Coordination Workshop (60 four-day courses at \$2,000 each) -30 participants per course -1800 total number trained	120,000	
D. Logistic System/Administration Support	<u>395,000</u>	<u>42,000</u>
E. Information/Education/Communication	<u>500,000</u>	
F. Supervision	<u>700,000</u>	
G. Technical Assistance		<u>460,000</u>
H. Research		<u>258,000</u>
II. <u>Social Security</u>		<u>900,000</u>
A. Equipment		<u>70,000</u>
1. Medical Equipment		
a. IUD Kits for 18 hospitals and 63 health centers (100 at \$120 each)		12,000
b. Mini-lap Kits for 18 hospitals (40 at \$300 each)		12,000
c. Mini-lap and Vasectomy Kits for 18 hospitals (40 at \$400 each)		16,000
2. Education and Communication Equipment		
a. Slide projectors for 18 hospitals (20 at \$500 each)		10,000
b. Film projectors for 18 hospitals (20 at \$1,000 each)		20,000

	<u>Loan</u>	<u>Grant</u>
<b>B. Medicines and Contraceptives</b>		
1. Contraceptives (1,054,800 oral contraceptive cycles; 1,160,000 condoms; 110,400 Lippes Loops IUDs; 27,500 Copper-Ts IUDs; other methods for 25,100 users)		610,000
<b>C. Training</b>		
		<u>160,000</u>
1. Program Management Course for Regional directors and national coordinator (1 five-day course at a cost of \$2,250 each) -9 participants per course -9 total number trained		2,250
2. Physician Refresher Course (1 two-day course at a cost of \$1,250 each) -10 participants per course -10 total number trained		1,250
3. Family Planning Trainer Course (1 ten-day course at a cost of \$12,000 each) -24 participants per course -24 total number trained		12,000
4. Family Planning Provider Course (11 ten-day courses at a cost of \$7,227 each) -20 participants per course -220 total number trained		79,500
5. Annual Population Policy Conference		9,000
6. Evaluation and Follow-up Supervision		16,000
7. Pamphlets, posters, paper, printing (in house) and distribution		25,000
8. Films and other audio-visual materials		15,000
D. Technical Assistance		<u>60,000</u>
III. <u>Semi-Autonomous Organizations</u>		<u>175,000</u>
A. Equipment		<u>10,000</u>
1. Medical Equipment		
a. IUD Insertion kits (50 at \$120 each)		6,000

	<u>Loan</u>	<u>Grant</u>
2. Education/Communication Equipment		
a. Slide Projector (2 at \$500 each)		1,000
b. Film Projector (2 at \$1,000 each)		2,000
3. Other Equipment		1,000
B. Training		<u>90,000</u>
C. Logistics System/Administrative Support		<u>10,000</u>
D. Technical Assistance		<u>60,000</u>
IV. <u>ASPEFAM</u>		<u>260,000</u>
A. Equipment		<u>10,000</u>
1. IUD Insertion kits (20 at \$120 each)		2,400
2. Mini-lap kit (12 at \$300 each)		3,600
3. Mini-lap/Vasectomy kit (10 at \$400 each)		4,000
B. Training		<u>130,000</u>
(20 two-week courses at \$6,500 each)		
- 15 participants per course		
- 300 total number trained		
C. Administrative Support		<u>20,000</u>
D. Contraceptives (Pills & IUD's)		<u>33,000</u>
E. Research		<u>47,000</u>
F. Technical Assistance		<u>20,000</u>

	<u>Loan</u>	<u>Grant</u>
V. <u>AMIDEP</u>		<u>100,000</u>
A. Training, Seminars, Materials		60,000
B. Research (Studies, publications)		40,000
VI. <u>INE</u>		<u>120,000</u>
A. Training, Seminars, Materials		65,000
B. Research/Evaluation		55,000
VII. <u>National Population Council</u>		<u>100,000</u>
A. Technical Assistance (US advisor, 8 mos. at \$10,000/Mo.)		80,000
B. Research/Evaluation		20,000

S U M M A R Y

		<u>T O T A L</u>
I	MOH	\$ 8,035
II	I.P.S.S.	900
III	Semi-Autonomous Organizations	175
IV	ASPEFAM	260
V	AMIDEP	100
VI	INE	120
VII	National Population Council	<u>100</u>
	Sub-Total	9,690
	Contingencies and Inflation	<u>1,110</u>
	TOTAL	\$ <u>10,800</u>

EQUIPMENT LIST

Medical Equipment for Health Centers

<u>Item</u>	<u>Unit Price</u>	<u>No.</u>	<u>Cost</u>
<u>U.S. Purchase</u>			
Gynecological table	238.50	1	\$ 238.50
Examining stool (Taboret)	66.50	1	66.50
Foot stool	25.90	1	25.90
Utility stand	105.00	1	105.00
Gooseneck examining lamp	35.80	1	35.80
Scale physician adult metric	161.15	1	161.15
Mercurial Sphygmomanometer	70.00	1	70.00
Stethoscope binauricular	6.65	1	6.65
Fetoscope (Pinard)	35.00	1	35.00
Dressing jar	25.50	2	51.00
Emesia basin	6.50	2	13.00
Instrument tray w/c	25.92	2	51.84
Instrument tray	8.73	1	8.73
Medium size speculum	9.15	6	54.90
Large size speculum	10.80	3	32.40
Small size speculum	8.70	2	17.40
Sterilizer Instrument - Boiling type	800.00	1	800.00
Sound uterine	9.10	2	18.20
Forceps uterine tenaculum	19.00	2	38.00
Hammer reflex testing	15.70	1	15.70
Thermometers	0.50	6	<u>3.00</u>
Sub-Total (estimate cost)			\$ 1,850.00

Local Purchase

Examining table	1	
Instrument Cabinet	1	
Small desk	1	
Slides	1	
		<u>400.00</u>
TOTAL (estimate cost)		<u><u>2,250.00</u></u>

	GSA Contract	Unit Price	No.	Cost
II. Minor Surgery kit	GS-00S-22006	\$200.00	300	\$60,000
III. IUD Insertion kit	GS-00S-22006	120.00	470	56,400
IV. Minilap kit	GS-00S-22006	300.00	102	30,600
V. Combined Minilap and Vasectomy	GS-00S-22006	400.00	100	40,000

AID HEALTH AND POPULATION SECTOR PROGRAM

ANNEX II  
EXHIBIT C-1  
Page 1 of 1

COMPLEMENTARY PROJECTS

Implementation Level	Maternal Child Health and Population-Health Region - Ica	Extension of Integrated Primary Health	Rural Water Systems and Environmental Sanitation	Integrated Family Planning/Health	TOTALS
1. Equipment	524,594	1'800,000	3'190,000	1'011,000	6'525,594
2. Transportation		220,000	283,000	100,000	603,000
3. Medicines	341,119	1'600,000		4'600,000*	6'541,119
4. Training	146,590	1'150,000	90,000	1'070,000	2'456,590
5. Supervision	191,136	720,000	43,000	700,000	1'654,136
6. Technical Assistance/Studies/Evaluation	43,000	880,000	360,000	1'232,000	2'515,000
7. Information/Education/Communication		540,000		500,000	1'040,000
8. Logistics System/Support			133,000	478,000	611,000
9. Environmental Sanitation		240,000			240,000
10. Goods and Services	255,596				255,596
11. Salaries	297,965		600,000		897,965
Inflation and Contingencies			801,000	1,109,000	1'910,000
<b>TOTALS:</b>	<b>1'800,000</b>	<b>7'150,000</b>	<b>5'500,000</b>	<b>10'800,000</b>	<b>25'250,000</b>

\* Includes contraceptives

<u>Coordination of AID Health and Population Assistance - MOH</u>	<u>Extension of Integrated Primary Health</u>	<u>Integrated Health/Family Planning</u>	<u>Total</u>
	(In thousands of U.S. Dollars)		
<u>I. Equipment</u>			
<u>1. Medical equipment</u>			
a) Health Posts	830	-	
b) Health Centers/Hospitals		756	
c) Promoters	510		
d) Traditional midwives	390		
<u>2. Education/communication equipment</u>			
Audiovisual/Regions/Areas	70		
Audiovisual/Health Centers		145	
3. Data processing and office supplies			20
<u>II. Transportation</u>			
1. Vehicles			100
2. Bicycles	150		
3. Mules	50		
4. Small boats and wagons	20		
<u>III. Medicines</u>			
1. Medicines	1,600	600	
2. Contraceptives		3,319	
<u>IV. Training</u>			
1. Courses for promoters	500	200	
2. Courses for midwives	280		
3. Courses for health auxiliaries	50		
4. Continuing education courses for promoters/traditional midwives	320		
5. Family planning courses			
a. Service delivery (nurses/ nursemidwives/auxiliaries)		230	
b. Mass media/communication		30	
c. Management/administration/ logistics		80	
6. Epidemiology for Health Center staff		40	
7. Coordination workshops (Central and Regional)		120	

<u>Coordination of AID Health and Population Assistance - MOH</u>	<u>Extension of Integrated Primary Health</u>	<u>Integrated Health/Family Planning</u>	<u>Total</u>
(In thousands of U.S. Dollars)			
<u>V. Supervision</u>			
1. Medical		500	
2. Nurse/auxiliaries		200	
3. Community level	260		
4. Health Post level	240		
5. Health Centers level	150		
6. Hospital area level	50		
7. Regional level	20		
<u>VI. Technical Assistance/Studies</u>			
1. Technical Assistance	210	500	
2. Studies/Research	670	258	
<u>VII. Inform/Educ/Communication</u>			
1. Mass media materials slides & Pamphlets	130	250	
2. Community education materials	280	200	
3. Information system	130	50	
<u>VIII. Logistic System/Administrative Support</u>			
1. Warehouse & repairs		30	
2. Transportation/services/per diem		150	
3. Logistics services/administration		143	
4. Maintenance of medical equipment and vehicles		11.5	
	6910	8036	
IX. Environmental Sanitation <sup>1)</sup>	240		
Total	7150	8036 <sup>2)</sup>	

1) Maintenance and repair of existing water and latrine systems.  
 For detailed budget of bilateral "Rural Water Systems and  
 Environmental Sanitation" (\$5,500,000) see Annex.

2) MOH only.

The AID Population and Health Sector Program

1981

Institutions and Projects **	Funding Mechanism	Type of Assistance				Sharing of Technology (T.A.)
		Services Urban	Rural	Training & Education	Policy & Research	
Ministry of Health						
-Extension of Integrated Primary Health	Bilateral		X	X		X
-Rural Water Systems and Environmental Sanitation	Bilateral		X		X	X
Integrated Health/ Family Planning	Bilateral					
MOH		X	X	X	X	X
Social Security		X	X	X		X
INE					X	X
ASPEFAM		X	X	X	X	X
AMIDEP					X	X
National Population Council					X	X
Instituto Marcelino	OPG Pathfinder I.P.	X	CBD*	X		
ALAFARPE	OPG Pathfinder	X	CBD	X		X
ADIFAM	FPIA	X	CBD	X		
PALF	FPIA	X	CBD			
Hospital Loayza	FPIA JPIEGO	X	CBD	X		
Maison Sante	I.P.	X		X		

\* Community Based Distribution

\*\* Other innovative private sector projects include:

- Marketing Women's Project (Pathfinder)
- Limoncarro Cooperative (Pathfinder)
- Chimbote Project (Pathfinder)
- Cuzco CBD (Pathfinder)
- Drug Store Project (Pathfinder)
- Villareal (Pathfinder)
- Chosica CBD (Pathfinder)
- Carmen de la Legua CBD (FPIA, USAID Special Project)

## SUMMARY OF SUR MEDIO PROJECT EVALUATION

In July 1979, a US\$ 1.8 million Project was signed between the Government of Peru and AID to develop MCH/Pop services in the Sur Medio Region (Ica) over a period of three years. The basic objectives were to deliver services through a network of some 100 health posts and up to 2000 promoters at the community level, and to develop logistics, information, and educational support components.

The Project was originally funded out of AID/W, using Operations Research Funds from the Population Office of the Development Support Bureau; management responsibility was divided between DS/POP and USAID/Lima. In 1980, the Project was transferred to the USAID bilateral program, directly managed by the Mission.

To date, some 21 months and \$ 500,000 into Project implementation, the Sur Medio MCH/family planning Project can only be qualified as a partial success. In essence, all of the elements are present to put the entire system into operation, but the administrative structure and leadership to put all of the pieces together in a balanced, coherent package has been missing.

### A. Evaluation Methodology

Three principal elements went into the present evaluation. First, a health management consultant, affiliated with APHA, was contracted to conduct an in-depth management assessment of the Project; the consultant spent a total of seven weeks in the Sur Medio region, examining management, logistic support, supervision, service delivery, and personnel systems. Second, following the management assessment, a team composed of two central-level MOH professionals (a public health physician and nurse/supervisor from the Directorate of Maternal/Child Health and Population) and two USAID officials visited the region in order to make an on-site inspection of services being offered at a series of health centers and sanitary posts. Eight such centers and posts were visited, without prior notice, in order to assess the following: level and quantity of personnel assigned to center or post; equipment in use; average number of consultations per day; and, availability of both health and family planning services. Finally, the supplementary feeding program, using PL 480 Title II commodities, was assessed in terms of its effectiveness and project complementarity.

### B. Executive Summary of Evaluation Results

#### 1. Management

a. An overwhelming volume of norms for task and job description has been developed, but the norms are overly ambitious and complicated. An information system is only marginally functional due to the low quality of

data and the delays in compilation.

b. No logistics or supervisory system exists at present. The latter is described in detail on paper and is in the beginning stages of implementation.

c. A series of manuals for promoter training has been developed, and will be distributed soon. These materials are costly, but well prepared, and may serve as a national model. To date, little effort has been made to prepare materials for use by the sanitarians and promoters at the community level, but the material in the manuals might be adapted for that purpose.

d. Only 12 promoters have been trained, with 9 working as paid full-time employees of cooperatives (thus not conforming to the anticipated model). This is far below the target, but in the absence of the support subsystems mentioned above, expansion should be further delayed.

e. Until very recently, the Project was supposedly managed at the area level by the area director with technical support from a project coordinator. This arrangement was complicated by the existence of the Primary Care Project with a separate coordinator. Neither coordinator has any executive authority. The area directors, with the equivalent of three full-time jobs, were unable to provide sufficient attention to any of them, and consequently, pressure to effect necessary changes in the peripheral services has been noticeably absent.

f. Area 3 in the sierra has essentially been cut off from the Project since July 1980, when its administrative responsibility was passed from Sur Medio to the Ayacucho Health Region for political reasons. This was an administratively unsound decision, and efforts are underway to return administration of the area to the Sur Medio region.

## 2. Delivery of Services

a. Most MCH/family planning services are being offered through the hospitals with a very gradual shift toward the peripheral services. Thus, the Project has had relatively little impact on the delivery of these services to date, as the hospital services already existed for the most part. On the other hand, services are being delivered from about 100 health posts, 45 of which are new. The number of monthly consultations at this level is very low, however, when compared to the number of professional and para-professional staff.

b. Family planning activities have gained increased acceptance, although to date about 80% of acceptors have entered through one of the hospitals. Materials have only recently been distributed to the health post level, and a gradual expansion of the program to the more rural areas

can be expected. In certain geographical areas, the advancement of services has been curtailed by resistance from the Church.

c. Considerable training has been carried out, principally for professional staff. Unfortunately, a large percentage of this staff was contracted, and has left the Project subsequent to training, primarily for higher pay and job security.

d. Equipment has been purchased and delivered to the 45 new health posts, allowing them to provide basic MCH/family planning services. The rationale behind equipment distribution is shaky, however, and site visits to the health posts and centers showed that much of the electrical equipment cannot be used because of lack of day-time electricity, whereas other posts with electricity lack the same equipment. Professional skills available at the center or post do not appear to be a criteria for equipment distribution.

e. Professional absenteeism at post and center levels was high during on-site visits.

### 3. Supplementary Feeding Program

The supplementary feeding program as currently designed, functions satisfactorily in the urban and semi-urban areas, but is primarily a short-range food subsidy program with no real long-range benefits. Modifications in terms of utilization of rations to encourage broader development activities are, however, possible and feasible.

### C. Conclusions

The present Project seeks to minimize the types of problems which have plagued Sur Medio.

First, while the Sur Medio project can point to a number of successes (above all, the expansion and delivery of MCH and population services to rural areas previously not served or insufficiently served by the GOP), it is obvious that these successes occurred within the context of a management vacuum, in isolation from other on-going primary health and maternal/child programs in the country. The original strategy was faulty in that the region was given financial resources that led to a great deal of autonomy vis-à-vis the Central-level MOH. Since the central MOH was not in a position to monitor Project activities closely, and since the Sur Medio region had the resources to contract its own personnel, carry out its own research, and guide its own training activities, there was never any effective central control over the Project. As a result of growing MOH concern over this point, which was clearly confirmed by the evaluation, the Sur Medio Project will be brought under the overall management of the central-level Ministry and funds re-programmed under the FY 81 Project Agreement Amendment to assist not only the

Department of Ica, but at least one other region.

Second, the Sur Medio project points out very clearly the need to concentrate attention on the development of management and logistics systems early on in the implementation of health-related programs. Also critical to program success is the development of an effective system of supervision which is able to track on a regularly scheduled basis all operations under health-related programs.

Third, the evaluation points out the danger of relying too greatly on contract personnel. While this will be necessary to some extent, to overcome the lack of full-time qualified personnel in peripheral areas, the present project will avoid setting up a situation similar to that in Ica, where contract and permanent MOH personnel come into active conflict.

BRIEF CHRONOLOGY OF POPULATION POLICY  
CHANGES IN PERU

- August, 1976 : Population Policy approved
- January-August, 1979: Some educational programs initiated in mass media, inflammatory articles on family planning appear in press, Church opposition.
- July, 1979 : Sur Medio MCH and Population agreement signed.
- September, 1979 : Ministerial resolution prohibits family planning services within the Ministry of Health.  
Primary Health Project Agreement signed, but contraceptive distribution is restricted within Primary Health Project.
- November, 1979 : A new resolution circulates permitting family planning services for medical indication in cases of health risk.
- December, 1979 : Conference for organization of Primary Health Project with Ministry of Health (MOH)
- January 1980-ongoing : Planning, program design and implementation of Primary Health Project.
- May, 1980 : Election of Fernando Belaúnde Terry, Acción Popular. In his campaign, Belaúnde cited the alarming population growth as the country's most serious development problem.
- August, 1980 : The Prime Minister/Minister of Economy and Finance, Ulloa, in a speech to Congress outlined the three fundamental goals of this government for the health sector: 1. Reduction of infant mortality and morbidity; 2. Protection of maternal child health; 3. Reorganization of hospital centers to achieve an improved utilization of existing new infrastructure.
- October, 1980 : The Minister of Health in a speech commemorating the Day of Peruvian Medicine repeated Minister Ulloa's goals but stated that the population component will foster a decrease in the exploding population growth rate.  
The Minister of External Affairs in a speech to a national convention of physicians from the Popular Action party expressed his concern for population control.

- November, 1980 : National Population Council established with direct responsibility to the Office of the Prime Minister.
- December, 1980 : The Minister of Health in a speech given to a "National Seminar of Basic Integrated Service in the Urban Marginal Areas" said that instruction would be offered to mothers who voluntarily wished to control their fertility.
- January, 1981 : Integrated Health/Family Planning GUID reviewed and approved.
- February, 1981 : The Minister of Health announces a national campaign for voluntary birth control.

TABLE 1

COUNTRY DATA- PERU

<u>AREA</u>	<u>POPULATION</u>	<u>DENSITY</u>
1285.2 K <sup>2</sup> , thousand	16.5 million (mid 1977)	13 per km <sup>2</sup> 54 per Km <sup>2</sup> of arable land
	Rate of Growth: 2.9 (from 1970 to 1977)	
<u>POPULATION CHARACTERISTICS (1,977)</u>		<u>HEALTH (1977)</u>
Crude Birth Rate (per 1,000)	41.0	Population per physician 1760
Crude Death Rate (per 1,000)	11.9	Population per hospital bed 500 <u>3/</u>
Infant Mortality (per 1,000)	65.1	
<u>INCOME DISTRIBUTION (1971-1972)</u>		<u>DISTRIBUTION OF LAND OWNERSHIP</u>
% of national income, highest quintile	58.6	% owned by top 10% of owners ..
lowest quintile	3.1	% owned by smallest 10% of owners ..
<u>ACCESS TO PIPED WATER (1975)</u>		<u>ACCESS TO ELECTRICITY (1972)</u>
% of population - urban	72.0	% of population - urban ) 34.9
- rural	15.0	- rural )
<u>NUTRITION 1974</u>		<u>EDUCATION (1976)</u>
Calorie intake as % of requirements	100.0	Adult literacy rate % 72.0
Per Capita protein intake	61.7	Primary School enrollment % 111.0
<u>GNP PER CAPITA IN 1977: US\$ 830</u>		

SOURCE: From World Bank

Peru: Long-Term Development

TABLE 2

MAJOR PERUVIAN CITIES BY SIZE OF POPULATION, 1975, 1978 & 1979

<u>City</u>	<u>Estimated Mid-Year Population</u>			<u>Average Annual Growth in Percent 1975-79</u>
	(1975)	(1978)	(1979)	
Lima-Metropolitan Area-	3,941,713	4,536,131	4,746,226	4.8
Arequipa	379,245	440,896	462,773	5.1
Trujillo	304,542	363,274	384,155	6.0
Chidayo	230,163	267,126	280,181	5.0
Chimbote	206,264	247,866	262,615	6.2
Huancayo	160,387	188,130	195,224	5.0
Piura	151,415	172,540	179,978	4.4
Cuzco	142,955	158,762	164,302	3.5
Iquitos	136,163	158,077	165,864	5.1
Pucallpa	72,386	85,561	90,049	5.6
Tacna	69,388	81,239	85,441	5.3
Ica	67,751	71,397	72,621	1.7
Ayacucho	53,105	61,604	64,639	5.0
Huánuco	49,544	56,085	58,392	4.2
A. Total Population in cities with Estimated Population for 1979 in excess of 50,000	5,965,021	6,886,688	7,212,460	4.9
B. Proportion of Total Peruvian Population represented by A. (In Percent)	38.6	40.9	41.7	

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TABLE 4  
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%)	273.1 (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 (19.44%)
Pregnant women <sup>*</sup>	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)

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
TOTAL	100.0	100.0	100.0

TABLE 6

An Index of Conditioning Factors in Health Condition

Rural and Urban Areas  
Peru 1972

I N D E X	R U R A L	U R B A N	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

<u>Cause</u>	<u>Number</u>
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
Anemias	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

\* Hospital only, does not include centers, posts or unreported  
incidence.

TABLE 8

Ten Primary Causes of Morbidity in Infants from 1 to 5 Years Old

According to Hospital Records - Peru 1977

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

SOURCE: Statistical Department - Ministry of Health

OTHER INTERNATIONAL DONORS IN THE HEALTH SECTOR

<u>FINANCIAL AGENCY</u>	<u>NAME OF PROJECT</u>	<u>PLACE</u>
A.I.D.	School Feeding Program (PAE)	PERU
AMAZONIC MEDICAL SOCIAL FOUNDATION	Yarinacocha Hospital	FUCALPA
DENMARK	Medical Care Extension	ORDELORETO
EYE INTERNATIONAL FOUNDATION	Ophtalmological Training	ORDESO
GERMAN FEDERAL REPUBLIC	Lupinos Project	INS (NATIONAL HEALTH INSTITUTIONS)
GERMAN FEDERAL REPUBLIC	Applied Nutrition	ORDEPUNO
HOLLAND	Extension of Health Services Program	ORDESO
HOSPICE INTERNATIONAL	Small Hospitals' Construction	R.S.C. MEDIO
INTERNATIONAL FOSTER PLAN	Protection and Medical Care	R.S.C.CENTRO MEDIO
INTERNATIONAL PHYSICIAN	Development/Health Services in Central Huallaga	R.S.C. ORIENTAL
PAHO	Special Health Projects Chagas disease, environmental health, vaccines, etc., more than 100 projects; technical assistance	PERU-Ongoing +
POPULATION COUNCIL	Project support for Health Professionals in Maternal Health, Family Planning, and Responsible Parenthood	ASPEFAM
	Project Support for Informatica -Information System	INFORMATICA
SWEDISH ASSOCIATION FOR DEVELOPMENT TRAINING	Survey on Family Participation in Multiple Problems	RSLM (Lima)
SWISS EVANGELIC MISSION	Voluntary Services	ORDESO ORDEPUNO

<u>FINANCIAL AGENCY</u>	<u>NAME OF PROJECT</u>	<u>PLACE</u>
SWISS TECHNICAL COOPERATION	Extension of Medical Services	ORDEPUNO
TERRE DES HOMES	Voluntary Services	ORDEPUNO
UNDP	Development and Extension Health of Services Program	ORDELORETO
UN FUNDS FOR DRUG ABUSE CONTROL	Epidemiology Studies on Drug Abuse	PERU
UNFPA	Maternal-Child Health Population	PERU
UNICEF	Development and Extension of Health Services Programs	ORDEPUNO
WORLD BANK	Construction of Health facilities and Primary Health Services and Equipment	To be decided (seven regions)
WORLD FOOD PROGRAM	Food Assistance Program for Mothers and Infants	PERU