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POPULATION PROGRAMS

AND

STRATEGY

USAID LIMA

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Executive Summary

Peru is the third largest country in South America. The Andean mountains separate the country into three regions which differ in climate, geographic and socio-cultural characteristics; the coastal desert, the mountainous highlands and the tropical jungle.

The estimated population of Peru is 17.3 million inhabitants, of the total population, 67 percent live in urban areas, 33 percent live in rural areas and approximately 50 percent of the population is Indian. The annual population growth is 2.9 percent. The result of this rapid growth is a triangular age structure typical of nations with high fertility. Along with the acceleration in population growth has come a massive migration to the coastal region and urban areas and a growing recognition of the need for implementation of a population program in Peru.

Over the past three decades, concern for the demographic problem has been recognized and expressed in the 1976 Population Policy Guidelines but government commitment to implementing its population policy and family planning program has been almost nil. During the past twelve years of military rule, government opposition to family planning halted almost all government and private sector family planning activities.

In May 1980, Fernando Belaunde Terry was elected President by popular vote. Belaunde recognizes the seriousness of Peru's population growth and in his campaign, he cited the alarming population growth as one of the country's paramount development problems. Both he and his key government officials are seriously concerned about the population problem and are strong advocates of the need for a national family planning program. In recent months, progress has been made in implementing the population program in Peru and it is expected that the new government will support the expansion of existing AID supported activities in both the public and private sectors.

Inroads have been made in the area of population programming with the development of the Sur Medio Maternal Child Health and Population bilateral agreement with the Ministry of Health. Expansion of the government's family planning program is anticipated utilizing the primary health care infrastructure for community based distribution of health and contraceptive services. Major advances also have been made in the number of beneficiaries and geographic spread of family planning activities in the private sector.

There are still several constraints to the implementation of the Peruvian family planning program. These include the current economic conditions and lack of financial resources, an inefficient and ineffective logistics system for contraceptive supplies, and bureaucratic inertia and centralization of decision-making in Lima. Nevertheless, government leaders in Peru have begun to view rapid population growth and its concomitant development problems as an area of legitimate concern. The changing political climate under the new government and the increasing demand for family planning services should permit major expansion in the population program. USAID has and will continue to expand the scope and depth of its population strategy and has laid the groundwork for continued growth of the program as the new government continues to formulate its population programs and new opportunities are created.

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ACRONYMS

ADIFAM	Association for the Integrated Development of the Family
AID	Agency for International Development
ALAFARPE	National Association of Pharmaceutical Laboratories
AMIDEP	Multidisciplinary Association for Training and Research in Population
APPF	Peruvian Association for Family Protection
ASPEFAM	Peruvian Association of Medical Schools
ATLF	Lay Family Work Association
CECOAAP	Peruvian Central Agrarian Cooperatives for Sugar Production
CEFA	Center for Population Activities
CEPD	Center for Population Development Studies
COAMSA	Executive Advisory Board and Advisory Committee for MOH
CPI	Consumer Price Index
FEPAFEM	Pan American Federation of Association of Medical Schools
FPIA	Family Planning International Assistance
GDP	Gross Domestic Product
GIPSEF	Peruvian Group for Sex and Family Education
HEW	U.S. Department of Health Education and Welfare
ICARPAL	Committee for Applied Research in Population in Latin America
IEP	Institute of Peruvian Studies
INAPROMEF	National Institute for Protection of the Family and Children
INP	National Institute of Planning
IPPF	International Planned Parenthood Federation
INPEARES	Peruvian Institute for Responsible Parenthood
INPTOMI	Institute of Neonatal, Maternal and Infant Protection
MCH	Maternal and Child Health
MOE	Ministry of Education
MOH	Ministry of Health
NCHS	National Center for Health Statistics of HEW
ONE	National Office of Statistics
PAHO	Pan American Health Organization
HALF	Lay Family Apostolate Program
SEN	National Statistics System
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
USAID	U.S. Agency for International Development, Lima, Peru
VISTIM	Vital Statistics Improvement Program

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I. POPULATION POLICY IN PERU

A. Background

Concern over demographic problems in Peru can be traced back to the early 1940's when Dr. Arca Parro, founder of Peruvian demography and director of the 1940 census, identified problems related to the rate of population growth and internal migration. National concern over other social and economic issues took precedence over population problems in the 1950's. In the 1960's there was increasing concern over the magnitude of the population problem but the government did not develop an explicit population policy. It was believed that a more equal distribution of the population would compensate for the high birth rate; thus, government efforts focused on redistribution to less populated areas. In 1964, the Center for Population and Development Studies was founded with the purpose of promoting research and training personnel in population. A number of small private and public family planning programs were also begun in the mid-1960's mostly in the Lima area. The Peruvian Association for Family Protection (APFF), an affiliate of the International Planned Parenthood Federation, was established in 1967.

In 1968, an agreement was signed by the government and Pan American Health Organization (PAHO) to integrate a maternal and child health and family planning program into public health facilities and hospitals. The military government took power however, before it could be implemented. During the next six years, government policies toward family planning/population activities became increasingly restrictive. In 1973, the government closed the eight clinics of APFF and later confiscated the property of the organization. The only programs to escape government closure were those supported by Catholic authorities (ADIFAM and EALF) and those associated with the Hospital Loayza and the Instituto Marcelino*.

In 1970, the "Comisión Horizontal de Población y Ocupación" was established to recommend a population and employment policy for the 1971-1975 development plan. The plan contained only one explicit demographic objective: reduce the disequilibrium in the distribution of the population. The plan did contain other policies, such as employment and education, that could indirectly have an impact on fertility. The Peruvian position at the 1974 World Population Conference and at the 1975 Latin American Meeting on Population was to reject efforts to quantify fertility reduction goals and to reject foreign assistance in this matter. The government later added that it did not plan to include family planning services in national development plans for 1970-1980.

* Note: For complete description, see Section IV.

However, several private institutions were allowed to continue their services, and the sale of contraceptives was allowed.

In 1976 after President Morales Bermudez took office he appointed a commission to suggest guidelines for a proposed population policy. In August 1976 the government of Peru (GOP) established "Guidelines for a Population Policy" as part of its 1975-1978 national development plan, revising the previous pro-natalist position. The policy announced three objectives: to achieve balanced growth; to reduce morbidity and mortality; and to modify patterns of internal distribution. The governments position, as described in the Population Policy Guidelines is as follows:

"Although the government has not...set quantitative targets, it considers that fertility—and population growth—will reach an acceptable level as a result of combined governmental and individual efforts...The government will provide educational services and contraceptives, but only as a means of facilitating free and responsible parenthood, and not with a view towards decreasing individual or aggregate levels of national fertility."

The policy also explicitly prohibits abortion and sterilization efforts as methods of contraception.

The following chronology outlines the efforts of the government to implement the official population policy:

August 31, 1976:	Population Policy Guidelines (Decree N° 00625-76-SA).
December, 1976:	National Seminar on Population Policy.
February 17, 1977:	Ministerial resolution citing norms for implementing the population policy in the health sector. (The technical norms have never been approved).
October 31, 1977:	Director of "Health and Population Division" appointed.
Jan.-June, 1978:	Ministry expenditures total only 10 percent of the 1978 grant from the United Nations Fund for Population Activities (UNFPA).
June, 1978:	Some equipment and supplies arrive.
July, 1978:	One-month strike of health sector personnel.
August 1978:	Due to cutback and consolidation of government offices, "Health and Population" is absorbed by a new division of "Epidemiology and Programming."
September, 1978:	Minimal distribution of equipment and drugs.
October, 1978:	Initiation of family planning services in Metropolitan Lima, Ica and Huancayo.
January, 1979:	Again "Health and Population" separated from Epidemiology and Program Directorate, consolidation with the Ex-Institute of Neonatal and Maternal Protection (INPROMI), for the formation of a new Directorate of "Maternal and Child Health (MCH) and Population."

Jan.-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.

October, 1979: Sur Medio MCH Population Project initiated.

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).

Jan.-June 1980: 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.

However, two years after the population policy was issued, no substantial change had occurred in the public sector. There was little evidence of concrete action to deliver family planning services or commitment to such action by high-level authorities. Expansion of services was also limited in the private sector.

Constraints to population program development in Peru include current economic conditions, traditional beliefs concerning contraception, political inertia, and a tendency on the part of some to identify concern with demographic problems as being politically inspired. There are some indications, however that these views are weakening as Peruvians have been forced to recognize the population growth as a basis for the intensity of the country's economic problems and for the deterioration of the urban areas.

B. Political Setting

The future of family planning in Peru is greatly improved with the election of Fernando Belaúnde Terry. Both he and his advisors are seriously concerned about the population problem and strong advocates of the need for a national family planning program. It is expected that the new government will support the expansion of existing AID supported activities in both the public and private sectors. Government leaders in Peru have begun to view rapid population growth and its concomitants as an area of legitimate concern, although they have failed to set quantitative fertility reduction goals. While it seems that the momentum for moving ahead in family planning is irreversible,

there remains a number of obstacles to the implementation of a successful nation-wide program. These obstacles include the lack of government financial resources especially for new programs, and opposition from a number of political interest groups.

Conservative elements within the Church have objected to some family planning programs on the grounds that they conflict with Church doctrine and fail to take into account the whole aspect of family life and education. The Bishopry in Peru has generally followed the Vatican's guidelines: "Although maintaining doctrinal opposition to 'artificial methods of birth control', (the Vatican) is striving to integrate its population policy with its recent emphasis on human dignity and development." At the same time, Church related agencies were themselves the principal source of family planning (child-spacing) services in the private sector in Peru. The advantages of having the support of Church groups is an important component of the AID strategy.

Family planning services have received mixed support from the various political parties. Opposition has been strongest from extreme conservative and extreme leftist groups. Some conservative groups (especially the military) believe in the "strength in numbers" philosophy; more pervasive though is the belief that population control efforts interfere with family life, especially the traditional roles of men and women. The communists usually object to family planning because they are suspicious of the "imperialist" motives of the U.S. (and now of the Peruvian government) and what the left views as U.S. emphasis on population control. The intellectual left is also often strongly opposed to family planning; they perceive the demographic explosion to be only a symptom of larger and more important social and economic inequities. There appears to be growing consensus, however, that social justice and freedom should also include the right to choose family size.

Women's groups have become a new political force in Peru. The traditional welfare groups still exist but there has been an increase in human and social rights groups calling for a recognition of women's rights. USAID has cultivated contact with several of these groups. Currently, the Mission has two grants assisting women's groups. One with the "Asociación de Cooperación con la Mujer Campesina" (ACOMUC) to train volunteers and implement a pilot project to assist "campesinas" (peasant women) to improve their homemaking, child-rearing and other domestic skills. A second grant is for the "Movimiento Derechos de la Mujer" (MDM) to provide information and assistance to low income women concerning their legal and social rights. Although still in early stages of growth, women's groups have the potential for becoming a major vehicle for family planning information. One of the major areas of concern is family planning as a right for women and women's groups are actively supporting efforts in that area.

C. Economic Setting

At the present time Peru continues to face severe economic problems, although recent economic improvements have brightened the outlook. Until 1973, Peru's economic growth was adequate and prices remained fairly stable. In subsequent years, particularly 1974 and 1975, the apparent economic health was disguised by a rapid increase in public debt, both domestic and foreign. The pace of inflation accelerated, the exchange rate became overvalued, and fiscal and balance payments disequilibriums grew rapidly. From 1974 until 1980, the Peruvian economy has had large balance of payments deficits, an accelerating rate of inflation, a declining rate of growth in Gross Domestic Product (GDP) and decreasing real income. The annual rates of increase in the Consumer Price Index (CPI) were 38.0% in 1977 and 51.8% in 1978. There was approximately a 30 percent decline in real income between August 1975 and December 1978. At present, inflation continues at an annual rate in excess of 70 percent.

In spite of the current economic recession, the medium term outlook is for moderate improvement of the economic welfare of most Peruvians. There is expected to be a moderate increase in real urban incomes in 1980 — probably in the order of 4-7% and a more impressive increase in 1981. The improvement is based on the very good performance of Peru's external sector in 1979, the increase of foreign exchange and export earnings, up 79% from 1978 levels. Also the brisk recovery of external account solvency has allowed for a substantial growth in imports. The combination of the expansion of export oriented industries and the real increase in public investment outlay resulted in a real growth in aggregate economic output of 3.5 percent after two years of economic recession. The outlook for the next couple years is for a strong external accounts position, a further pick up in the domestic economy and a dampening of inflationary pressures.

The economic recession has magnified the nutritional problems of the poor, especially of the inhabitants of the urban "pueblos jóvenes" and the rural "sierra" among whom malnutrition and unemployment have always been severe. A recent study estimates that between 420,000 (9.6 percent of Metropolitan Lima population) and 1,141,000 (26.1% of Metropolitan Lima population) are receiving a severely nutritionally inadequate diet. The situation is probably more severe among vulnerable groups such as pregnant and lactating women. In certain areas of the country, 13.7 percent of women and 33.3 percent of pregnant women have been found to be anemic. The government has also removed price supports that it was paying for many food products, resulting in dramatic increases in food prices. Another problem that has complicated efforts to improve health services and reduce unemployment has been the continued migration from rural to urban areas. Internal migration from the rural areas to urban centers has exacerbated the monetary hardship faced by Peruvian families. Newly and recently arrived migrants place a strain on the already inadequate public service systems in the cities particularly Metropolitan Lima. In the period 1961-1972, the most

recent intercensal period, Peru's total population grew at a rate of 2.9% annually, rural population at 0.7% and urban population at 5.6%.

D. Social and Cultural Setting

Critical constraints to the development of an extensive family planning program begin with the traditional beliefs and attitudes of the Peruvian people, particularly the poorly educated and low income groups. Tradition influences views concerning the role of the female, the male and the family; family size, sex and contraception; and fear of modern methods. Other problems occur due to the aggregated educational level of the country, insufficient (and often incorrect) family planning information and pronatal incentives within the society.

While these social and cultural constraints persist to a large extent, there is persuasive evidence that the demand for family planning services is increasing. A study done by the Center for Studies on Population and Development (CEPD) on "The Role of the Peasant Woman", clearly indicates a change in attitudes. Most rural women prefer to have fewer children, although the lack of modern family planning information and methods limits their choices. Though the jungle is not heavily populated, the study further indicates that half of the women in that region do try to exercise some control over their fertility and that a large percentage of peasant women rely upon herbal formulas to avoid contraception. Thus, the frequently cited assumption that campesino families perceive a large number of children as an economic benefit no longer appears to be valid. It has often been asserted that campesino parents hope to receive economic assistance from their children when they become too old to work. However, the increasing fragmentation of farm units makes whatever land available too limited to be productive and consequently, the sierra youth are migrating to the cities in growing numbers. Unfortunately, the increasing desire to limit the number of offspring has not been coupled with dissemination of scientific birth control information and devices among the target population.

Although women might want to limit the size of their families for economic and/or health reasons, they may not feel free to decide to use a contraceptive method without discussing it with their husbands. Cultural values still support the concept of "machismo"; a large family is an affirmation of masculinity. Some men are also afraid that their wives might have relations with other men if they had access to contraceptives. In addition couples are often hesitant to discuss subjects related to sex with each other; they may even be ignorant of the facts of reproduction. To have a greater impact on women and family life, a family planning program in Peru must also educate men about contraception and seek to involve them in all aspects of parenthood.

The social and cultural characteristics of Peru are varied and multiple. The urban life style is completely different and separate from the rural. There are three distinct geographic areas, the coast, ("la costa") the high lands ("la sierra") and the jungle ("la selva"), each with its own unique ethnic groups, and culture. Combined with the inadequate lines of communication and transportation, adapting family planning to each separate subcultural is a difficult undertaking.

Nevertheless, the World Fertility Survey in Peru indicates that a majority of couples want to limit their family size, thus providing a firm basis for a potential demand for family planning services.

II. DEMOGRAPHIC PERSPECTIVE

A. Population

According to the 1972 Census, Peru's population was 14,237,899 more than double that recorded in 1940. The annual population growth rate in this period increased from 1.8 to 2.9 percent, making Peru the third fastest growing country in Latin America. The estimated population in 1979 was 17,293,000 (Table I).*

An effect of the rapid population growth is the changing age structure of the population. The age structure of Peru has the triangular shape typical of nations with high fertility.

The rural population is 5,762,800. Forty eight percent (48%) are 0-14 years old, 47.4% are 15-64 years old and 3.9% of the rural population is 65 years or above. The urban population is 11,530,300. 40.2% are 0-14 years old, 56.7% are 15-64 years old and 3.1% are 65 years or above.

Of the total population of Peru, 43.3% are 0-14 years old, 53% are 15-64 years old and 3.4% are over 65. Peru has one of the highest child dependency ratios in Latin America; 44% of the population is under 15. In terms of child bearing ages, 70.9% of the population is under 30 and 81.4% of the population is under 40. (Table 2).

Along with the acceleration in population growth has come a massive migration to the coast and to urban areas, particularly Lima. As seen in Table 1, only 27 percent of the population lived in urban areas in 1940; the 1972 census indicated that 53 percent were living in urban areas, and 24 percent of those were living in Lima. It is estimated that 67 percent of the population now live in urban areas and that this figure could rise as high as 79 percent by the end of the century. Urban areas are presently growing at an annual rate of 5.6 percent; at this rate, the urban population will double in 13 years. However, there are also some positive aspects to urbanization. It probably has been an important factor in lowering fertility and has also somewhat reduced the cost of providing services to a larger proportion of the population. Moreover, access to commercial outlets and reduced cost of commercial distribution in urban areas has provided access to modern methods.**

* Note: For more information, see Annex II.

** Note: More than 90% of modern methods are provided in commercial sector in Peru, i.e., through the pharmaceutical supply outlets.

TABLE I

ESTIMATED POPULATION AS OF JUNE 30 OF EACH YEAR AND GROWTH
OF POPULATION IN PERCENT, 1961 - 1979

<u>YEAR</u>	<u>Mid-Year Population</u>	<u>Growth in Percent</u>
1961	10,321,810	2.99
1962	10,630,025	2.99
1963	10,946,671	2.98
1964	11,272,067	2.97
1965	11,606,810	2.97
1966	11,951,653	2.97
1967	12,307,402	2.98
1968	12,674,830	3.00
1969	13,054,614	3.00
1970	13,447,306	3.00
1971	13,830,266	2.85
1972	14,223,899	2.85
1973	14,628,277	2.84
1974	15,043,570	2.84
1975	15,470,020	2.83
1976	15,907,907	2.83
1977	16,357,526	2.83
1978	16,819,165	2.82
1979	17,293,083	2.82

SOURCE: Oficina Nacional de Estadística

B. Fertility

There was little variation in the most important measure of fertility the birth rate (estimated to be 44 per thousand in 1940) until 1960, when it ascended to 45.4 per thousand, the highest level recorded in history. It then began a gradual decline to the present rate of approximately 41. This decline has not been enough to offset the reduction in mortality, however, and thereby reduce the rate of natural increase.

Peru's high fertility can also be expressed in terms of the total fertility rate (6.46 in 1970) and the net reproduction rate (2.38 in 1970) which is more than double the replacement fertility level. The general fertility rate has actually decreased slightly over the past twenty years from 200.9 per thousand women in 1950-1955 to 190.7 in 1965-70.

It is difficult to explain with certainty the cause of changing birth rates. Generally, as socio-economic conditions improve, mortality rates decline and an initial increase in the fertility rate follows. If the improvement in socio-economic conditions continues, fertility rates will eventually turn downward. Such a decline may be determined by a variety of factors including educational levels, labor force participation rates for women, access to medical care and family planning services, and the overall status of women in society. The data from Peru follow this general pattern. The migration from sierra to the coastal regions, where socio-economic conditions are improved, caused a rise in Peru's birth rate in the sixties. However, as the majority of the population moved to urban areas, the aggregate fertility rate decreased; fertility rates remain higher on the coast but decline greatly with city size. If this trend continues, fertility rates in large cities will decline further, probably decrease in other coastal areas, but remain high in the sierra. Two factors that have been identified as significant in relation to fertility rates are education and female labor force participation. Fertility varies inversely with education and as the proportion of the population with higher educational levels grows, a fall in fertility should be forthcoming (Table 3). Fertility rates in the 1961 census were also lower for women who were economically active.

C. Mortality and Morbidity

Mortality in Peru has declined remarkably over the past 100 years. The crude death rate was approximately 33 per thousand in 1876, 27 per thousand in 1940 and is presently estimated to be 14 per thousand. Although the decrease in the mortality rates, particularly infant mortality (presently estimated at 101 per 1000), indicates better knowledge and access to health services, this rapid fall in mortality has also been a principal cause for the rapid population growth.

TABLE 2

AGE DISTRIBUTION OF POPULATION
(In Thousands)
1979

<u>Age Groups</u>	<u>Total</u>	<u>Percent of Total</u>	<u>Men</u>	<u>Percent of Total</u>	<u>Women</u>	<u>Percent of Total</u>	<u>Urban Area</u>	<u>Percent of Total</u>	<u>Rural Area</u>	<u>Percent of Total</u>
0-4 years	2,824	16.3	1,427	16.5	1,397	16.2	1,682	14.6	1,142	19.8
5-9 years	2,433	14.1	1,223	14.1	1,209	14.0	1,491	12.9	942	16.3
10-14 years	2,183	12.6	1,101	12.7	1,082	12.5	1,463	12.7	720	12.5
15-19 years	1,873	10.8	944	10.9	929	10.8	1,330	11.5	544	9.4
20-29 years	2,860	16.5	1,437	16.6	1,423	16.5	2,116	18.4	744	12.9
30-39 years	1,913	11.1	956	11.0	957	11.1	1,367	11.9	545	9.5
40-59 years	2,294	13.3	1,142	13.2	1,153	13.4	1,528	13.2	766	13.3
60 and over	913	5.3	438	5.0	475	5.5	553	4.8	360	6.3
TOTAL	17,293	100.0	8,668	100.0	8,625	100.0	11,530	100.0	5,763	100.0

SOURCE: Boletín Analisis Demográfico N°20, Oficina Nacional de Estadística.

TABLE 3

AVERAGE NUMBER OF CHILDREN BORN ALIVE PER WOMAN AT THE END
 OF THE REPRODUCTIVE PERIOD, BY EDUCATIONAL LEVEL,
^{1/}
 1972

EDUCATION LEVEL	Number of children	PERCENTAGE DISTRIBUTION OF WOMEN IN THE GROUP AGED:	
		45-49 years	25-29 years
<u>TOTAL</u>	<u>6.57</u>	<u>100.0</u>	<u>100.0</u>
No education	7.32	51.5	30.5
Incomplete primary	7.00	23.7	30.0
Complete primary	5.33	12.8	15.0
Incomplete secondary	3.94	4.5	8.9
Complete secondary	3.42	4.7	8.0
University education	3.03	2.2	6.3
Other higher education	2.40	-	0.1
Not disclosed	4.69	0.8	1.4

^{1/} End of reproductive period, 45-49 years old.

SOURCE: Perú: Long-Term Development Issues, Appendix Table 1.13

Mortality rates also vary with city size and degree of regional urbanization. One study estimated the crude death rate per thousand in the period 1969-72 at 18.7 nationwide; 10 in Lima, 15.2 for cities of 2,500 and more, and 23.9 for cities smaller than 2,500.^{1/} Mortality rates are expected to decline further in the future as health and sanitation conditions improve.

High morbidity rates for transmissible diseases persist despite programs to prevent and treat diseases such as whooping cough, tuberculosis, measles, etc. These health problems are related to poor sanitation and nutritional conditions as well as inadequate distribution of health services. A national health program to expand basic services, especially preventive services, is currently underway with AID financial support.

The mortality statistics in Peru are constrained by the quality and coverage of civil registration. The deficiencies in the registration system are compounded by the high degree of illiteracy and the isolation of a large portion of the population. Knowledge of the causes of mortality is also limited as not all deaths are medically certified. In 1976, the government estimated that 170,000 deaths had occurred in 1975, of which only 120,585 were registered, and of these, only 67.0 percent were medically certified.^{2/} AID is supporting a model registration/vital statistics program at Vital Statistics Improvement (VISTIM), sponsored by the National Center for Health Statistics and the National Statistics Office of the GOP.

D. Impact on Women

The potential impact on women of a well organized, nationwide family planning program is enormous. 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. With the delivery of a fourth child, the incidence of maternal death, stillbirth, and infant mortality rise and increase with each subsequent delivery. The fertility rate in Peru is 6.4 children per woman. Maternal and infant mortality and morbidity are also higher among adolescent mothers and women in their thirties and older. Clearly, the general health of women

^{1/} C. Bazan "Fecundidad, Mortalidad y Crecimiento", CEPD unpublished, quoted by the Ministry of Labor in "Informe Sobre la Situación Ocupacional del Perú 1972".

^{2/} Lineamientos del Plan Nacional de Desarrollo para 1975-1978 (Lima, Ediciones del Centro, 1975).

would improve dramatically if family planning measures were more widely available and used, especially given that only 22.1% of Peruvian women receive pre-natal care, 26% receive medical attention at the time of birth, and 6.6% receive post-natal care. Abortion complications are also one of the leading causes of death among women of reproductive age. The nutritional status of women would be improved as would the health of her offspring. As previously mentioned, a large percentage of pregnant and nursing women in Peru suffer from protein/caloric deficiency and anemia. The chances of malnourished woman miscarrying are high, as is the probability of having a low birth weight infant.

Access to family planning services also offers psychological security for women; they may perceive themselves as having more control over their lives. The economic benefits cannot be over-emphasized either; 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 open up opportunities for women to seek employment outside the home (although it is very difficult given employment conditions in Peru) 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 contraception even though they would like to have more children - and thus are using contraceptives for the purpose of spacing their children. Contraception to postpone wanted childbearing is practiced less, however, than in Colombia, Costa Rica, or Panama.

E. Access to Contraceptives

Since the initiation of the Population Policy in 1976 there has been almost no access to contraceptives outside of the commercial sector (pharmacies, small stores in rural areas), private physicians and nurse midwives, contraband sold in the streets (condoms) and a small number of private sector activities supported by AID funded grantees. (See Annex).

Contraceptives distributed by the Ministry of Health in 1979 to the Health Regions include:

- 30,800 IUDs (Lippes)
- 47,485 cycles of pills
- 2,080 gross of condoms
- 2,230 IUDs (Copper T)
- 2,650 units of foam

The commercial sector distribution has actually shown a decline in both dollar value and volume of oral contraceptives and injections over the past two years. (Table 4).

TABLE 4

TOTAL MARKET FOR ORAL CONTRACEPTIVES AND INJECTIONS,
PERU, 1976 - 1979

	<u>Units</u>	<u>US Dollar Value</u>
Feb. 1976 - Jan. 1977	1,268,000	\$1,706,000
1977 - 1978	1,308,000	\$1,466,000
1978 - 1979	1,117,800	\$1,319,000

SOURCE: Farley and Samuels, "A Preliminary Assessment of the Feasibility of a Subsidized Contraceptive Marketing Program for Peru", 1979.

TABLE 5

STOCK IN CENTRAL LEVEL MINISTRY OF HEALTH

Oral Contraceptives	99,716 cycles
Neosampoon	748 tubes
Emko foam	396
IUDs	4,400
Condoms	7,444 gross

As of 12/31/79

SOURCE: MOH

Clearly, the high inflation rate for medicines has contributed to the decline in sales. The prices, e.g., \$.43 - \$1.27 for oral contraceptives, are beyond the purchasing power of the majority of Peru's potential consumers.

Although no scientific survey has been made, private physicians and nurse-midwives often charge inflated fees for the services, especially for IUD insertions.

In summary, contraceptive availability has been almost totally restricted to commercial distribution, (without prescription but at a price beyond the reach of the at risk population); private practice for the upper class (including sterilization); small scale A.I.D. supported grantee funded private sector activities. Table 5 shows the stock of contraceptives in Central Level Ministry of Health.

F. Contraceptive Knowledge

Knowledge of contraceptive methods is fairly high in Peru; only 18 percent of the women interviewed were not familiar with any contraceptive method. Familiarity has also risen substantially in the period between 1977-78 and 1979; in 1969, 36 percent of the women had not heard about specific methods (Table 6). However, Peruvian women are not as well informed as women in other Latin American countries where 96 to 99 percent have heard of contraceptive methods. (See Annex II)

Although knowledge of contraceptive methods is fairly high, it should be noted that this knowledge can often be both inefficient and inadequate. Given the educational level, traditional family practices and religious beliefs, modern contraception methods are viewed with suspicion. With extensive distribution of proper information it is hoped that these constraints can be alleviated.

Knowledge of specific methods differs also. The greatest familiarity is with the pill (63%), injection (61%), female sterilization (59%), and the rhythm method (55%). Only half of the women reported knowing about the IUD. Male sterilization is recognized by the fewest women, only 19 percent. Knowledge of all methods is less than in other countries in Latin America.

G. Current Use of Contraception

As can be seen in Table 7, Peru has a relatively low level of contraceptive use when compared to other countries, especially other Latin American countries. In Peru, 24 percent of exposed women 15-19 and 31 percent of those 45-49 are current users of contraceptives, compared with a peak of 50 percent of those aged 30-34.

TABLE 6

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

METHOD	ENAF (1977-78) *	PECFAL (1969) **
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 7

PERCENTAGE OF CURRENTLY MARRIED (NOT "EXPOSED") 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.

TABLE 8

PERCENTAGE OF EXPOSED WOMEN
ESTIMATES OF UNMET NEED

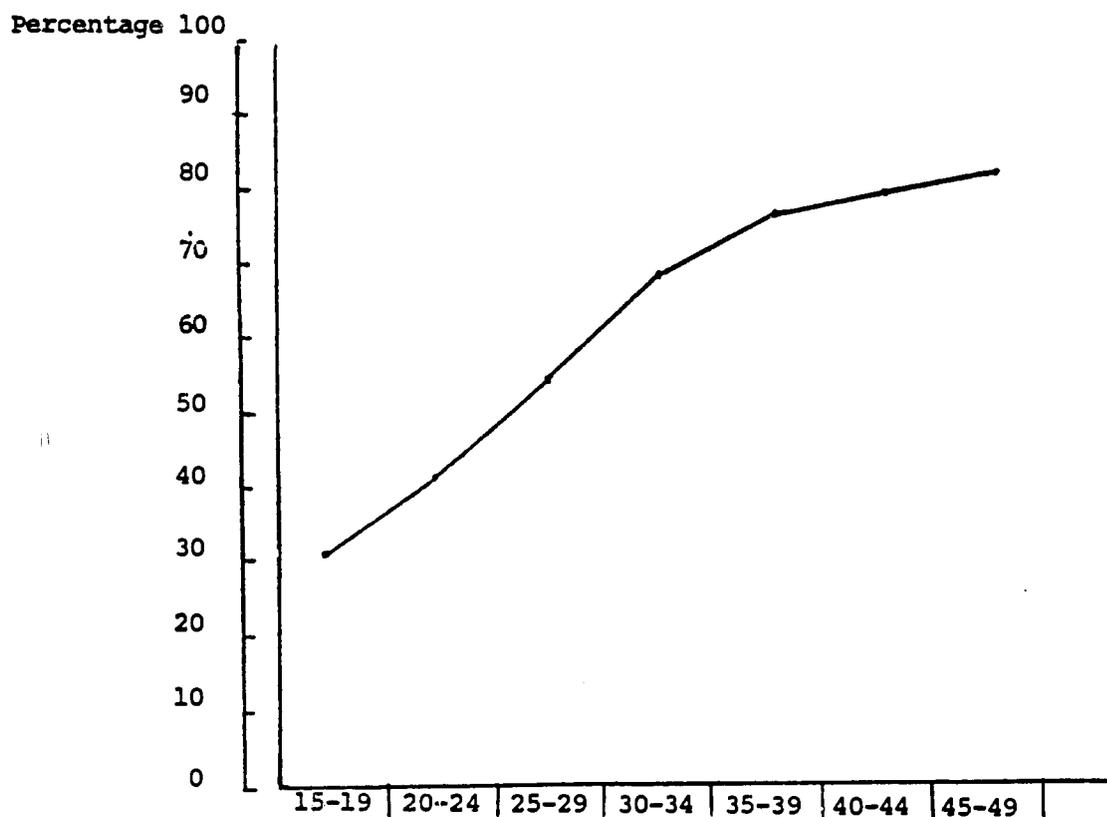
TYPE	PERCENT
1. Exposed women	(N = 3,851)
a. Not using any method	59%
b. Not using efficient method	85%
2. Exposed women percent who want no more children	(N = 2,307)
a. Not using any method	54%
b. Not using efficient method	83%
3. All Exposed women who want no more children and are not using any method	(N = 3,851)
a. Not using any method	27%
b. Not using efficient method	50%

SOURCE: First Country Reports,
Tables 5.2.3 and 5.2.3.B

TABLE 9

PERCENTAGE OF WOMEN (CURRENTLY MARRIED, FECUND AND STERILIZED)
AGED 15-49, WHO WANT NO MORE CHILDREN, BY CURRENT AGE

Actual Age	Women 15-49 years	Percent of women who want no more children
15 - 19	100.0	30.8
20 - 24	100.0	41.5
25 - 29	100.0	53.7
30 - 34	100.0	68.0
35 - 39	100.0	76.2
40 - 44	100.0	79.3
45 - 49	100.0	80.1
Averaged Percentage	100.0	61.4



Population: 4,530 = 16206

Actual Age

Source: La Encuesta Nacional de Fecundidad del Peru (ENFP) 1977-1978.

Only 38 percent of Peruvian women with five or more children currently practice contraception. This percentage is substantially higher in Colombia, Costa Rica, Dominican Republic, and Panama. It does not appear to make a substantial difference whether the living children are male or female, among those now contracepting.

As is to be expected, contraceptive use is higher among urban women and among women with more education. In Peru, the most important education and fertility variable seems to be primary school education. This result is consistent with the findings in other Latin American countries. Finally, female sterilization (2.7%) and the pill (4.2%) are the most commonly used modern methods in Peru (see Table 7). A similar pattern is evident in other countries, especially in Latin America.

H. Estimate of Unmet Need

As discussed above a considerable number of women have knowledge of some type of contraceptive methods. However, knowledge does not necessarily promote the use of contraceptives. In Peru, the proportion of women who are exposed but not currently using any method of contraception is an outstanding 59 percent. (Table 8). Eighty-five percent of those using contraception are not using an efficient method. There is also a very high unmet need of 27% for exposed women who do not want more children. Table 9 indicates that a large percentage of women at risk might benefit from voluntary sterilization services, if available, for those at the upper end of the age spectrum.

The estimate of unmet need for contraception is 27 percent and 50 percent for efficient contraception, i.e., 27% of the women "at risk" need some contraception and 50% of the women "at risk" need efficient or modern methods, if need is based on utilization of efficient methods only. The substantial unmet need in Peru suggests that it is possible to reduce fertility levels by increasing the availability of services, especially in the rural areas and in areas where the average educational level is low. Additional emphasis must be placed upon increasing the accessibility of efficient methods to women who do not want more children.

I. Future Population Growth

The question that remains is whether, without direct government intervention, the decline in fertility will be rapid enough to significantly slow down population growth in the next few years. ONEC constructed four population projections for the period 1975/2000 (Table 10): (1) Moderate fall in fertility (Alternative I); (2) No change in fertility (Alternative II); (3) A slow fall in fertility (Alternative III); and (4) A rapid fall in fertility rates (Alterna-

3/
tive IV). Table 10 and Graph 2 summarizes the results of these projections. ONEC assumes that average life expectancy will increase from 55 years (1970-75) to 63 years in 2000 and applies this assumption to all four projections.

If fertility rates continue to decline as they have in recent years (Alternative I), the population would double in size by year 2000 to 31.9 million. Assuming a more rapid fall in fertility, such as that suggested by Alternative IV, the total population would be 29.7 million or 2.2 million smaller than in Alternative I. However, the rapid decline in fertility calculated in Alternative IV could only be achieved with a strong population policy and expansion of health/family planning services. As previously discussed, the government has recently shown increased interest in and commitment to family planning activities, but it is doubtful whether the government is willing to set strong quantitative goals.

In the context of development and international assistance focused on economic and social programs in Peru, a strong case can be made that indeed the lack of a coherent and operational population program is the number one problem for the government and international agencies working in the country.

The current rate of population growth (2.9) has severely hampered efforts to address the educational service needs of the country. One-third of the population is still illiterate and the quality of the education remains problematical. Health services are also inadequate and the health sector proportion of the GOP budget has decreased. Relative health service expenditures have actually declined and will continue to remain insufficient in efforts to provide even minimal coverage for the burgeoning dependent population.

Population growth further exacerbates interregional inequities in both resources allocations and infrastructure development.

Urban migration places ever increasing demands on weak public services and governmental and private sector efforts to improve the quality of life in the already overburdened urban centers.

In relation to problems of the economically active population, even the most vigorous population program will offer no immediate relief due to the disproportionate distribution of the population growth (see Figure 1). However, continued population growth at existing levels effectively limits efforts to increase incomes in rural areas

3/ ONEC, "Perspectivas de Crecimiento de la Población del Peru, 1960-2000" Boletín de Análisis Demográfico No. 16, December, 1975, pp. 35-119.

TABLE 10

PERU: ALTERNATIVE POPULATION PROJECTIONS ASSUMING
DIFFERENT FERTILITY RATES, 1970 - 2000 ^{1/}

	1970-75	1975-80	1985-90	1995-2000
<u>Alternative I - Moderate fall in fertility rates.</u>				
Total fertility rate	6.33	6.00	5.33	4.68
Crude birth rate (o/oo)	43.56	42.14	39.06	35.42
Crude death rate (o/oo)	13.71	14.27	10.18	8.53
Natural growth rate (o/oo)	29.84	27.87	28.88	26.90
Population (in millions) ^{2/}	15615	18135	23615	31938
Average growth rate ^{4/}	3.0	3.0	2.9	2.5
Age dependency ratio ^{3/}	43.56	93.19	87.70	82.92
<u>Alternative II - No fall in fertility rates</u>				
Total fertility rate	6.33	6.33	6.33	6.33
Crude birth rate (o/oo)	43.56	44.11	44.21	43.41
Crude natural growth rate (o/oo)	29.84	31.61	33.63	34.59
Population (in millions) ^{2/}	15615	18195	25530	36023
Average growth rate ^{4/}	3.0	3.3	3.5	3.8
Age dependency ratio ^{3/}	93.19	91.49	92.55	96.24
<u>Alternative III - Slow fall in fertility rates</u>				
Total fertility rate	6.33	6.19	5.91	5.62
Crude birth rate (o/oo)	43.56	41.25	42.12	40.15
Natural growth rate (o/oo)	29.84	30.86	31.70	31.65
Population (in millions) ^{2/}	15615	18116	25012	34709
Average growth rate ^{4/}	3.0	3.2	3.2	3.3
Age dependency ratio ^{3/}	93.19	91.49	90.69	90.70
<u>Alternative IV - Rapid fall in fertility rates</u>				
Total fertility rate	6.33	5.81	4.79	3.75
Crude birth rate (o/oo)	43.56	40.97	35.97	30.15
Natural growth rate (o/oo)	29.84	28.84	26.03	21.82
Population (in millions) ^{2/}	15615	18141	23591	29685
Average growth rate ^{4/}	3.0	2.9	2.6	1.9
Age dependency ratio ^{3/}	93.19	91.49	84.86	75.19

- ^{1/} Prepared in October 1975 by ONEC. All alternatives assume the same change in death rates (shown in Alternative I).
^{2/} Refers to last year of five-year period.
^{3/} Refers to initial year of five-year period.
^{4/} Growth rate during the last year of the five-year period.

SOURCE: ONEC

FIGURE 1

AGE AND SEX STRUCTURE OF POPULATION, 1876-1972

(in percentage)

	Total				Male				Female				1 9 7 2					
													Urban			Rural		
	1876	1940	1961	1972	1876	1940	1961	1972	1876	1940	1961	1972	F	M	F	F	M	F
A. Age Structure by Sex																		
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
0-4	14.2	15.4	16.9	16.3	14.5	15.8	17.1	16.3	13.9	15.0	16.7	16.2	15.1	15.3	15.0	17.9	17.9	17.9
5-14	22.7	26.6	26.5	27.6	22.9	27.7	27.2	28.1	22.7	25.5	25.8	27.1	26.7	27.0	26.4	29.9	29.8	29.1
15-49	51.6	45.3	45.4	45.0	51.4	46.0	45.3	45.0	51.6	46.7	45.5	45.3	47.7	47.7	47.7	40.9	40.7	40.1
50-64	8.8	8.3	7.3	7.1	8.6	6.9	7.0	7.1	9.0	7.7	7.6	7.2	6.8	6.7	6.9	7.6	7.5	7.1
65 and over	2.7	4.4	3.9	4.0	2.6	3.6	3.4	3.5	2.8	5.1	4.4	4.2	3.5	3.1	3.0	4.4	4.1	4.1
B. Sex Ratio by Age																		
Total	100.8	97.6	98.8	100.4									100.0			101.2		
0-4	105.8	102.6	101.2	101.2									101.2			101.5		
5-14	102.7	106.2	103.8	104.2									102.2			107.1		
15-49	100.0	96.2	98.3	99.8									100.2			99.0		
50-64	95.6	87.2	92.1	98.5									97.4			100.0		
65 and over	92.9	89.2	77.3	87.9									81.3			87.0		
C. Other																		
Age Dependency ratios :																		
Total	65.6	86.6	89.8	91.6									83.0			105.8		
Child ^{2/}	61.1	78.4	82.4	84.2									76.6			96.7		
Aged ^{2/}	4.5	8.2	7.4	7.4									6.4			9.12		
% of males 15-64					60.0	52.9	52.3	52.1								54.4		48.2
Median age	n.a.	19.6	18.9	18.5	n.a.	18.8	18.4	18.2	n.a.	20.4	19.3	18.8						

SOURCE: World Bank Peru: Long-Term Development Issues, Vol. II, Main Report, 1979, Appendix Tables 1.5, 1.6

and accelerates pressures for job creation in urban areas. Clearly, the country will not be able to adequately absorb the exploding population into the existing labor force. In fact, the accelerating growth of the labor force in the next 15 years will be the highest in the history of the country.

At the existing rate of growth the population will double by the year 2000, to 32 million. Development efforts in all sectors - food, energy, public services and employment will meet with limited success if population growth continues to accelerate unchecked by government support for an active population program.

J. Summary

Continued rapid population growth is placing severe strain on the already inadequate supplies of natural resources. It will also be difficult if not impossible to create employment opportunities for the ever expanding labor force and underemployment and unemployment will probably rise. The demand for public services will increase and it is doubtful whether the government can meet this demand especially given the current fiscal situation. The principal conclusion that can be drawn from the discussion of demographic indicators is that Peru's development prospects will be adversely affected by the population growth and that a more active population program will be required if the growth rate is to decline substantially.

III. POPULATION POLICY AND PROGRAMS IN PERU UNTIL 1980

A. Introduction

Although the population policy of Peru is a significant document in relation to setting the legal precedents for government support for population/family planning/sex education activities, its implementation has been slow. The causal factors are multiple - economic, social, cultural and political; yet the fact remains that the government's moves into the population field until 1980 have been only tentative at best.

B. Health System in Peru

1. Ministry of Health

The MOH is composed of central level management support, advisory and lineal or executive organizations.

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

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

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

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

The MOH includes 17 Health Regions or Administrative Units, 110 hospitals, 396 health centers and 1,192 health posts.

Less than 3.0 percent of the GNP (down from 4.1 percent in 1964) is allocated to the Ministry of Health. Of that amount some 85 to 90 percent is used to cover personnel, leaving less than 15 percent for program operations. The MOH, in spite of the lack of financial resources is responsible for public health, including approximately 68% of the total population uncovered by any other health insurance or medical program. As a result, funds from donor agencies for specific projects and programs are greatly coveted.

2. Social Security

Social Security represents the second most important public institution within the health system and covers approximately 10% of the total population. Social Security resources include 30 hospitals and 70 health centers distributed in the major Departments of Peru. Approximately 30% of all the doctors in the country work with Social Security; although it is important to mention that almost 60% of the resources and facilities of this institution are in Lima.

3. Medical Services of the Armed Forces

The Armed Forces have their own health resources and facilities to deliver services to the military population, their families and civil employees of the institution. These resources include 12 hospitals, 50 health centers and 30 sanitary posts.

4. Private Sector Services

The private sector in Peru includes approximately 178 hospitals, 50 health centers, 90 health posts, and private consultation services of the medical community which provide health care to approximately 10% of the population.

Some of the most important institutions within the private sector are: Instituto Marcelino, ALAFARPE, ADIFAM, and PALF.

C. Types of AID Assistance to Peruvian Institutions

The AID supported Population Program incorporates the range of activities which foster the development and implementation of the country's indigenous population policy in both the public and private sector. Every effort must be made to assure that the program represents a balanced set of actions which together support the overall goal and specific objectives.

Therefore, the program includes the following types of assistance and seeks to incorporate the major indigenous institutions in its design and implementation:

- Technology Sharing
- Family Planning Services, Training and Educational Program
- Research/Population Policy/Demography
- Voluntary Sterilization Services

D. Technology Sharing

One of the critical factors in the success or failure of population programs has been the availability and continuity of expert consultative services to fledgling private organizations and public bureaucratic institutions as they initiate and implement their population policy and programs.

Peru is in a unique position in this regard since long term efforts have been underway for some time to train local professionals and para-professionals in the range of population field specialities, i.e., clinical services, administration, demography, program design, policy research and education. Moreover, the Latin American Region has a wealth of training programs and excellent population projects which have been utilized by Peruvians to obtain valuable experience and technical skills.

In this regard, AID has fostered a collaborative relationship between Peruvian government and private sector representatives with the leaders and staff in programs in Colombia, Mexico and to a lesser extent Central America. Latin American population professionals have also provided valuable assistance in Peru advising both the public and private sector in specific aspects of program administration, design of policy and practical training.

U.S. institutions have also played a major role, often utilizing experts from other L.A. countries and drawing on the wealth of experience in the region. These institutions include: The Population Council, Pathfinder Fund and Development Associates.

Ford Foundation has also provided invaluable assistance in its Regional Office in Lima, both in population research and training. The Population Council has offered both its own advisory staff for training, research and information systems, plus the excellent support from Social Security officials in Mexico. Pathfinder Fund has played an effective advisory, monitoring and program development role in Peru utilizing every opportunity to provide training and technical support services for newly developing projects.

E. Family Planning Services, Training and Educational Programs

This assistance is designed to promote cost effective family planning services, encourage the development of in-country training capability in family planning and demonstrate the social, economic and political feasibility of government support for widespread availability of contraceptive services.

The most important advances in this area have been: 1) the implementation of sound, cost effective small projects in the private sector with little or no opposition and ever-increasing demand by consumers for services and 2) the introduction of a bilateral project in community based distribution of family planning services within the context of simple service components in maternal and child health.

Each project or program has an educational component and films and sex education materials are utilized with increasing frequency, especially at the community level. A series of posters and pamphlets has also been developed and an indigenous manual in family planning for para-professionals. These will be reproduced in bulk pending final review by the institutions involved.

Finally, an informal network of population groups and individuals has been established which offers the potential for mutual reinforcement of objectives, sharing of experience and supplies, interchange among operational staff and support for a growing consensus that family planning is both a human right and public responsibility.

This kind of assistance has been given to:

- Public institutions such as: the Directorate of MCH and Population of the Ministry of Health (MOH), Sur Medio Region (ORDEICA), Piura Region (ORDENORTE) and Social Security.
- Private institutions such as: Instituto Marcelino, ALAFARPE, ADIFAM, PAF, and ASPEFAM.
- Universities such as: Cayetano Heredia, Federico Villarreal and San Marcos.
- Other institutions such as: the municipalities and cooperatives.

Following is a brief description of the Peruvian institutions and their programs:

1. Ministry of Health

The resources of the health sector in Peru are distributed among multiple institutions, representing a total of nine sub-systems, including those of the Ministry of Health, Social Security and the Armed Forces. Although the Ministry of Health is apparently characteristic of many such institutions (unwieldy bureaucracy, poor coverage, traditional

approach to medicine, lack of resources, etc.), it does represent the principal sub-system for reaching the poorest sectors of the population.

In 1979, the MOH created the Directorate of Maternal Child Health and Population. However, the administration and support for this organizational body within the MOH have been disappointing and few advances have been made to date with the exception of a few seminars and education activities.

2. Sur Medio Maternal Child Health and Population Project

The MOH, with approval from the highest levels of government, has demonstrated a willingness to accept bilateral assistance from the U.S., utilize technical assistance, and consider incorporation of family planning as a component of integrated health care.

In September 1978, the project for Maternal Child Health and Population for Sur Medio was initiated. With funding from the Operations Research Division of the Office of Population and technical assistance from USAID, AID/W and Columbia University, the Region of Sur Medio developed a Community Based Distribution Project for Maternal Child Health and Population. The project plan was fully supported by the MOH and was signed by the government in July, 1979 after a series of lengthy reviews by the National Institute of Planning and other key government offices. Major political support was offered by the Minister of Health and the key political leaders of the Ica Region.

The project clearly provides for services in maternal and child health and family planning at all levels of the health infrastructure, i.e., hospital, health center and post. Simple MCH and family planning services will be offered door-to-door by paraprofessional health workers.

The project is the first program with a major family planning component. Its success will provide methodology and service content for primary health care activities in other regions and provide the precedent for including family planning as an integral service in primary health. Moreover, the government has used the project to test for political repercussions which might jeopardize further government support for family planning. The project will also substantiate the extent and nature of the demand which exists for family planning, especially among the marginal urban poor.

3. Maternal Child Health and Population Project - Ministry of Health

USAID formerly supported INPROMI, an independent institute of the MOH, under a bilateral agreement for research and training in maternal child health. After a series of organizational problems within the MOH, INPROMI was dissolved and its functions transferred to the Directorate of Maternal Child Health and Population. The project has also been transferred and provides for completion of research activities including an abortion survey, services in family planning and population

education in the Maternity Hospital of Lima (45,000 deliveries and 8000 abortions per year) and in Huancayo, and studies of the cost effectiveness of alternative service systems in MCH and family planning.

4. Primary Health

In September, 1979 the GOP signed a major grant/loan of \$7,150,000 with AID for "Extension of Integrated Primary Health." The original preliminary document, PID, was approved by the MOH and included contraceptives for the health centers of the country.

Shortly thereafter, the MOH suspended contraceptive services in response to increasing Church opposition and the final project agreement was signed without contraceptives. The document, however, includes specific references to responsible parenthood education and training in family planning. The Director of Primary Health is opposed to the inclusion of community level family planning services, but has left the door open for family planning services at the health center level.

Major requests have been made by the Lima Region for inclusion of family planning services in primary health. Anticipating this request, the project document includes a maternal child health and population project for a marginal urban area of Lima. Planning documents are almost completed for this portion of the grant and loan funds. Additional requests have also been received for a training program for 100 nurses to provide family planning training and contraceptive services in all the health centers of Lima.

5. Ministry of Labor/Social Security

Both the Pathfinder Fund and the Population Council have been working with Social Security to provide: a) seminars and conferences on the theoretical and programmatic requirements for family planning services; b) training programs and field trips for key leaders in Social Security in Lima to assure that decision makers and program service providers are fully prepared to implement a family planning program; and c) project support, equipment and contraceptives for a family planning project in Hospital No. 2 under the coordination of Dr. Horacio Tregear.

The hospital has some 20,000 admissions per year, of which more than half (56%) are obstetrical cases. There are 1,300 beds with 336 in maternity. There is also an abortion unit with 20 beds.

Thirteen percent of the deliveries are by Caesarian, and, with the couple's consent, sterilization is medically indicated after the third Caesarian. Abortions, as a percentage of all obstetrical cases, have almost tripled in the past ten years and four out of five women treated for abortion want to use contraception.

With a middle class clientele desirous of a small family size and concerned with "spacing", the coordinator of the Pathfinder supported family planning program is anxious that the program

generate valid data for purposes of evaluation and research. Therefore, only two doctors will work in family planning initially, with the others to become involved over time. The contraceptive services will include IUDs, pills and condoms. The ob/gyn department is also going to establish an endoscopic center with a laparoscope from the John Hopkins Project (JHPIEGO).

Although the program initiation has been delayed due to a series of administrative and bureaucratic concerns about the political implications of family planning services, the service component is now underway. The potential family planning service population of Social Security is approximately 500,000 women.

6. Instituto Marcelino

The Instituto Marcelino, which was established in 1966, is a non-profit organization located in one of Lima's most populated districts. The Institute evolved from a private rural clinic on a large orange plantation in Huando, north of Lima, which began in 1964 with support from a pharmaceutical company. The gynecological services offered by the Institute include contraceptive methods, treatment of infertility and cancer detection. The Institute provides services to some 150-200 poor and lower-middle class women per day, of whom about 85 percent seek family planning services.

The principal programs of the Institute are related to training, family planning services and contraceptive distribution.

Following is a brief description of each one of the Institute's program:

a. — Training Program. The Institute has provided the major in-country family planning training activities. A total of 300 doctors and midwives have received training in the period 1977-79. At present, the Institute has agreements with San Marcos and Cayetano Heredia Universities for the training of resident physicians.

Training will also be provided on a limited basis for physicians in minilaparotomy in accordance with the medical indications permitted by Peruvian law. Requests have already been received from San Marcos, Maternidad, ORDENORTE Region, ORDEICA Region and the Metropolitan Region of Lima.

Under project proposals with the Pathfinder Fund and the International Project, the Institute will receive financial support for the expansion of training services to include over 200 physicians, nurse-midwives and nurses in all aspects of family planning service delivery. A majority of the participants will be employees of the MOH in MCH and Population Program activities at the operational level, i.e., hospital, health center and post levels. The major component of the training is clinical practice. Other trainees will include staff members of existing private sector programs, e.g., ALAFARPE and ADIFAM, and new staff from programs developing outside of Lima, e.g., cooperatives, hospitals and Social Security.

Instituto Marcelino has already trained the doctors, midwives and nurses of the ORDENORTE Region (Piura/Tumbes) and ORDEICA (Ica). Follow up supervision will be provided on-site by Regional ob-gyn staff.

b. -- Family Planning Services Program. Both clinical and community based distribution of family planning services will be provided under an OFG grant to the Institute in two major regions of the country - north and south. Clinical centers will be developed in Chiclayo and Arequipa with community based services provided through community agents.

Physicians and nurse-midwives will provide direction and clinical services and a social worker will assist in the supervision and training of community agents. ADIFAM will assist in the training of community agents and contraceptives will be provided through Pathfinder Fund. Technical assistance will be provided in follow-up visits to each of the centers upon initiation, and every six months for the life of the project.

Services will be provided in a form similar to existing methods used at the Instituto Marcelino clinic in Lima. The Institute serves approximately 3000 women each month and provides family planning, treatment for infertility and cancer detection. Eighty-five percent of the women request family planning services.

The purpose of this program is to extend these services to other areas of the country for the benefit of 600,000 women, primarily for the poorest fifty percent. (Services will be provided on a sliding fee basis and fees will be utilized to improve the service program of the grant).

The population of the cities selected for the program are not presently receiving family planning services. These regional centers will extend services including clinical and community based family planning services, and information and education, to a larger segment of the population.

It is anticipated that 23% of eligible women will request a family planning method at an estimated cost of \$3.00 per user.

c. -- Contraceptive Distribution Program. An integral part of the Institute's comprehensive program will be the distribution of contraceptives. Under this component of the program, the Institute will provide administrative support for the distribution of contraceptives to private physicians, training participants and medical institutions. Contraceptives will be provided at cost to private doctors and donated to family planning service programs for the poor.

The program will introduce the concept of family planning to general practitioners and will provide them with technical information on birth control methods. This will be provided personally by a medical visitor who will inform the physicians about the distribution program. Additional supplies for the system will be provided by local distributors. It is projected that five medical suppliers will be utilized; 5000 doctors contacted and 20% are estimated to request supplies.

This project will also provide contraceptives for all participants in the training programs and resupply for these trained personnel in their local area. This project has been approved by USAID and is under review by Pathfinder and AID/W.

7. ALAFARPE

The members of the National Association of Pharmaceutical Laboratories (ALAFARPE) include 95 percent of the laboratories in the country. As part of its social commitment, ALAFARPE has coordinated community, government and private enterprise to establish a social and health service program in four "pueblos jóvenes" of Lima.

Each project is based on an agreement signed by "ALAFARPE" and the community and involves the active participation of community organizations to assist in health campaigns and to help with secretarial and administrative chores.

To provide medical care to mothers and children, the Association has constructed four health centers with space for meetings and conferences. Contraceptive methods available include IUDs, pills and condoms.

The program has been successful in demonstrating that community based services can be provided in the "pueblos jóvenes" with few political repercussions.

8. ADIFAM

The Association for the Integrated Development of the Family (ADIFAM) is a private, non-profit organization founded by Catholic laymen with the support of the Bishop's Commission for Social Action. Its "Programa de Promoción Conyugal y Familiar en los Pueblos Jóvenes" began in 1967 as part of the Christian Family Movement, promoting responsible parenthood through education and family planning services.

ADIFAM operates some 20 clinics, most of which are in the poorest areas of the "pueblos jóvenes" in Metropolitan Lima. Until 1979, family planning services had been limited to oral contraceptives and instruction in the rhythm method. The pill is authorized by the Church for up to two years after the birth of a child. This year the project has expanded its services to include condoms, foam and a few diaphragms.

Members of the Directorship have actively expanded activities to include community based distribution services in the populous area of Chosica. This year, the entire project will be revised and modified to transfer service delivery from traditional clinical services to community based distribution, commencing FY 81.

9. FALF

The Lay Family Apostolate Program (FALF) is the family education and

medical program of the Lay Family Work Association (ATLF), a private non-profit organization founded in May, 1970. FALF administers responsible parenthood programs, principally outside Metropolitan Lima with the aid of community health workers.

FALF has twenty-two clinics, including ten in local parishes, plus three in collaboration with INAPROMEF, a national social child welfare institution. The program educates couples in responsible parenthood and provides family planning services, which are limited to the rhythm method and oral contraceptives.

10. ASPEFAM

The Peruvian Association of Medical Schools (ASPEFAM), a private non-profit organization, was founded in January, 1964. The Association's membership includes the six medical schools and the School of Public Health, for which ASPEFAM serves as a channel for funds and resources to support teaching, service and research programs.

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

ASPEFAM has prepared a three-year program for the training of health professionals in maternal health and family planning funded by the Population Council. The program is designed to train health professionals and medical students while providing family planning services. The directors of the ob/gyn departments of the universities are responsible for its execution.

The program was originally to begin in July, 1977. Unfortunately, the project was greatly delayed. Services have now been initiated in several of the large Lima based teaching hospitals including the Maternidad de Lima Hospital and in Trujillo, plans have been completed to secure contraceptives for the project through the Instituto Marcelino.

11. INPHARES

The Peruvian Institute for Responsible Parenthood was founded in April, 1978 and has been chosen by International Planned Parenthood Federation (IPPF) to represent them in Peru.

The previous organization, Peruvian Association for Family Protection (APFF), was a private, non-profit organization, founded in 1967 by a group of doctors. In March, 1969, after two years of promoting family planning through conferences and seminars, the Association expanded its board, hired a full-time director, and sponsored a number of family

planning clinics. By 1970, with support from the International Planned Parenthood Federation, the APPF program had eleven clinics, eight in Lima-Callao plus locations in Chimbote, Ica and Huancayo.

The official pressures against family planning, which began in 1968 when the military assumed control of the government, became particularly severe in December, 1973. The President ordered the Minister of Health to halt the activities of the APPF. Thus, in January, 1974, the Association was forced to close the eleven clinics.

In late 1974, the Association entered into an agreement with INPROMI, a decentralized institute of the Ministry of Health responsible for training, research and norm-setting with respect to maternal and child health (MCH), to include family planning instruction in MCH courses, beginning in the northern part of Peru. However, that program too was soon thwarted by the government.

Finally, in December, 1975, the Supreme Court advised APPF that in April that year the Ministry of Health had requested the dissolution of the Association. The government then took possession of APPF's property, equipment and vehicles. Although the Association wrote a letter of protest to the President in April, 1976, there has been no answer to date.

Because of its problems with the GOP and the confiscation of its clinic and equipment, it should be desirable for the Association to maintain a low profile and secure approval from the MOH for its family planning service operations.

The organization has received financial support and technical assistance from IPPF for training in sex education and some minimal integrated services.

12. Cayetano Heredia University

The ob/gyn department of Cayetano Heredia University in Lima has continued to provide training to medical, nursing and midwifery students and to health professionals in population, and family planning since 1967 through its program of "Studies in Human Fertility". The practical training includes the provision of family planning services at the Rimac Hospital and Hospital Loayza.

The program provides training for health professionals (doctors, midwives, nurses), fourth-year medical students, third-year midwifery students and third-year student nurses. It also includes post-graduate courses for doctors, nurses, social workers and teachers, and prepares graduate students for their field work as "secigristas" (primary health interns).

The costs of the services are minimal \$1.00 for a pap smear (paid by the hospital) and less than \$.05 for the clinic service.

The program is giving increased attention to community education and service programs, particularly in factories in and around Lima. The current efforts include the training of factory-employed doctors and midwives, the provision of contraceptive and medical supplies and clinical services at Hospital Loayza.

The program received some initial support (1966) through the Population and Development Studies Center (CEPD), from the Pathfinder Fund (1967-69) and USAID/Lima (1970-72). Its principal support since 1973, however, has come from the FPIA.

13. University of Trujillo

The ob/gyn department of the University has a project with FPIA which is similar to the family planning training and service program at Cayetano Heredia.

14. Federico Villarreal University

This public university has a family planning training and service project for medical students at the University Medical School, and a service program in the Lima community of Lince. The latter activity is operated by the Medical School in conjunction with the Ministry of Health.

15. Mutual Cooperation for Family Development - Municipality of San Juan de Lurigancho

The project promotes family planning in a large "pueblo joven" in the northern part of Lima, using promoters from the community who are trained as part of the program. Family planning services are being offered and the project has reached over 5000 new users in the first year of operation. Family planning promotion reaches approximately 50,000 persons. Education and information about pre-natal services, family planning and child care is given to expectant and nursing mothers and sex education lectures are provided for adolescent students.

16. Carmen de la Legua Mother and Child Community Project

Through this project, family planning is provided as well as pediatric and odontology services. As part of its educational program, persons are contacted through home visits to inform them of the services offered at the Educ-Medical Center.

FPIA provided financial support for the first year and the project is now being transferred from FPIA budget support to USAID special projects funding for continuation.

F. Demography/Population Policy/Research

This assistance is designed to reinforce the GOP capability to provide ongoing population data including census information, vital registrations

of births and deaths, surveys on contraceptive prevalence (including the World Fertility Survey) follow up and analysis and dissemination population information as it relates to policy issues.

This assistance is also designed to provide a public forum for discussion, debate and consensus on the issue of population as it impacts upon development. The existing projects are now creating the scientific, intellectual, and informational channels required to foster national policy-making, and to implement mechanisms allowing the GOP to make new policies operational.

The most important advances in this area relate to the potential development of a functional National Population Council, a multisectoral advisory body which includes institutional representation of both the public and private sectors. The initial process of instituting this National Council is the outgrowth of the multiplicity of effort by organizations and national institutions supported by AID program funds. Moreover, the support of AID funded projects in population policy has directly resulted in the approval by the GOP of the major public family planning and research activities instituted thus far.

AID, and AID supported grantees have worked with a variety of individuals and institutions to support population policy objectives by providing information, material, conference assistance, training and observation trips to encourage public and government awareness of population issues.

Countless individuals have dedicated hours to discussing policy and strategy as well as attempting to minimize opposition from opposing groups. Press releases, publication, television and radio interviews, meetings with Church and public officials have brought the population debate to the public and fostered the current movement of change in relation to the acceptability and necessity for government support for family planning activities.

These include: ONE, AMIDEP, IEP, ALAFARPE, ADIFAM, INP, Social Security, MOH, MOE, the major hospitals, ASPEFAM and other private and academic institutions.

The following are only some of the most important participating institutions involved in population research, policy and demography.

1. National Office of Statistics

The National Office of Statistics (ONE) is the directive organ of the National Statistical System (SEN), 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.

ONE 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 Registrations Project (VISTIM).

To date, the Population and Economics seminars have been carried out in the major regions of the country. The seminars are organized for some 30-40 high-level government officials, in collaboration with regional development and planning entities. Significantly, the Director of the National Planning Institute has participated in all the seminars. 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 is supported by the National Center for Health Statistics (NCHS) as part of the VISTIM Program to improve vital registration systems in developing countries throughout the world.

The project has developed a model system which includes a central office in ONE with demonstration areas in the provinces of Cailloma and Castilla (Department of Arequipa), Santa (Department of Junin), and Coronel Portillo (Department of Loreto).

A "Decreto Ley" has been recently signed by the President of Peru permitting a series of legal and administrative reforms to be instituted in the demonstration system, thus permitting a simplification of the registration process and securing stability for local registrars, and improving the flow of documents, (birth and death data) between ONE and the field.

To extend the registration network to remote areas, increase registration coverage and improve the quality of data, auxiliary, as well as existing local registrars, have been trained and are now functioning in the new system. Within a short time, a number of mobile registrars will be trained and sent out to the most remote areas in the sierra (Cailloma-Castilla) and the selva (Coronel Portillo).

To improve the processing, publication and dissemination of vital statistics, VISTIM, in collaboration with UNDP-Lima, obtained a medium-sized computer for ONE in March of this year. Data entry facilities (key-to-tape machine) were also doubled. As a consequence, ONE is now becoming self-sufficient in data management, not only in vital statistics, but in its other statistical activities as well. UNFPA is planning to double the computer capacity of this system during 1980.

Thanks to the computer and the VISTIM contract, ONE is now producing annual vital statistics (including detailed tabulations with estimates of coverage) for the first time in the history of Peru. Previously,

the birth and death data were only published in annual reports of general statistics. At this moment, the annual report on birth statistics for 1975-1976 is ready for publication, and the 1977 report will be ready shortly. Death statistics reports may be expected during 1980.

Looking to the future, a draft document of a "Decreto Ley" has been prepared and is now under consideration in the "Instituto Nacional de Planificación". This "Decreto Ley" will establish a national vital registration system reflecting the innovations and reforms developed under the VISTIM project.

2. AMIDEP

The Multidisciplinary Association for Research and Training in Population (AMIDEP) is a private, non-profit organization, which was founded in May, 1977 by a group of university professors in Lima and the regions. True to its name, the objective of the Association is to promote research and training in the population field in Peru and the Andean Region. AMIDEP is governed by a general assembly, a board of directors and executive committee.

By November, 1978 AMIDEP had increased its membership from nine founding members to thirty, all from universities in Lima (about twenty), Arequipa, Ayacucho, Cajamarca, Cuzco and Trujillo.

Since its foundation, AMIDEP has concentrated its efforts on consolidating and promoting the Association, training through seminars and conferences and promoting population policy and research activities.

AMIDEP sponsored the National Population Conference in Tarma and will continue to present conferences of a similar nature on a regional basis. The conference included participants from the appropriate Ministries, National Institute of Planning and private institutions. A similar program was held at the CAEM, the Military College for Government Policy and Administration.

AMIDEP has organized five-day seminars for university professors and government officials. The objective is to review research findings on the seminar topic and promote new research on same. Seminar topics have included fertility studies in Peru, social research on women, employment and population, social research methodology applied to population problems and internal migration in Peru. In addition to the seminars, AMIDEP has sponsored seven conferences in Lima.

In the beginning, AMIDEP received funds from G.E.TEMPO, and is currently supported by Battelle and the Ford Foundation.

3. CEPD

The Center for Population and Development Studies (CEPD), is a private, non-profit institution. This center is conducting an inventory of the existing studies on population and related subjects. The Battelle funded program includes a newsletter enumerating available sources, new titles and acquisitions and an up-dated comprehensive annotated bibliography and index of published and unpublished works on population in Peru. These service activities are extended to libraries, researchers and policy-makers throughout the country.

The CEPD is also carrying out a law and population project in collaboration with Tufts University with funds from the UNFPA. The objectives of the study are to conduct an inventory of existing population-related laws in Peru, prepare a summary analysis of their effects and make recommendations for change in light of the findings. A major Peruvian Population Law publication is now available in bookstores and planning offices.

4. Institute of Peruvian Studies

The Institute of Peruvian Studies (IEP), is the foremost private non-profit social research institution in Peru.

The IEP is conducting extensive research on fertility, family structure, and social change in one major rural Peruvian region with Battelle support. The expected results will document specific demographic changes and will also provide the Peruvian Government with a framework for analysis of the impact of major development projects upon population dynamics.

G. Voluntary Sterilization Services

Johns Hopkins and the International Project have provided surgical equipment to major hospital and medical facilities in Lima and several other major cities throughout the country. The surgical program is designed to provide teaching programs and services and is restricted to medical (not contraceptive) indications for service in conformance with Peruvian law.

In the private sector, it is well known that surgical procedures are freely provided for fee paying patients, and the World Fertility Survey indicates that of all women using some method of contraception, 2.6% have been sterilized. For women with less than four children, the percentage is 1.6, but with four or more children, 3.9% have already chosen sterilization.

There is reason to believe that the potential demand for sterilization may be high. If the major financial barrier to access were removed, a large number of the 61.4% of the women of fertile age in union who do not want any more children might prefer sterilization. The demand might also be high among the 46.1% of the women who report that they

did not want their last pregnancy. The percentage is 68.6% for women with five living children.

Serious legal, political and social factors limit the development of an effective surgical program in the near future. Plans are underway by ASPEFAM, the Ob/Gyn Society and prominent ob/gyn physicians to establish and publish norms for broadening the definition of medical indication for surgery to include the various indications associated with high risk pregnancy. This action would foster public acceptance of medical indications of high risk pregnancy as valid criteria for sterilization, permitting more widespread use of sterilization for couples who do not want any more children.

Many physicians are already trained and providing services (Table 11). However, until the prohibition of sterilization for contraceptive purposes is removed, the government will permit only selective, small scale teaching programs to exist.

H. Other International Donor Organization Assistance to Peruvian Institutions

At present, the only other international organization involved in maternal and child health and population in Peru is the United Nations Fund for Population Activities (UNFPA). The Pan American Health Organization (PAHO) is the executing agency for the United Nations project, now revised to include \$499,000 for services during 1980.

Previously, UNFPA had been working to implement a nationwide project in the Directorate of Maternal Child Health and Population. The project has been revised several times and now focuses on a regional approach to service implementation which includes five regions for priority consideration.

The United Nations Project places major emphasis upon hospital based actions in maternal and child health and little, if any, family planning services at the health center, post or community level. Even the hospitals in Lima report little user data since severe bureaucratic problems exist in securing contraceptives from the MOH Directorate of MCH and Population. No data has been reported for the project outside Lima at this time.

The United Nations Fund has worked with the Directorate of MCH and Population, but has encountered serious problems in implementing the family planning service component of each of the revised project documents. The problems include: 1) administrative disorganization within the Directorate, 2) emphasis upon educational actions which only focus on family planning in the most tangential manner, 3) contract personnel problems in payment of staff, excessive costs and little or no monitoring of activities, 4) resistance of other offices within the MOH to family planning programs, 5) little or no decentralized regional programming to achieve objectives of the national plan, 6) MOH resistance to distribution of contraceptives, 7) strong opposition of the Church focused specifically on the Directorate

and the United Nations Project, 8) emphasis on MCH equipment, objectives and activities to the exclusion of family planning and 9) inadequate data systems to provide user, commodity inventory and management information.

It is not expected that the UNFPA Project will offer any major expansion of family planning services beyond the hospital level and in fact, program activities, in all probability, will be restricted to the five priority regions.

The Inter-American Development Bank (IDB), and the World Bank (IDRB) Governments of West Germany and Holland have all been involved in the health sector, but not in family planning. Preliminary discussions have been undertaken with the World Bank and now their involvement should be officially encouraged due to the new civil government's support for implementing family planning programs.

TABLE 11

VOLUNTARY STERILIZATION SERVICES

LIST OF INSTITUTIONS AND PROFESSIONALS IN PERU

INSTITUTION	PROFESSIONAL
Hospital del Rimac	Dr. Eduardo Maradiegue Dr. Manuel Gonzales del Riego
Hospital Arzobispo Loayza	Dr. Victor Díaz H. Dr. José Exebio
Hospital del Empleado	Dr. Alejandro Valdivia
Hospital San Bartolomé	Dr. Alejandro Barreda Dr. Abraham Iudmir
Hospital Daniel Carrión	Dr. John Nagahata
Maternidad de Lima*	Dr. Luis Tang Dr. Manuel Acosta
Hospital Central Militar	Dr. Jorge Pérez
Hospital Universidad San Agustín Arequipa	
Hospital General de Arequipa	Dr. Benjamín Lozada Stambury Dr. Victor Hugo Pinto
Hospital General de Trujillo	Dr. Félix Guillén Dr. Mario Llontop
Hospital Regional de Ica	Dr. Rafael Caparó
Hospital Regional del Cuzco	Dr. José Ponce Tejada
Ladislao Prozak**	
Clinica Anglo Americana**	Dr. Alvaro Muñiz
Instituto Marcelino**	Dr. Alfredo Larrañaga
Social Security*	Dr. Carlos Bravo
Hospital Center Maison de Santé*	Dr. Alfredo Guzmán

* Request being processed

** Private clinics

IV. USAID POPULATION STRATEGY FOR FUTURE YEARS

A. Transition to Civilian Government

The new government of Fernando Belaunde Terry is expected to provide both political and program support for the Peruvian Population Policy and the implementation of family planning services within the government infrastructure of service delivery. We are cautiously optimistic that the new civilian government will take a stronger position favoring family planning program implementation both in the public and private sectors.

Notwithstanding the traditional biases already indicated, there is increasing evidence that official, press and political party support is emerging with greater strength in favor of family planning. For example, there has recently been a spate of newspaper and magazine articles published by both the leftist and rightist press supporting family planning as both a human right and development necessity.

Moreover, while previous GOP officials have demonstrated extreme sensitivity to the opposition of the Church hierarchy to family planning services, the new civilian government will remain cognizant of Church doctrine without sacrificing its responsibility for implementation of government policy. This minimized Church-State relationship should reduce Church interference in GOP population policy and permit a more expansive program at the operational level, not only in the public, but also in the private sector.

B. Strategy Goal - Diversified Mission Approach

The goal of AID's population strategy in Peru is to build upon the momentum for family planning services already underway in the private sector and to support the government's implementation of an expanded multi-sector, action-oriented population program in the public sector.

Thus, AID continues to stress the importance of an active, dynamic program which focuses upon: 1) the health benefits of providing access to voluntary family planning services to the population of Peru, 2) the desirability of incorporating population policy objectives into the primary health and development program of the country, and 3) the provision of financial and technical assistance required to implement a range of population programs in the public and private sectors, e.g., family planning services, population policy projects, sex and population education, training in family planning services and project management and research in population areas.

Thus, within the framework of the political support of the newly elected civilian government, tempered by the ongoing bureaucratic limitations and social, cultural and fiscal constraints, the Mission expects the momentum established under existing population programs will expand to meet the active demand for family planning services.

1. Public Sector Focus

The main emphasis of the population strategy is the expansion of the family planning program in the public sector and an accelerated development of activities in the private sector - especially outside of Lima.

USAID expects to support the new government initiative in implementing the population policy by providing: a) more rapid and effective utilization of program resources under the primary health loan and grant to foster a major emphasis on family planning within primary health, b) the joint development by the central and regional levels of the Sur Medio Maternal Child Health and Population Project for promotion of model program components to be utilized in the Central level Primary Health/Family Planning initiative including: training, education and information modules for replication (when appropriate) and c) the design and execution of a marginal urban health and family planning project in the "pueblos jóvenes" for expansion under the FY 81 Marginal Urban Project included in the Annual Budget Submission (ABS).

It is anticipated that the UNFPA will augment its support for calendar year 1980 and finalize a three to four year agreement with the GOP for a maternal child health and family planning project which might focus upon hospital service and a health center delivery system for MCH and Family Planning. This support will reinforce the institutional capability to deliver clinic based family planning services required for post-partum programs and referrals from the primary health and community education activities financed through bilateral support from AID.

While the new government continues to formulate its population policy and strategy for implementing family planning services over the first few months of civilian rule, it is clear that key officials are committed to major social and political objectives which foster family planning service delivery as a major component of their development programs and expansion of primary health as the mechanism for effecting community and populist actions in the health sector.

2. Private Sector Initiatives

The other major program component of the strategy focuses upon the

accelerated expansion of activities in the private sector, particularly outside of Lima. Moreover, the goal of private sector activities is to provide innovative service delivery through community based family planning services rather than clinic oriented activities. Thus, the private sector organizations will offer both a variety of delivery systems and experiment with a range of education, training and service systems to be replicated, if successful.

Many of these programs are new projects currently in the planning phase, or older projects in the process of being revised. The major programs are: 1) the OPG project with the Instituto Marcelino, 2) the new Community Based Distribution Program of ADIFAM (FPIA), 3) the ALAFARPE "pueblos jóvenes" project in Lima (Pathfinder), 4) the PALF Community Based Distribution Program (FPIA), 5) the marketing Women's Project (Pathfinder), and 6) the Sugar Cooperatives Project of CECOAAP (Population Council).

It is expected that the new government will foster the development of new program activities in family planning and facilitate the government related processing of contraceptives, equipment and educational materials through customs.

C. Organizational Factors

The major organizational factors which influence the implementation of these program approaches in Peru include:

1. Integration of Family Planning in Public Sector Programs

Family planning services will be incorporated in maternal child health and/or primary health services within the Peruvian government program. Therefore, the strategy for the MOH must include population funds within the broad primary health activities, not as a separate bilateral population program. The Mission has already initiated this approach in both the Sur Medio and Primary Health Care Projects.

Therefore, both the primary health and maternal child health programs provide an ideal infrastructure for the rapid, low cost introduction of family planning services at the health center, post and community levels. As government restrictions on family planning have relaxed, the decentralized regional sectors are initiating family planning services which may be expanded through the newly developing infrastructure with minimal initiation costs.

Moreover, regions are already experimenting with logistics, information, paraprofessional training and supervisory systems which can be easily modified to include family planning. The Sur Medic Region will develop these systems with models which incorporate family planning

and can be utilized with regional modifications in other parts of the national system.

2. Decentralized Project Development in Public and Private Sector

The implementation of the Peruvian population program will occur in incremental stages utilizing decentralized project development in both the public and private sector. Carefully designed projects implemented in decentralized regions will permit the GOP to test the acceptability of the policy, demonstrate the demand for family planning services and evaluate the political reaction of the Church and extremist political groups to the implementation of family planning services.

However, the Mission cautiously anticipates accelerated program expansion in the next several years as active demand for services increases and active Church opposition declines. The fact remains that the forward trend is developing continued momentum and no major backslide is expected. Therefore, the Mission will continue to maintain open and constant communication with the government in relation to population activities in both the public and private sector, utilizing to full advantage the support of the new civilian government.

3. Diversified Private Sector Program Support

The private sector in Peru in the population field is composed of a variety of institutions, organizations and extremely capable technical and medical professionals. It would be both unwise and in the long run detrimental to attempt to unify the various coalitions into one private organization.

However, these groups do coalesce and unite depending upon the issue, problem or activity contemplated. For example, contraceptive supplies are loaned to fledgling groups by older more established programs pending arrival and removal of supplies from customs. Seminars, informal meetings and working groups have formed to: a) respond to Church opposition, b) stimulate the formation of a multisectoral government supported population council, and c) provide practical training and assistance in project development.

However, the disadvantage of this approach is that project development remains small (average project funding \$15-20,000) and requires a variety of U.S. grantee organizations to meet the particular needs of each indigenous organization.

The Mission is exploring the feasibility of initiating Mission supported P.V.O. activities in population utilizing the O.P.G. funding stream to minimize processing time and improve project coordination and project monitoring within the country. The first effort is an OPG grant

to the Instituto Marcelino for clinic and training centers outside Lima and private sector contraceptive distribution to physicians and nurse-midwives. As this approach is successful, the Institute could be utilized as the umbrella agency for such private sector activities particularly in the area of family planning service delivery.

D. Constraints

One of the major constraints in implementing an effective population program has been severe limitations imposed on program development and expansion by a rigid government bureaucracy in Lima which restricts contraceptive distribution and decentralized program decision-making.

The inability to assure adequate supplies and stock of contraceptives is caused by a lack of government support for the logistics system required for efficient and effective contraceptive distribution from the port, through customs and from the MOH warehouse to the existing MOH infrastructure and private sector groups.

Both in the Sur Medio Project and Primary Health Program, the Mission is exploring alternative channels to reduce bureaucratic constraints imposed by the Lima Central Ministry. One of the major efforts underway is the decentralized program planning with health sector officials of the decentralized regional development committees and health regions.

This strategy has been effective in initiating the Sur Medio Project, the special marginal urban project in the Primary Health Program and in centrally funded programs being developed in other health regions.

In the private sector, plans are in process to assist the various institutions in their effort to obtain expeditious removal of contraceptives from customs. Instituto Marcelino, for example, has been able to assist other private groups in the provision of supplies and plans are underway to expand their role in this regard.

Other constraints to implementing the population policy include those political, social and cultural factors already discussed previously such as: Church opposition, political pressures from groups opposed to family planning, Latin "machismo" which fosters male opposition to family planning and cultural resistances to change in the traditional role of women in society.

Lack of private sector development for social welfare action programs in all facets of voluntary organization institution building creates severe barriers to the initiation of projects such as family planning. Since responsibility for health services rests primarily with the

state for the poor and primarily with the private physician for those who can pay, private voluntary support receives little attention. Peru has a history of eliminating private sector activities in family planning under Velasco and it is only recently that professionals have been willing to risk public expression and support of the need for family planning services.

Severe financial limitations exist in both the public and private sector making it difficult to develop the infrastructure required to support preventive services, including family planning. Community groups rarely are willing or able to provide financial support for initial development costs in equipment, professional staff or educational supplies. The government has reduced its support for the health sector as a whole and family planning is rarely viewed as a priority need for already scarce existing health resources.

Finally, it is difficult to establish low cost family planning services due to resistance by some members of the medical profession to community based contraceptive distribution by paraprofessionals.

E. Types of Assistance

The population program includes five components which interrelate and form the basis of the strategy. These include: 1) Technology Sharing, technical cooperation and transfer of information regarding already proven, successful actions which the government or private sector can modify and utilize to foster an indigenous population policy, e.g., experts in systems planning for service delivery, family planning service components in training, demographic research expertise, information and data collection for sound management of programs in the field and fertility research design; 2) Services, Training and Education, financial support for the development of government and private projects designed to demonstrate effective service and education actions for family planning, sex and population education, specialized training activities for management, administration and operational level skills in these areas; 3) Research programs in demography surveys for baseline data, vital registrations, operations research to test the efficacy of various service delivery modalities, population policy issues and fertility research designed to investigate causal and contributing factors in fertility reduction, indigenous research in method utilization, effectiveness and acceptance; 4) Supplies and Equipment, contraceptives, medical and surgical equipment, audiovisual and educational materials and simple basic medicines which are utilized within MOH and family planning programs, and 5) Commercial Retail Sales, subsidized commercial distribution of contraceptives through existing channels.

It is certain that these categories of assistance cannot be considered in isolation from one another since each one forms an integral part of the total strategy. Moreover, it is critical to consider the particular issues, barriers and socio-economic and political factors which influence the utilization of these approaches with the Peruvian context.

The strategy is based upon expansion of activities in the public and private sector building upon the diversified approach already underway which includes U.S. bilateral projects, AID supported contractors and grantees, and other international donor agencies.

Table 12 and Figure 2 graphically express the variety of program activities and institutions included in the population strategy. Annex IV-1 lists the Peruvian institutions, the U.S. sponsoring agencies and a brief note on the program activities.

F. Technology Sharing

Major expanded responsibility for technical cooperation will be provided by Peruvian professionals and Peruvian institutions including: Instituto Marcelino, which will expand in-country training in family planning and provision of surgical procedures; ASPEFAM, which will provide assistance in clinical administration and program development at the hospital level in ten health regions; Cayetano Heredia University, which includes experts in population, family planning, research and education and will expand its role as advisors to the central level of the Ministry of Health; and AMIDEP, whose institutional members form a respected professional association of technical advisors in population policy, research and program development and will continue in its present role in population policy and research. U.S. institutions which will continue to play a major role in technology sharing include: Pathfinder Fund, which provides assistance in project administration and management, and will expand its technical support for logistics systems and contraceptive supplies, especially to Instituto Marcelino, women's projects and support interchange of information of Latin American experts in conferences and seminars on community based distribution of family planning services, contraceptive technology, and population program development. Develop-Associates which supports observation trips, technical assistance in development of training programs and will expand its role in support of para-professional training in specific health regions.

Other U.S. institutions which provide other forms of assistance but also perform technology sharing functions, include: International Project, NCHS, Battelle, IFRP, Population Council, Johns Hopkins (JPIEGO), and FPIA. A.P.H.A. has also provided excellent support for program monitoring and evaluation and will continue in this important function.

FIGURE 2

PERUVIAN POPULATION INSTITUTIONS

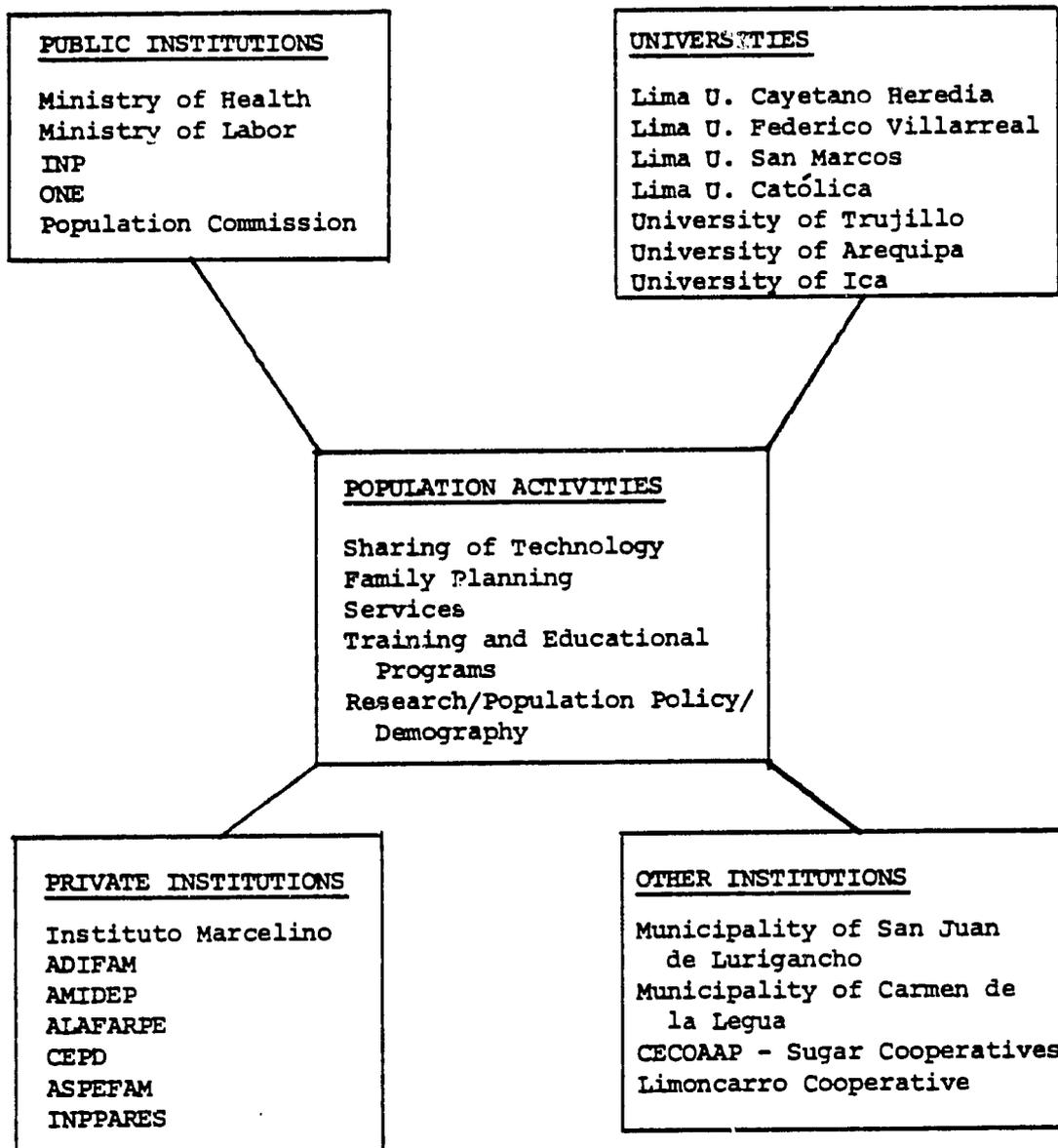


TABLE 12

POPULATION RELATED PUBLIC AND PRIVATE INSTITUTIONS

Public Institutions	Services	Training and Education	Research	Sharing of Technology (T.A.)
Ministry of Health	O.G.	O.G.	O.G.	O.G.
Ministry of Education		P		P
Ministry of War (Prodocisa)		IP	IP	
Ministry of Labor (SSP) Social Security	IP O.G.	O.G. O.G.	C O.G.	C - P O.G.
Ministry of Agriculture and Food	P	P		P
National Office of Statistics		O.G.	O.G.	O.G.
National Planning Institute		C	IP	P
<u>UNIVERSITIES</u>				
University of San Marcos	O.G.	O.G.		
Federico Villarreal University	O.G.	O.G.		
Cayetano Heredia University	O.G.	O.G.		O.G.
Catholic University		C	C	P
University of Trujillo	P	O.G.		P
University of Arequipa			O.G.	O.G.
University of Ayacucho	P	P		P

NOTE: O.G. Ongoing
P. Possibility, being explored
C. Completed

I.P. In process,
Project in approval
Process

TABLE 12 (Continuation)

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POPULATION RELATED PUBLIC AND PRIVATE INSTITUTIONS

	Services	Training and Education	Research	Sharing of Technology (T.A.)
University of Ica	P	P	IP	P
University of Cuzco	P	P		P
Peruvian Association of Medical Schools	O.G.	O.G.		O.G.
<u>PRIVATE ORGANIZATIONS</u>				
Association for Integrated Development of the Family	O.G.	O.G.		
Peruvian Association of Pharmaceutical Laboratories	O.G.	O.G.		
Peruvian Group for Sex and Family Education		C		
Peruvian Institute for Responsible Parenthood	O.G.	O.G.		
Marcelino Institute	O.G.	O.G.	O.G.	
Lay Family Apostolate Program	O.G.	O.G.		
Multidisciplinary Association for Training and Research in Population		O.G.	O.G.	O.G.
Population and Development Studies Center		O.G.	C	O.G.
Institute for Peruvian Studies			O.G.	

TABLE 12 (Continuation)

POPULATION RELATED PUBLIC AND PRIVATE INSTITUTIONS

-54

	Services	Training and Education	Research	Sharing of Technology (T.A.)
<u>OTHER INSTITUTIONS</u>				
Municipalities	O.G.	O.G.		
Private Businesses	P	O.G.		
Factories	P	O.G.		
Cooperatives	O.G.	O.G.	I.P.	O.G.

G. Family Planning Services, Training and Education

Major expansion is expected in the Ministry of Health through coordination of the national primary health and maternal child health and population programs. Initial support will be provided through the Primary Health Loan and Grant (\$7,150,000), the Sur Medio Maternal Child Health and Population Project (\$1,800,000) and the amended project to the Directorate of Maternal Child Health and Population (\$118,000). Follow on activities include: the Marginal Urban Project (\$2,100,000, FY 81) and the Primary Health II Project (\$9,000,000, FY 82).

The strategy includes the implementation of family planning services through the developing primary health infrastructure and improved hospital and clinic referral services for MCH and family planning which might be appropriately financed through the UNFPA Project. Additional training activities in MCH and family planning and sex education will be provided at the Regional level through the ORDES with assistance from Development Associates, Pathfinder Fund and IFRP. These include the Regions of Lima, Piura/Tumbes, Trujillo and Huancayo. Population Council is supporting the ASPEFAM Project of training for clinical personnel and services in the Regions of Trujillo, Cuzco, Arequipa, Puno and several major hospitals in Lima, including the Maternidad of Lima (45,000 births per year).

The Ministry of Labor and the Social Security Program receive assistance from Pathfinder Fund for services and from the Population Council for training. Efforts are underway and will be expanded to include family planning services in all of the major Social Security Hospitals (30) throughout the country.

The program will commence with training both in-country and in other Latin American training programs supported by Development Associates, International Project and IFRP. Thus, with a development cost for supplies and training, the program should expand rapidly under the new government.

The major expansion in population and family planning education activity will be in the public sector through the Directorate of Maternal Child Health and Population Program with UNFPA and more recently the AID bilateral project. A family planning/sex education focus is expected in the further development of indigenous educational materials, television and radio spot announcements and training for MOH personnel in this field. In addition, the Primary Health Grant and Loan includes a major program component for the distribution of health, population, family planning and sex education materials for both professionals and paraprofessionals throughout the public and private sectors.

Many private institutions and organizations in Peru are providing family planning service, administration and education training for participants from the public and private sectors. The priority program is the Instituto Marcelino Family Planning Training for doctors, nurses and midwives. Staff of public programs from all of the major health regions will be trained in Lima with follow up supervision in their respective regions.

Other important training programs that are underway and will be expanded include: Social Security, (Population Council, Development Associates), ADIFAM, community based distribution (FPIA), PALF, community based distribution, (FPIA), ALAFARPE, community based distribution (Pathfinder), CECOAAP, Sugar Cooperatives Project, (Population Council) and the Association of Nursemidwives, (Development Associates).

Development Associates is also sponsoring a program on Community Based Distribution for public and private project administrators.

All of the major university medical schools and related hospital facilities have training programs including: Cayetano Heredia and Hospital Loayza, San Marcos and Maternity Hospital, University of Trujillo and the Regional Hospital, Federico Villarreal University, and the University of Ica. One area for expansion under the new government will be family planning training and services under the "secigrista" program of field work for one year for physicians, nurses and nurse-midwives. San Marcos, Cayetano Heredia University and University of Trujillo already have programmed curriculum but this program will be coordinated by the Central level of the MOH and promoted through the Regional Health Sectors of the ORDES.

Programs with the cooperatives and factories will commence this year. A major gap still exists in working with other sectors including agricultural extension workers, other major cooperatives, the business community and governmental programs in the health divisions of the Armed Forces and public authorities, e.g., ELECTROPERU and CENTROMIN.

H. Research/Population Policy/Demography

The Mission strategy will focus on the expansion of the role of ONE in the public sector and AMIDEP in the private sector to promote and foster population policy development and research under the new civilian government.

ONE will consolidate the vital registration program of the country and utilize the VISTIM Project model (N.C.H.S.) to replicate the system on a national basis. Moreover, ONE is expected to expand its leadership role within the Andean Pact countries and has already entered into discussions with officials of the "Pacto Andino" in Lima

to explore the feasibility of creating a regional program in vital registration improvement methods with Peru serving as the headquarters.

Considering the great similarity of current registration systems and problems in the andean region, the ONE andean proposal seems to merit consideration. Arrangements are now underway to support this proposal through the sponsorship of "Pacto Andino", ONE, NCHS, VISTIM, AID/W, USAID, UNFPA and the U.N. Statistical Division and PAHO.

Under the new government, USAID will explore the alternatives available to support a strengthened and consolidated Population Council. The proposal of the military government to establish a multisectoral population commission did not create either the organizational framework nor the concentrated technical expertise required to strengthen and support the policy directives needed to implement a broad based national program. If feasible, the Mission will foster the development of a population council within the National Institute of Planning which would have representatives from key public and private institutions and multidisciplinary technical staff support to provide direction for the implementation of the Government's population program.

As part of this effort, USAID is initiating a joint development of a population projection and analysis presentation for the government with the U.S. institution, the Futures Group, and the local Peruvian organizations, ONE and AMIDEP. If successful, this project would institutionalize the collection and analysis of population data for utilization in government development planning and research.

ONE will also continue its programs in population and development, follow up on the World Fertility Survey, and expansion of its work in relation to the 1981 census.

AMIDEP will expand its program of population policy advocacy analysis and research including demography, fertility, migration and social research methodology applied to population problems. It is expected that the new contract of the AID/W Population Policy Division will support the expanded activities of AMIDEP and those under consideration with the public sector in ONE and INP.

The program of CEPD and its potential for expansion will be considered as part of the evaluation of the existing project with Battelle. However, it is expected that unless the leadership is changed, the program will be discontinued.

IEP has recently expanded its program in fertility research and is being considered for a major sub-contract for fertility research with CECOAP under a Population Council grant. Since IEP is considered to be the foremost social science research institution in the country, USAID supports its expanded role in the population research field.

The Population Council project for MCH and family planning data collection with Informatica will be terminated and emphasis will be placed upon the simplified data system for services which will be utilized in the Sur Medio Project. Moreover, efforts will be made to identify a private sector institution, e.g., AMIDEP, which will collect service data from all the major private sector programs under a Mission contract for data collection and analysis. If successful, the project could be expanded to the public sector, if approved by the new government. Such a system has been utilized in Guatemala and Colombia.

Major expansion is expected in cooperation with the Westinghouse Corporation to assist in the design and implementation of a simplified health and contraceptive prevalence survey as part of the National Primary Health Project. The baseline survey for the Sur Medio Project will be completed and analyzed with the assistance of designated Peruvian demographers and statisticians from ONE.

1. Population Policy Project

Preliminary work has been completed for a possible project in population policy designed to provide multisectoral private support for the implementation of Peru's population policy. The proposal will provide for dissemination of population/sex education/family planning information through an information center for distribution of films, books, monographs and educational materials; the development of a series of population seminars regarding population issues, the need for family planning services, W.F.S. data analysis and sex education for the national professional associations, e.g., lawyers, social workers, pharmacists and teachers; publication of press, magazine articles and pamphlets; the introduction of radio and television messages; and establishment of an ongoing dialogue in population and sex education among interested public and private organizations and institutions.

The project proposal was submitted by Dr. Luz Jefferson, a well known advocate of family planning services and one of the principle members of the Population Commission which designed the population policy. Violeta Gonzales, Director of the World Fertility Survey and capable demographer/spokesperson regarding the results of the survey has been considered as a part-time consultant for the presentation of the demographic analysis/population implications of the World Fertility Survey for the proposed seminars. The proposal is under review by AID/W, Battelle, and USAID.

2. Population and Development

It is clear that AID should assure that its total comprehensive development program support and complement the specific activities of a traditional population/family planning program. In cooperation with AID/W and other grantees and contractors, the Mission continues to

support projects which link population and development activities and strengthen the design, monitoring and evaluation components of these programs.

Therefore, USAID has initiated a series of actions to explore the interrelationship of the overall development program and the population policy objectives. Briefly, these include: a) a research project designed to examine the impact of a specific development project upon fertility patterns (DS/POP/Policy); b) a training program to provide management skills for women including project design, administration and evaluation (PPC); c) a research project in determinants of fertility in rural areas (DS/POP/Policy); and d) seminars in economics, development and population (DS/POP/Policy).

The major new program in this area is the Population Council Project with the Peruvian Center of Agrarian Cooperatives for Sugar Production (CECOAAP). The project is a research and action program designed to examine the population policy issues of the cooperatives, to implement a fertility service and education program and to make recommendations to the Peruvian government regarding population policy guidelines for this agricultural sector.

CECOAAP will implement the service and education component and IEP will implement the research design. Thus, the combined program of population and development research coupled with action oriented family planning education and services, forms the basis of a dynamic innovative program with excellent technical assistance of both a respected Peruvian institution and the Population Council. If successful, the project might provide both the model for service delivery in the cooperatives throughout the country and the basis for population and development guidelines for a major government sector. This project is under review by USAID and AID/W.

The Mission will be exploring the feasibility of implementing other similar projects which assist both USAID and the Peruvian Government to expand the population program beyond the health sector to include population policy, research and services in other development sectors.

I. Family Planning Supplies

1. Previous Constraints

One of the major constraints to implementing a successful family planning program has been the serious problems of providing contraceptive supplies due to loss and delays in customs, MOH restrictions of contraceptive supply distribution to the Health Regions, and no GOP support for contraceptive distribution in the private sector.

The MOH logistics system is dysfunctional for both political and technical reasons. Often, the MOH refuses to process the documents to release supplies from customs not only for the private sector, but also for its own health system. Church opposition to family planning has delayed processing supplies for university based programs through the Ministry of Education, e.g., Hospital Loayza/Cayetano Heredia University Project, (FPIA) and Tarma/Cayetano Heredia University Project (Pathfinder). Strikes in Social Security, hospitals and customs have also paralyzed distribution of supplies.

The previous Director of MCH and Population refused to support technical assistance for streamlining the unwieldy bureaucratic processing and creating an inventory supply and control system for the MOH contraceptive program.

Police investigators also restricted customs clearance for a series of programs in the private sector.

2. Contraceptive Distribution System

These problems are being resolved under the new civilian government. Commitments have been made to: a) Utilize technical assistance for the logistics system to streamline bureaucracy and standardize inventory, supplies, control and distribution. Major advances have been made to improve health center, post and community level logistics system under the Primary Health Project. Standardized procedures and central level and regional logistics plans are being developed for the primary health supplies which can be utilized for contraceptives as the GOP population program is implemented. b) Formulate a logistics information system to compile supply data and plan for inventory and resupply and c) Provide GOP support for customs processing of contraceptive supplies especially for the universities, hospitals and other private sector organizations. As the GOP program is formalized, supplies will be processed with fewer delays due to administrative and bureaucratic redtape, especially in customs and the MOH.

3. Private Sector Supply System

Plans are underway to utilize the Instituto Marcelino as the major supply distributor for the private sector. This system is already in operation with the support of Pathfinder Fund. In addition, the project proposal for Private Sector Distribution modeled on the successful SOMEFA Program in Colombia will complement the distribution of supplies to grantee funded projects in the private sector with a low cost sales program to physicians and nurse-midwives. This proposal is under review in Pathfinder and AID/W.

Additional technical assistance will be provided to the Institute to: a) formalize accounting and information procedures and reports, b)

provide for the assessment of storage and supply mechanisms, quality control and stock, c) review possible alternatives for coordinating contraceptive distribution to MOH health centers, and d) systematize information collection and resupply of "secigristas" as part of a private sector supply program. The complete plan will be finalized and submitted to AID/W and Pathfinder pending the technical assistance report and Mission review.

J. Commercial Retail Sales Program

1. Feasibility

Mission staff has had several meetings with Office of Population project officers for the Commercial Retail Sales Project. In September, 1979, John Farley and Steven Samuels visited Peru to undertake a preliminary analysis of the feasibility of a subsidized Contraceptive Marketing Program for Peru.

An excellent report of their findings is available on request. Briefly, the report indicates that the program is both economically and technically feasible, although political support remains a potential barrier.

The socio-economic conditions in Peru coupled with the evidence of family planning service demand suggests that approximately 500,000 households, who now practice ineffective methods have been priced out of the commercial market for contraceptives. If only one-fifth of these households become consumers, the number of families practicing contraception would be doubled.

It is programmed that \$500,000 will be needed for initial development costs, as well as administration for the first two years. The project, if successful, could become self-sufficient except for contraceptive commodities and small cash subsidies for distribution.

Several products would be considered including pills, condoms and spermicides at a price of approximately \$0.32 for a one month's supply. Initial distribution would be through pharmacies using distributors and wholesalers with later expansion to other outlets. Media advertising will be required and point-of-purchase educational materials provided.

2. Barriers to Development

Several problems must be resolved for the program to become workable: a) finished products must be purchased in country, e.g., UNFPA purchase of contraceptives locally, b) test-marketing is required, c) some government support is necessary regarding potential advertising, private sector program development and GOP support of local sponsoring group.

3. Project Development

Prior to project development a meeting will be held to discuss the implementation of a subsidized commercial retail sales (C.R.S.) program with interested Peruvians in both the GOP and private sector with C.R.S. program managers from other countries, e.g., Mexico, Jamaica and El Salvador.

The meeting will focus on the general concepts of such a project and the specific issues of implementation within various political and socio-economic conditions. If successful, the meeting will form the basis for a carefully planned, evolutionary development of the project including contract development for management of the project, formulation of the Peruvian sponsoring organization and a series of meetings with supportive new GOP officials to plan for effective implementation.

K. Program Budget Projections

The budget projections on the following pages are based upon a series of interrelated factors and must be considered as a guide for discussion pending interaction with the various contractors and grantees involved and a realistic assessment by AID/W of the needs throughout the L.A. Region. Nevertheless, these planning estimates will assist all parties in establishing priorities for scarce resources and measuring the relative potential for a major impact on population goals over the next few years. The alternatives which have been developed are for FY 80/81 and can be projected with a ten percent increase over the next three years. The first alternative is a maintenance of effort level with selected expansion in areas of opportunity and a realistic assessment of reduced population funding availability through centrally funded grantees and contractors.

Major increases can be expected for DAI as their involvement in Peru expands and requests from major institutions and organizations are met, e.g., Lima Region, Social Security, Instituto Marcelino, Association of Midwives, etc. Population Council has expanded its program with ASPEFAM, Association of Medical School Faculties and developed a major new project of services and research with the Sugar Cooperatives (CECOAAP). International Project program support will expand with training/fertility management centers in the private sector and the Maternidad Training Center in the public sector. Westinghouse Corporation will provide support for a health/contraceptive survey if local technical support and administrative arrangements can be made. Additional requests for family planning training services in the major health regions under the Primary Health Care Project can be expected. The Mission views Pathfinder assistance in both project development and financial resources as the priority grantee program. FPIA will

expand its program in Peru as its more traditional private sector grantee organizations expand into community based distribution services. NCHS has maintained the vital registration project and perceives some expansion in relation to the nationwide system and joint training and collaboration among the Andean Pact countries in this field of speciality. Battelle has been active in Peru and the new population policy contractor (DS/POP/PPD) will be considered as an important potential financial support for the population development actions of the new government.

The second alternative projects an increase in support for private sector activities especially outside Lima; increased interest by the GOP to permit regional, university, hospital and multisectorial institutional support for population service and education programs and expansion of opportunities in training and community based family planning service delivery. This alternative also provides for some expansion of family planning as an integral component of primary health. Such actions are expected in Lima Region, ORDELIB (Trujillo), ORDENORTE (Piura/Tumbes), Centro Medio (Huancayo), Centro Oriental (Huánuco), and ORDEPUNO (Puno).

The third alternative could be utilized as the new civilian government formulates its public support for the implementation of a strong, clear population policy and provides the institutional and organizational framework for concerted action. Funds could be more rapidly deployed from the Primary Health Loan and Grant if a directed and well-coordinated program of primary health and family planning were established.

I. Conclusion

With the election of the new civilian government, the Mission views the future implementation of the population program with cautious optimism. Expansion of the population program in Peru is in progress and plans are underway to continue the momentum already established utilizing both public and private channels. Inroads have been made in the area of population programming with the development of the Sur Medio Maternal Child Health and Population bilateral agreement with the MOH and for the expansion of family planning utilizing the primary health care infrastructure for community based distribution of health and contraceptive services.

Major advances have been made in the variety of grantees, number of beneficiaries and geographic spread of family planning activities in the private sector. Many small projects have been initiated with little or no negative political reaction. Training activities have increased especially in the area of family planning services. Young

physicians, nurse-midwives, nurses and auxiliaries are taking a special interest in this area and this group expresses support for broad accessibility to services and favorable attitudes toward family planning.

The new Ministry of Health recognizes the need for increased coordination between the MCH and Population Program and Primary Health. Moreover, the new Government will provide approval for private sector activities and this GOP support will increase as the government stabilizes and its policies are firmly in place; thereby permitting more rapid expansion in the private sector in the very near future. Major private sector activities to be expanded include, for example, clinical and community based services, training, and distribution of contraceptives, e.g., Instituto Marcelino, CECOAP, and ADIFAM; population policy actions, e.g., AMIDEP, Population Policy Project, and ONE; information and education, e.g., Primary Health loan and grant including a subcontract for family planning information distribution network and community education and population research, e.g., ICARPAL, Population Council and IFRP grants.

Church groups are being supported under AID funded grants. Many priests and nurses are actually providing family planning information and services. Church opposition has been reduced in recent months. ADIFAM, a major Church supported group will be greatly increasing its community based program with support from FPIA.

Nevertheless, some limitations remain including: 1) some possible problems relating to GOP capability to utilize large additional bilateral population funds effectively due to existing bureaucratic centralization and some fiscal and program management deficiencies; 2) lack of organizational infrastructure for a large private sector program due to historical political sensitivities, limitation of private sector leadership, lack of experience in program management and fiscal controls and difficulties in customs processing of contraceptives for private sector use; and 3) years of inertia due to political constraints which limited development of innovative or potentially "controversial" projects with international donors due to possible reaction of groups opposed to family planning and lack of clarity regarding support for population programs.

USAID believes that the traditional Church, government bureaucratic, and social cultural limitations can be overcome and has already taken steps to alleviate them. Government centralization, fiscal constraints and management deficiencies are being resolved through management technical assistance in conjunction with the Primary Health Care Project and decentralized regional planning and logistical supply distribution. Organizational and management deficiencies in the private sector are being overcome through the support of the successful private sector models such as the Instituto Marcelino, whose expansion will be funded under the OPG grant mechanism. Marcelino will also be the major contraceptive supply distributor for the private sector.

Finally, the changing political climate under the new government and the increasing demand for family planning services should permit major expansion of the population program through government and private channels. USAID has and will continue to expand the scope and depth of its population strategy and has laid the groundwork for continued growth of the program as the new government continues to formulate its population programs and new opportunities are created.

TABLE 13

USAID PROGRAM BUDGET
1980

	<u>Expenditures</u> CY 80	<u>Obligations</u> FY 80
Sur Medio Project	\$500,000	\$600,000
Directorate MCH and Population (Ex-INPROMI)	118,000	-
Primary Health	200,000	-
O.P.G. - Instituto Marcelino	<u>25,000</u>	<u>150,000</u>
	<u>\$843,000</u>	<u>\$750,000</u>

TABLE 14

USAID PROGRAM BUDGET
THREE YEAR ESTIMATE*
(FY)

	<u>1980</u>	<u>1981</u>	<u>1982</u>
Program	\$750,000	\$1,450,000	\$9,600,000
Centrally Funded/ Grantees/Contractors	\$1,090,000	\$2,860,000	\$3,150,000
Other Donors	<u>\$500,000</u>	<u>\$1,000,000</u>	<u>\$2,000,000</u>
	<u>\$2,340,000</u>	<u>\$5,310,000</u>	<u>\$14,750,000</u>

1. Sur Medio MCH and Population Project and OFG Instituto Marcelino Project
2. Sur Medio and Marginal Urban Projects (ABS)
3. Primary Health II and Marginal Urban Projects (ABS)
4. UNFPA (possible projection)
5. UNFPA and World Bank (possible projection)

* Includes Health and Population Funds for Bilateral Programs.

TABLE 15

POPULATION BUDGET ALTERNATIVES

AID/W CENTRALLY FUNDED GRANTEES/CONTRACTORS

Centrally funded AID/Grantee/ Contractors		BUDGET ALTERNATIVES		
		1st. Alternative	2nd. Alternative	3rd. Alternative
P.F.	Pathfinder	150,000	450,000	800,000
I.P.	International Project	10,000	100,000	200,000
JHPIEGO	John Hopkins Program for International Education in Gyn. Obstetrics	100,000	160,000	200,000
IFRP	International Fertility Research Program	40,000	110,000	130,000
FPIA	Family Planning International Assistance	100,000	300,000	600,000
P.C.	Population Council	110,000	150,000	200,000
B.I.	Battelle	60,000	70,000	80,000
DAI	Development Associates	100,000	150,000	200,000
BARFR	Program for Applied Research on Fertility Regulation	10,000	10,000	10,000
BUCEN	U.S. Bureau of the Census	30,000	50,000	50,000
F.G.	Futures Group	10,000	10,000	10,000
APHA	American Public Health Association	20,000	30,000	30,000
DHEW	Department of Health, Welfare	175,000	175,000	175,000
W.C.	Westinghouse Corporation	<u>175,000</u>	<u>175,000</u>	<u>175,000</u>
	TOTAL	1,090,000	1,940,000	2,860,000

TABLE 16
POPULATION BUDGET 1980

DONORS	PERUVIAN INSTITUTIONS				TOTAL
	PUBLIC ORGANISMS (Ministries)	UNIVERSITIES	PRIVATE ORGANIZATIONS	OTHER INSTITUTIONS	
Program	1) 600,000	-	2) 150,000	-	750,000
Contraceptives	150,000	90,000	100,000	-	340,000
Centrally funded/Grantee/ Contractors	295,000	200,000	550,000	45,000	1,090,000
Other Donors	3) <u>500,000</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>500,000</u>
T O T A L	1,545,000	290,000	800,000	45,000	2,680,000

- 1) Sur Medio Project
- 2) OPG - Instituto Marcelino
- 3) UNFPA Project - CY 1980 - latest proposal

A N N E X E S

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|-----------|--|
| ANNEX I | Additional Statistical Tables Relating to Economic, Social and Cultural Factors. |
| ANNEX II | Additional Statistical Tables Supporting the Demographic Perspective |
| ANNEX III | Charts on the Health System in Peru |
| ANNEX IV | Charts on Donor/Grantee Organizations and Institutions |

ANNEX I ADDITIONAL STATISTICAL TABLES RELATING
TO ECONOMIC SOCIAL AND CULTURAL FACTORS

TABLE I-1

LABOR FORCE 15 YEARS AND OVER BY OCCUPATION CATEGORY AND BY ECONOMIC SECTOR, 1978

(In Thousands)

	Total	Agri- culture	Mining	Industry	Electri- city	Contruc- tion	Com- merce	Transpor- tation	Finan- cing	Services
<u>TOTAL</u>	<u>5,273.6</u>	<u>2,197.3</u>	<u>66.5</u>	<u>670.8</u>	<u>11.4</u>	<u>232.7</u>	<u>735.1</u>	<u>240.6</u>	<u>85.0</u>	<u>1,034.2</u>
White-collar	949.9	31.5	14.3	120.7	5.7	23.8	132.7	63.8	65.6	491.8
Blue-collar	1,253.1	388.0	50.0	309.8	5.7	159.5	78.0	91.1	7.1	163.9
Independent Workers	2,496.1	1,485.4	1.7	216.9	- -	47.8	470.5	78.1	11.5	184.2
Employers	31.0	11.0	0.1	4.3	- -	0.8	7.4	3.2	0.5	3.7
Family Workers	363.3	281.4	0.4	19.1	- -	0.8	46.5	4.4	0.3	10.4
Household Workers	180.2	- -	- -	- -	- -	- -	- -	- -	- -	180.2

SOURCE: Oficina Nacional de Estadística (ONE)

NOTE: Electricity includes electricity, gas, water and sewerage. Commerce includes wholesale and retail trade and restaurants and hotels. Transportation includes transportation, warehousing and communication. Financing includes banking, insurance and real estate.

TABLE I-2

GROSS DOMESTIC PRODUCT (GDP) PER CAPITA DATA, 1968-1978

A.	Growth Rate based on 1973					B. Constant Prices	
	In	Current	Market	Prices		Annual Per	Annual Percent
	GDP in millions of Soles	Population in thousand (Mid-year)	GDP per Capita in Soles	GDP in Millions of dollars c/	GDP per Capita in dollars c/	cent Change in GDP	change in GDP Per Capita
1968	210,457	12,675	16,604	5,438	429	-0.3	-3.1
1969	236,147	13,055	18,089	6,102	467	3.9	0.8
1970	267,121	13,447	19,864	6,902	513	5.4	2.3
1971	295,279	13,830	21,350	7,630	552	5.0	2.1
1972	327,249	14,224	23,007	8,456	594	1.7	-1.2
1973	392,559	14,628	26,836	10,144	693	4.3	1.4
1974	494,406	15,044	32,865	12,775	849	7.5	4.5
1975	627,392	15,470	40,555	15,553	1,005	4.5	1.7
1976	830,446	15,908	52,203	14,893	936	2.0	-0.8
1977	1,132,678	16,357 a/	69,245	13,441	822 a/	-0.1	-2.8
1978	1,744,907	16,819 b/	103,745	11,188	665 b/	-0.7	-3.4

a/ Preliminary figures. b/ Estimated. c/ Conversion to US dollars effected at a rate of exchange of S/ 38.70 = US\$1.00 for the years 1968-74, S/40.34 = US\$1.00 for 1975; S/55.76 = US\$1.00 for 1976; S/84.27 = US\$1.00 for 1977 and S/ 155.96= US\$ 1.00 for 1978.

SOURCE: Oficina Nacional de Estadística : Cuentas Nacional del Perú -1950-1978 (Pub.May 1978)

TABLE I-3

POPULATION 4 YEARS AND OVER BY KNOWLEDGE OF LANGUAGE

<u>LANGUAGE</u>	<u>1972 Census</u>	<u>Percent of Total</u>
<u>Monolingual</u>	<u>9,433,629</u>	<u>81.9</u>
Spanish	7,920,891	68.8
Quechua	1,311,062	11.4
Aymara	149,664	1.3
Other Native language or Dialect	39,346	0.3
Others	12,666	0.1
<u>Bilingual</u>	<u>2,081,797</u>	<u>18.1</u>
Spanish & Quechua	1,715,869	14.9
Spanish & Aymara	182,241	1.6
Spanish & Other Native Language	77,894	0.7
Spanish & Foreign Language	45,730	0.4
Spanish & Others	60,928	0.5
<u>TOTAL a/</u>	<u>11,515,426</u>	<u>100.0</u>

SOURCE: Oficina Nacional de Estadística y Censos, Boletín de Análisis Demográfico No.16 (1975), p.13

a / Excludes 274,724 persons who did not specify whether they did or did not speak Spanish.

TABLE I-4POPULATION 5 YEARS AND OVER BY EDUCATIONAL LEVEL

<u>Educational Level</u>	<u>a/</u>	<u>1961</u> <u>Census</u>	<u>Percent</u> <u>of Total</u>	<u>1972</u> <u>Census</u>	<u>Percent</u> <u>of Total</u>
Without Education		3,588,845	44.5	3,425,477	30.5
Pre-School		379,270	4.7	697,623	6.2
Primary <u>b/</u>		3,305,501	41.0	5,103,003	45.4
Secondary <u>c/</u>		664,092	8.2	1,673,574	14.9
Higher & Normal		131,319	1.6	335,614	3.0
TOTAL		8,069,027	100.0	11,235,291	100.0

a/ Excludes persons not responding to questions related to educational level

b/ Approximates the first five years of formal schooling.

c/ Secondary schooling was a five-year course.

SOURCE: Oficina Nacional de Estadística y Censos,
Boletín de Análisis Demográfico
No.16 (1975) p. 20.

TABLE I-5An 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

CENSUS 1 9 7 2

TABLE I-6
Percentage Distribution of Food Consumption
Per Capita in Peru (1971 -72)

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

Analysis of family expense
structure, Agreement
MEF-ENCA

TABLE I-7

Percentage Distribution of Food Expense

Per Capita
PERU 1971 - 1972

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

Family Expense Analysis
Agreement MEF - ENCA

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

TABLE I-8

Annual Food Consumption Per Capita in KilosM.E.F. M.Alim. (1971-72)

Products	Lima		Rural Areas	
	<u>Kilos/year</u>	<u>grs/days</u>	<u>kilos/year</u>	<u>grs/day</u>
White Potato	42	115	100	270 per day
Fresh Milk	40	109	10	30
Common Rice	30	82	16	40
Fresh Style Bread	28	76	4	10
Refined Sugar	19	52	4	10
Beef	15	41	3	10
Onion	13	35	4	10
Spaghetti	12	32	7	20
Other Bread	5	13	9	20
Yucca	3	8	17	50
Brown Sugar	1	2	11	30
Dry corn	-		16	40

ANNEX II - ADDITIONAL STATISTICAL TABLES
SUPPORTING THE
DEMOGRAPHIC PERSPECTIVE

TABLE II - 1

COUNTRY DATA- PERU

<u>AREA</u>	<u>POPULATION</u>	<u>DENSITY</u>
2 1285.2 K ,thousand	16.5 million (mid 1977) Rate of Growth: 2.9 (from 1970 to 1977)	13 per km ² 54 per Km ² of arable land
<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 II-2

POPULATION GROWTH AND DISTRIBUTION; 1940-72

	<u>In Millions</u>			<u>Percentage Structure</u>			<u>Average Growth p. a. (%)</u>		<u>Years to double</u>	
	<u>1940</u>	<u>1961</u>	<u>1972</u>	<u>1/</u>	<u>1940</u>	<u>1961</u>	<u>1940</u>	<u>1961</u>	<u>1940</u>	<u>1961</u>
				<u>1940</u>	<u>1961</u>	<u>1972</u>	<u>61</u>	<u>72</u>	<u>61</u>	<u>72</u>
TOTAL	<u>6.7</u>	<u>10.3</u>	<u>14.1</u>	<u>100</u>	<u>100</u>	<u>100</u>	<u>2.1</u>	<u>2.9</u>	<u>34</u>	<u>24</u>
Urban	1.7	4.0	7.2	27	40	53	4.2	5.6	17	13
(Lima)	(0.5)	(1.8)	(3.3)	(8)	(19)	(24)	(6.2)	(5.5)	12	13
(Other Urban)	(1.2)	(2.2)	(3.9)	(19)	(21)	(29)	(3.0)	(5.7)	(23)	(13)
Rural	4.5	5.9	6.3	73	60	47	1.3	0.6	54	116
Costa	1.7	3.8	6.2	28	38	46	3.8	4.7	19	15
Sierra	4.0	5.3	6.0	65	53	44	1.3	1.2	54	58
Selva	0.4	0.9	1.3	7	9	10	3.5	3.8	20	19
Census ^{2/} omission	0.5	0.4	0.6	-	-	-	-	-	-	-

1/ Excludes census omission.

2/ Estimated Census error.

SOURCE: ONEC.

TABLE II-3

Chart No. 3 - Estimated Population by State for
each Calendar Year Period 1972-1979

	Population to June 30				Women in Per. age 20%
	1976	1977	1978	1979	
REPUBLIC	15,907,907	16,357,526	16,819,165	17,293,083	3,458,616
Amazonas	256,444	267,784	279,502	291,605	58,321
Ancash	827,717	845,755	864,279	883,304	176,661
Apurimac	329,941	331,800	333,708	335,671	67,134
Arequipa	630,121	655,013	674,421	694,355	138,871
Ayacucho	507,059	513,851	520,909	528,235	105,647
Cajamarca	1,034,229	1,052,959	1,072,075	1,091,590	218,318
Callao	383,394	396,173	409,220	422,540	84,508
Cuzco	803,340	816,793	830,038	843,688	168,738
Huancavelica	360,943	364,048	367,203	370,414	74,083
Huámuco	468,625	477,690	486,990	496,530	99,306
Ica	426,026	439,260	452,814	466,697	93,339
Junín	806,523	828,264	850,636	873,652	174,730
La Libertad	902,753	926,289	950,412	975,132	195,026
Lambayeque	620,291	642,459	665,233	688,624	137,725
Lima	4,322,460	4,509,179	4,701,045	4,898,139	979,628
Loreto	605,753	622,277	639,331	656,901	131,389
Madre de Dios	25,193	25,170	25,148	25,127	5,025
Moquegua	90,358	93,522	96,781	100,137	20,927
Pasco	199,249	202,597	205,977	209,393	41,878
Piura	975,605	996,910	1,018,616	1,040,737	208,147
San Martín	265,222	273,185	281,379	289,809	57,962
Tacna	114,631	118,459	122,379	126,401	25,280
Tumbes	88,955	91,304	93,692	96,120	19,224
Puno	856,495	866,785	877,377	888,282	177,565

SOURCE: Extension of Integrated Primary Health, Peru,
Project Paper, August 1979.

TABLE II-4

GROWTH AND SHARE IN TOTAL URBAN POPULATION OF CITIES, 1940-1972 ^{1/}

City size ^{1/}	L O C A T I O N ^{2/}	In thousands			Share of urban population (in %)			Average annual growth rates (in %)			Number of years to double population	
		1940	1961	1972	1940	1961	1972	1940-61	1961-72	Rate ^{3/}	1940-61	1961-72
Total population		6208.0	9906.7	13572.1				2.3	2.9	1.26	30	24
Rural population		4536.8	5933.0	6373.3				1.3	0.7	0.54	51	90
Urban population ^{4/}		<u>1671.2</u>	<u>3973.7</u>	<u>7198.8</u>	<u>100.0</u>	<u>100.0</u>	<u>100.0</u>	<u>4.2</u>	<u>5.6</u>	<u>1.33</u>	<u>17</u>	<u>13</u>
Lima-Callao	CC	<u>601.8</u>	<u>1692.7</u>	<u>3158.4</u>	<u>36.2</u>	<u>42.6</u>	<u>43.6</u>	<u>5.0</u>	<u>5.8</u>	<u>1.16</u>	<u>14</u>	<u>12</u>
100 - 350000		<u>280.7</u>	<u>691.4</u>	<u>1377.7</u>	<u>16.8</u>	<u>17.4</u>	<u>19.3</u>	<u>4.4</u>	<u>6.6</u>	<u>1.50</u>	<u>16</u>	<u>11</u>
Costa		100.6	330.8	729.0	6.0	8.3	10.1	5.8	7.4	1.28	12	9
Trujillo	NC	(37.0)	(103.0)	(253.6)				(5.0)	(8.5)	(1.70)	(22)	(12)
Chiclayo	NC	(31.5)	(95.7)	(189.7)				(5.4)	(6.4)	(1.19)	(13)	(11)
Chimbote	NC	(4.2)	(60.0)	(179.0)				(13.4)	(9.3)	(0.69)	(6)	(8)
Piura	NC	(27.9)	(72.1)	(126.7)				(4.6)	(5.3)	(1.15)	(15)	(13)
Sierra		148.3	302.8	552.4	8.9	7.0	7.7	3.5	5.6	1.60	20	12.7
Arequipa	SS	(80.9)	(158.7)	(304.7)				(3.2)	(6.2)	(1.94)	(22)	(12)
Cusco	SS	(40.7)	(79.9)	(140.9)				(3.3)	(3.9)	(1.18)	(21)	(16)
Huancayo	CS	(26.7)	(64.2)	(126.8)				(4.2)	(6.4)	(1.52)	(17)	(11)
Selva		31.8	57.8	111.3	1.9	1.5	1.5	2.9	6.2	2.14	24	12
Iquitos	LS	(31.8)	(57.8)	(111.3)				(2.5)	(6.2)	(2.14)	(24)	(12)
50 - 99999		<u>22.5</u>	<u>158.2</u>	<u>301.4</u>	<u>3.3</u>	<u>4.0</u>	<u>4.2</u>	<u>5.1</u>	<u>6.0</u>	<u>6.18</u>	<u>14</u>	<u>12</u>
Costa		53.1	131.8	238.1	3.1	3.3	3.3	4.4	5.5	1.25	16	13
Ica	CC	(20.9)	(54.2)	(95.7)				(4.6)	(5.3)	(1.15)	(15)	(13)
Sullana	NC	(21.2)	(50.1)	(83.6)				(4.2)	(4.8)	(1.14)	(17)	(15)
Tacna	SC	(11.0)	(27.5)	(59.2)				(4.4)	(7.2)	(1.64)	(16)	(10)
Selva		2.4	26.4	63.3	0.1	0.7	0.9	12.1	8.3	0.69	6	9
Pucallpa	LS	(2.4)	(26.4)	(63.3)				(12.1)	(8.3)	(0.69)	(6)	(9)
20 - 49999 ^{5/}		<u>212.1</u>	<u>403.7</u>	<u>719.6</u>	<u>12.7</u>	<u>10.2</u>	<u>11.0</u>	<u>5.2</u>	<u>5.4</u>	<u>1.54</u>	<u>20</u>	<u>13</u>
2 - 19999		<u>521.1</u>	<u>1027.7</u>	<u>1626.7</u>	<u>31.2</u>	<u>25.9</u>	<u>22.6</u>	<u>3.3</u>	<u>4.3</u>	<u>1.30</u>	<u>21</u>	<u>16</u>

^{1/} Ranking by city size based on 1972 population. The Table shows how cities with a given size in 1972 grew in 1940-72. It therefore differs from Table 22 that shows the concentration of population by city size.

^{2/} NC = North Costa CC = Central Costa SC = Southern Costa CS = Central Sierra SS = South Sierra LS = Low Selva.

^{3/} Urban population defined as all cities with 2000 inhabitants or more.

^{4/} A close look at the Census data showed that the metropolitan areas of various cities had absorbed contiguous districts. The latter were added to the population of the city:

City	Districts added
Trujillo	El Porvenir, La Esperanza, Victor Larco Herrera and Laredo
Huancayo	Chilca and El Tambo
Ica	La Tinguina, Parcona, Salas, San Juan Bautista and Subtanjalla
Sullana	Bellavista
Pucallpa	Callaria and Yarinacochoa
Tacna	Pocollay

^{5/} Excludes Bellavista, included with Sullana.

SOURCE: ONEC and Mission estimates.

TABLE II-5

DEMOGRAPHIC INDICES - PERU 1975-1985

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

SOURCE: World Fertility Survey of Peru, 1977-1978

TABLE II-6

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	186,130	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	

TABLE II-7

COMPARISON OF DEMOGRAPHIC INDICATORS BETWEEN PERU AND OTHER
LATIN AMERICAN COUNTRIES WITH SIMILAR PER CAPITA INCOME ^{1/}
 (1975 or average 1970-75)

Country	1975 Popul.	Birth Rate e/100	Death Rate e/100	Rate of Natural Growth	Life expectancy at Birth	Popul. under 15
Unit	mill.	numbers	numbers	%	years	%
Latin America ^{2/}	290.3	38	9	2.9	62	42
Peru	12.6	44	1	1.0	52	44
Brazil	107.2	37	9	2.8	61	42
Chile	10.6	28	8	1.9	63	39
Costa Rica	2.0	28	9	2.3	69	42
Mexico	60.2	46	6	3.8	63	46
Nicaragua	2.2	48	4	3.4	53	48
Panama	1.7	31	9	2.6	66	43
Uruguay	2.8	21	10	1.1	70	28
Venezuela	12.0	36	7	2.9	65	44
Rank of Peru ^{3/}	3	3	1	3	5	3

^{1/} Countries of mainland Latin America which in 1970 had GNP per capita between US\$375-1000, calculated with IBRD World Atlas methodology.

^{2/} Mainland only.

^{3/} Rank of Peru vis-a-vis other countries with a higher value for indicator.

SOURCE: IBRD World Atlas 1976; USAID, Family Planning Service Statistics Annual Report, 1975.

TABLE II-8

AGE AND SEX STRUCTURE OF POPULATION, 1876-1972
(in percentage)

	Total				Male				Female				1 9 7 2					
													Urban			Rural		
	1876	1940	1961	1972	1876	1940	1961	1972	1876	1940	1961	1972	T	M	F	T	M	F
A. Age Structure by Sex																		
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
0-4	14.2	15.4	16.9	16.3	14.5	15.8	17.1	16.3	13.9	15.0	16.7	16.2	15.1	15.3	15.0	17.9	17.9	17.1
5-14	22.7	26.6	26.5	27.6	22.9	27.7	27.2	28.1	22.7	25.5	25.8	27.1	26.7	27.0	26.4	29.0	29.8	29.1
15-49	51.6	45.3	45.4	45.0	51.4	46.0	45.3	45.0	51.6	46.7	45.5	45.3	47.7	47.7	47.7	40.9	40.7	40.2
50-64	8.8	8.3	7.3	7.1	8.6	6.9	7.0	7.1	9.0	7.7	7.6	7.2	6.8	6.7	6.9	7.6	7.5	7.1
65 and over	2.7	4.4	3.9	4.0	2.6	3.6	3.4	3.5	2.8	5.1	4.4	4.2	3.5	3.1	3.8	4.4	4.1	4.1
B. Sex Ratios by Age																		
Total	100.8	97.6	98.8	100.4									100.0			101.2		
0-4	105.8	102.6	101.2	101.2									101.2			101.5		
5-14	102.7	106.2	103.8	104.2									102.2			107.1		
15-49	100.0	96.2	98.3	99.8									100.2			99.0		
50-64	95.6	87.2	92.1	98.5									97.4			100.0		
65 and over	92.9	89.2	77.3	87.9									81.3			87.0		
C. Other																		
Age Dependency ratios:																		
Total	65.6	86.6	89.8	91.6									81.0			105.8		
Child ^{2/}	61.1	78.4	82.7	84.2									76.6			96.7		
Aged ^{2/}	4.5	8.2	7.4	7.4									6.4			9.12		
% of males 15-64					60.0	52.9	52.3	52.1								54.4		48.2
Median age	n.a.	19.6	18.9	18.5	n.a.	18.8	18.4	18.7	n.a.	19.4	19.3	18.8						

SOURCE: World Bank Peru: Long-Term Development Issues, Vol. II, Main Report, 1979, Appendix Tables 1.5, 1.6.

TABLE II-9

BIRTH RATES AND AGE SPECIFIC FERTILITY RATES, 1940 - 2000

	Estimated					Projected			
	1940	1961	1960-65	1965-70	1970	1970-75	1975-80	1980-90	1990-2000
15-19	0.085	0.101	0.115	0.111	0.108	0.106	0.100	0.086	0.074
20-24	0.261	0.298	0.313	0.302	0.296	0.290	0.278	0.256	0.233
25-29	0.292	0.314	0.338	0.326	0.321	0.314	0.302	0.278	0.253
30-34	0.246	0.255	0.275	0.264	0.259	0.253	0.240	0.212	0.185
35-39	0.179	0.193	0.207	0.202	0.202	0.198	0.184	0.154	0.126
40-44	0.090	0.087	0.095	0.088	0.084	0.082	0.076	0.066	0.054
45-49	0.027	0.028	0.030	0.026	0.023	0.022	0.020	0.014	0.010
Total fertility rate n.a.	n.a.	n.a.	6.86	6.60	6.46	6.33	6.00	5.33	4.68
Crude birth rate (per 1,000)	45.0	46.5	47.09	45.04	44.5	43.50	42.14	39.06	35.42
Gross reproduction rate	n.a.	n.a.	3.35	3.22		3.08	2.93	2.60	2.28
Net reproduction rate n.a.	n.a.	n.a.	2.38	2.34		2.40	2.36	2.21	2.02

SOURCE: Peru: Long-Term Development Issues, Appendix Table 1.7.

TABLE XI-10

PERU: LIFE EXPECTANCY, 1976 - 2000

	Gross Death Rates o/oo	Both sexes		Males at:		Females at:		Percentage difference between:			
		at:		Birth		Age 5		Female and male at:		Birth and age 5 for:	
		Birth	Age 5	Birth	Age 5	Birth	Age 5	Birth	Age 5	Birth	Age 5
<u>Census years</u>											
1876	32.5	n.a.	n.a.	30.08	42.55	30.00	43.35	-0.3	-0.4	44.8	44.5
1940	27.1	n.a.	n.a.	34.62	41.29	36.77	47.44	6.2	7.1	27.9	29.0
1961	15.4	n.a.	n.a.	40.56	57.03	52.50	57.23	5.9	4.0	11.0	9.0
<u>Group periods</u>											
1963-65	17.3	49.58	58.27	48.27	57.67	50.54	58.92	4.7	2.0	29.5	16.4
1965-70	15.7	51.95	59.54	50.75	51.93	53.21	60.22	4.8	2.2	16.1	13.2
1970-75	13.8	54.55	n.a.	53.25	59.81	55.92	61.17	5.0	2.3	12.2	9.4
1975-80	12.3	56.53	n.a.	55.15	63.56	57.98	61.93	5.1	2.3	9.8	6.6
1985-90	10.2	59.60	n.a.	58.05	61.77	61.23	63.39	5.5	2.6	6.4	3.5
1995-2000	8.5	62.46	n.a.	60.71	62.96	64.30	64.84	5.9	3.0	3.7	0.5

SOURCE: Peru: Long-Term Development Issues, Appendix Table 1.17.

TABLE II-11Percentage Distribution of Total Death Rate by Age Groups. Peru 1972

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

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

TABLE II-12Ten Primary Causes of Morbidity in Infants from 1 to 5 Years OldAccording to Hospital Records - Peru 1977

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

SOURCE: Statistical Department - Ministry of Health

PERCENTAGE OF EVER-MARRIED WOMEN AGED 15-49 BY EXPOSURE TO PREGNANCY RISK

ENAF-PERU 1977-78

Exposure to Pregnancy Risk	Percentage
Exposed	65.84
Pregnant	11.93
Not in Union-Non Pregnant	10.01
Not Fertile	9.73
Sterilized	2.49
Total	100.00

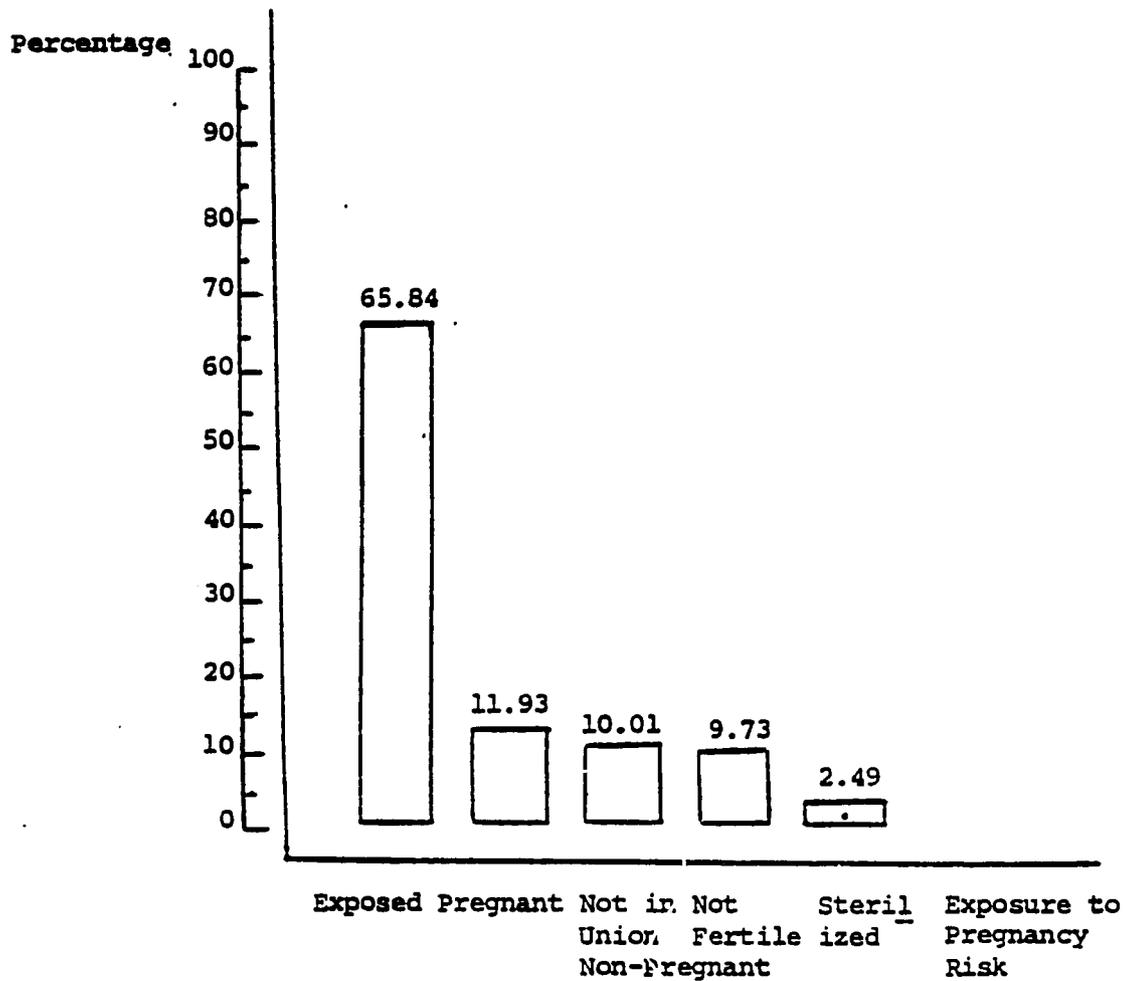


TABLE II-14

EXPOSED WOMEN WHO WANT MORE CHILDREN, PERCENTAGE WHO ARE CURRENTLY
USING CONTRACEPTION, ACCORDING TO NUMBER OF LIVING CHILDREN COLOMBIA,
COSTA RICA, DOMINICAN REPUBLIC, PANAMA, AND PERU

<u>Number of living children</u>	<u>Colombia (N=574)</u>	<u>Costa Rica (N=182)</u>	<u>Dom. Repub. (N=4-8)</u>	<u>Panama (N=550)</u>	<u>Peru (N=463)</u>
TOTAL	45%	78%	25%	51%	36%
0-2	46	81	27	54	40
3	48	82	25	43	35
4	48	79	23	41	31
> 5	36	74	14	33	19

SOURCE: First Country Reports, Table 5.2.3 for Colombia, Dominican Republic, and Panama; percentages for Costa Rica calculated from Table 5.2.3.A, and for Peru from Cuadro 5.4.

TABLE II-15

PERCENTAGE OF EXPOSED WOMEN AND OF EXPOSED WOMEN WHO WANT NO MORE CHILDREN NOT CURRENTLY
USING CONTRACEPTION, AND ESTIMATES OF UNMET NEED FOR CONTRACEPTION,
COLOMBIA, COSTA RICA, DOMINICAN REPUBLIC, PANAMA, AND PERU

Category	Colombia	Costa Rica	Dom.Repub.	Panama	Peru
1. Of exposed women, percent not using any method	(N=2,323) 48%	(N=2,222) 22%	(N=1,357) 58%	(N=2,257) 35%	(N=3,851) 59%
Efficient method *	63	35	65	45	85
2. Of exposed women who want no more children, percent not using any method	(N=1,423) 44%	(N=1,158) 16%	(N=717) 43%	(N=1,413) 26%	(N=2,307) 54%
Efficient method *	60	29	57	36	83
3. Of all exposed women, percent who want no more and are not using any method	(N=2,323) 27%	(N=2,222) 8%	(N=1,357) 23%	(N=2,257) 16%	(N=3,851) 27%
Efficient method *	37	15	30	23	50
4. Of all currently married women, percent who are exposed <u>and</u> want no more <u>and</u> are not using any method	(N=2,843) 22%	(N=2,699) 7%	(N=1,808) 17%	(N=2,723) 14%	u
Efficient method *	30	12	23	19	u
* Pill, injectable, IUD, sterilization, condom, diaphragm, and spermicide.					
+					

SOURCE: First Country Reports, Tables 5.2.3 and 5.2.3B.

TABLE II-16

PERCENTAGE OF EVER-MARRIED WOMEN WHO HAVE EVER HEARD
OF SPECIFIC CONTRACEPTIVE METHODS,
COLOMBIA, COSTA RICA, DOMINICAN REPUBLIC, PANAMA, AND PERU

Method	Colombia (N=3,302)	Costa Rica (N=3,037)	Dom.Repub. (N=2,56)	Panama (N=3,203)	Peru (N=5,640)
Any method	96%	99%	97%	99%	82%
Pill	90	98		95	63
Injectable	71	88	92	u	61
IUD	82	92	78	89	49
Condom	60	91	72	76	40
Female Sterilization	72	94	95	93	59
Male Sterilization	38	67	30	65	19
Diaphragm spermicides	56	71	70	56	31
Rhythm	56	81	43	66	55
Withdrawal	47	67	56	61	40
Abstinence	28	31	u	35	u
Douche	41	60	u	62	47
Other	8	7	61	u	11

Note u = unavailable

SOURCE: First Country Reports, Table 4.2.1A for Colombia, Dominican Republic and Panama. Tables 4.2.1A for Costa Rica, and for Peru Cuadro 4.2.

TABLE II-17

Percent Women Married and Exposed in WFS countries 1974 - 1976.
 Percentage currently practicing contraception among all currently married women aged 15-49 and among "exposed" women, i.e., those currently married, fecund (but including the contraceptively sterilized) and nonpregnant-in 11 WFS countries, 1974 - 1976.

COUNTRY	CURRENTLY MARRIED	EXPOSED
Costa Rica, 1976*	64%	78%
Panama, 1975*	54	65
Colombia, 1976	42	52
Fiji, 1974 +	40	56
Korea, 1974	35	46
Thailand, 1975	33	46
Malaysia, 1974	33	42
Sri Lanka, 1975	32	41
Dominican Republic, 1975	31	42
Peru, 1978	25	41
Pakistan, 1975 †	5	7
Nepal, 1976	2	3

+ Women aged 20-49.

+ Three hundred and twenty women practicing postpartum abstinence are excluded from the numerator since the practice is not engaged in for the purpose of contraception.

† Women aged 10-49.

SOURCE: Derived mainly from First Country Report. Tables 5.2.3. and 1.6.1 and Tables B5 and H7 for Fiji; Tables 11.3 and 5.3.2 for Korea; Tables 1.5.1 and 5.2.1 for Thailand; and Tables 1.6.1 and 4.4.2 for Nepal.

TABLE II-18

Percentage of exposed women who are currently practicing contraception,
by selected characteristics, Colombia, Costa Rica, Dominican Republic
Panama and Peru

CHARACTERISTICS	COLOMBIA (N=2,323)	COSTA RICA (N=2,222)	DOM. REPUB. (N=1,357)	PANAMA (N=2,257)	PERU (N=3,851)
Total	52%	78%	42%	65%	41.2%
Current age					
15-19	38	u	33	u	24
20-24	52	77		56	38
25-29	56	79	51	70	46
30-34	65	82		66	50
35-39	53	80	44	67	42
40-44	45	77		64	39
45-49	31	64	27	65	31
No. of living children:					
0	24	39	15	31	16
1	50	75	32	58	36
2	60	82	44	70	49
3	57	83	51	73	48
4	59	81	51	71	43
5	49	78	45	63	38
No. of living sons:					
0	46	70	22*	54	37
1	55	81	42*	68	43
2	58	78	53*	68	44
3	52	85	39*	68	41
4	50	75	37*	66	37
5	45	74	37*	60	39
No. of living daughters:					
0	45	68	27*	56	36
1	57	82	39*	70	46
2	56	82	42*	70	44
3	53	81	46*	64	40
4	48	77	53*	70	39
5	52	73	17*	56	35
Type of residence:					
Urban	62	81	53	72	56
Rural	34	74	32	56	16
Education:					
None	27	64	21	41	16
Primary	52	77	41	63	39
Secondary	75	82	64	73	56
Higher	65	82	69	77	68

* Includes infertile women and women sterilized for medical reasons.

Note u = unavailable

SOURCE: First Country Reports, Tables 4.4.2, 4.4.3, 4.4.5A, and 4.4.5B for Colombia; Tables 4.4.2; 4.4.3; 4.4.5A, and 4.4.5B for Costa Rica; Tables 4.4.2, 4.4.3, 1.4.5.A, and 4.4.5C for Dominican Republic, with infertile women (from Tables 1.6.1 and 1.6.2) subtracted from the denominator; Tables 4.4.2, 4.4.4, 4.4.5A and 4.4.5B for Panama; and Tables 4.4.2, 4.4.3, 4.4.5B, 4.4.5C for Peru.

PERCENTAGE OF EVER-MARRIED WOMEN AGED 15-49,
ACCORDING TO SOCIO-ECONOMIC CHARACTERISTICS

ENAF-PERU 1977-78

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TABLE II - 19

Socio Economic Characteristics	Total	Pregnant	Not in Union-not pregnant	In Union		
				Steri-lized	Not Fertile	Exposed
<u>Years since first union</u>						
Less than 5 years	100.0	22.5	8.1	0.3	0.9	68.2
5-9 years	100.0	16.5	9.1	2.0	2.7	69.7
10-14 years	100.0	10.6	8.1	3.5	4.1	73.7
15-19 years	100.0	8.1	8.7	4.3	7.8	71.1
20-24 years	100.0	5.7	12.5	3.0	18.0	60.8
25-29 years	100.0	1.9	14.4	2.4	32.9	48.4
30 and more years	100.0	1.4	19.4	3.1	39.1	37.0
<u>No. of Living Children</u>						
0	100.0	37.9	6.0	-	16.3	39.8
1	100.0	14.8	19.5	0.1	5.2	60.4
2	100.0	12.0	10.1	0.8	5.5	71.6
3	100.0	11.3	9.7	3.9	7.6	67.5
4	100.0	9.7	8.8	2.9	8.7	69.9
5 and more	100.0	7.4	7.0	4.0	14.2	67.4
<u>Region of Residence</u>						
Lima Metropolitana	100.0	10.1	9.2	3.1	9.5	68.1
North	100.0	13.0	11.6	3.1	8.6	63.7
Center	100.0	13.2	8.3	1.6	9.6	67.3
South	100.0	10.6	10.3	1.2	12.9	65.0
West	100.0	15.3	9.7	3.8	6.6	64.1
<u>Urbanization</u>						
Urban Lima Metropolitana	100.0	9.8	9.4	3.1	9.5	68.2
Urban	100.0	11.1	12.0	3.9	8.9	64.1
Rural	100.0	14.4	8.4	0.6	10.7	65.9
<u>Educational Level</u>						
None	100.0	10.9	10.8	1.1	15.5	61.7
Elementary	100.0	12.8	10.2	2.3	7.6	67.1
High School and Higher	100.0	11.3	8.9	4.3	7.7	67.8
<u>Place of Birth and Present Residence</u>						
City-Childhood *	100.0	10.3	10.0	5.0	8.7	65.9
Town or rural Childhood & present place of Res.	100.0	13.5	9.2	0.9	11.1	65.3
Town or rural Childhood (City) Residence-Present Resid.	100.0	10.6	11.4	3.1	8.2	66.7
Average Percentage	100.0	11.93	10.01	2.49	9.73	65.84

* and Present Place of Residence

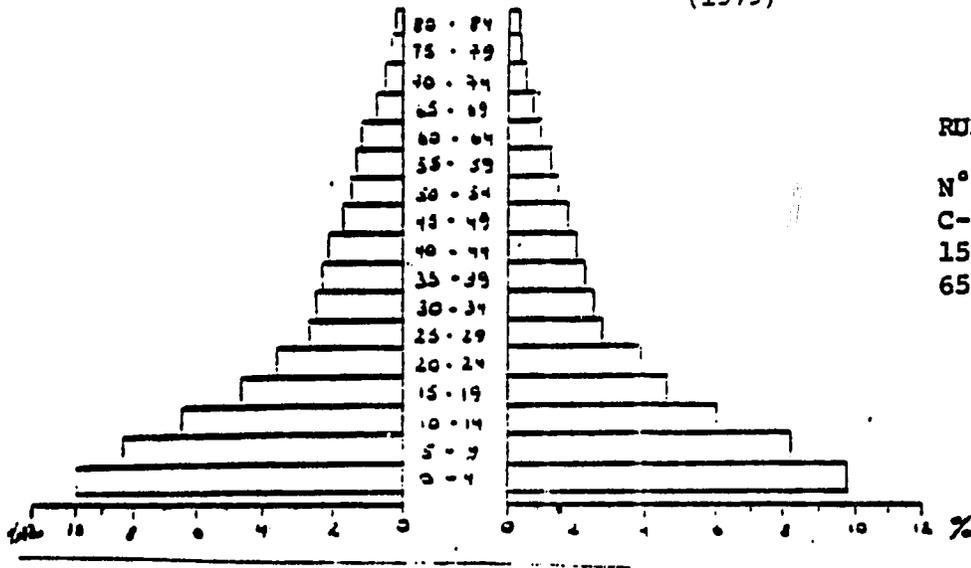
PERCENTAGE OF EVER MARRIED WOMEN BY NUMBER OF BORN
ALIVE CHILDREN AND CURRENTLY LIVING CHILDREN
ENAF-PERU 1977-78

TABLE II-20

Number of born alive children	Percentage of women with currently living children										Total	
	0	1	2	3	4	5	6	7	8	9		
0	100.0%											4.8%
1	5.5	94.5										12.4
2	1.0	14.0	85.0									14.4
3	0.4	4.1	21.8	73.7								14.0
4	0.2	0.7	9.1	29.4	60.6							11.4
5		1.0	4.0	14.1	26.2	54.7						9.7
6		1.0	2.2	6.5	20.3	29.3	40.7					8.2
7		0.4	0.9	5.3	10.8	20.8	33.3	28.5				7.0
8		1.1	1.2	3.5	5.1	16.6	26.6	22.4	23.5			5.6
9	0.2		0.5	2.0	5.2	10.2	16.9	17.1	17.3	30.6		12.6
* Total	5.7%	14.7	17.1	16.4	12.8	11.3	9.3	5.4	3.5	3.8		100.0

GRAPHIC II-1

POPULATION IN PERU
(1979)

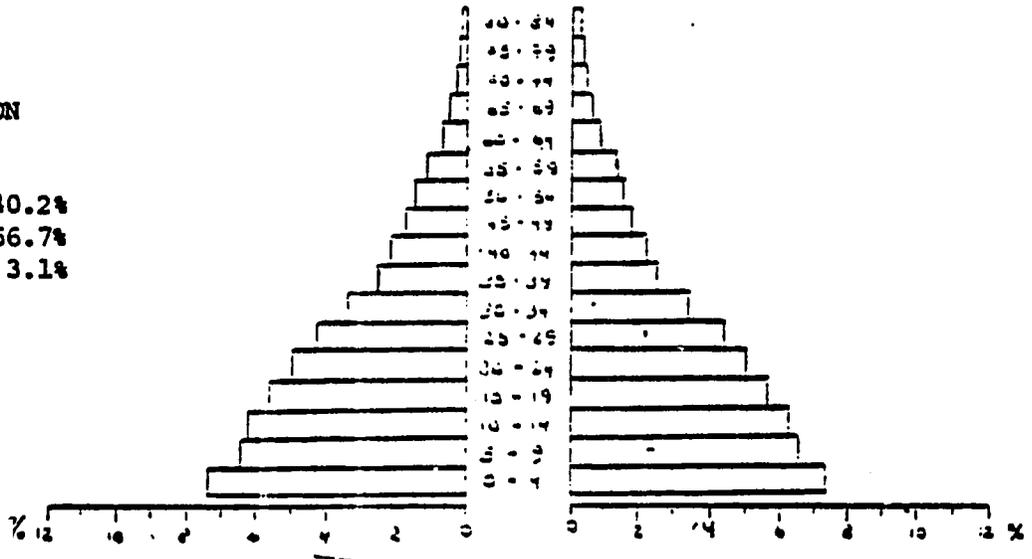


RURAL POPULATION

N° - 5'762.8
 0-14 years - 48.7%
 15-64 years - 47.4%
 65 and older - 3.9%

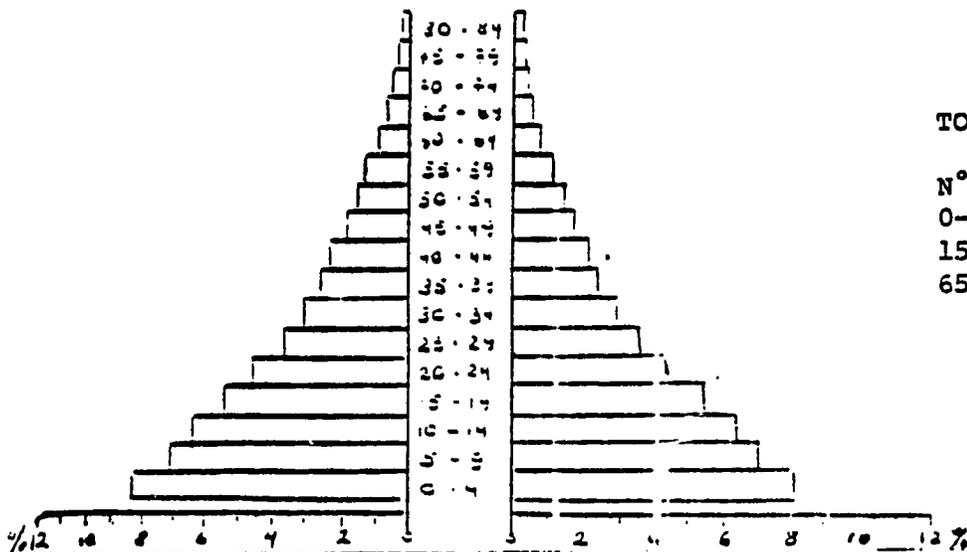
URBAN POPULATION

N° - 11'530.3
 0-14 years - 40.2%
 15-64 years - 56.7%
 65 and older - 3.1%



TOTAL POPULATION

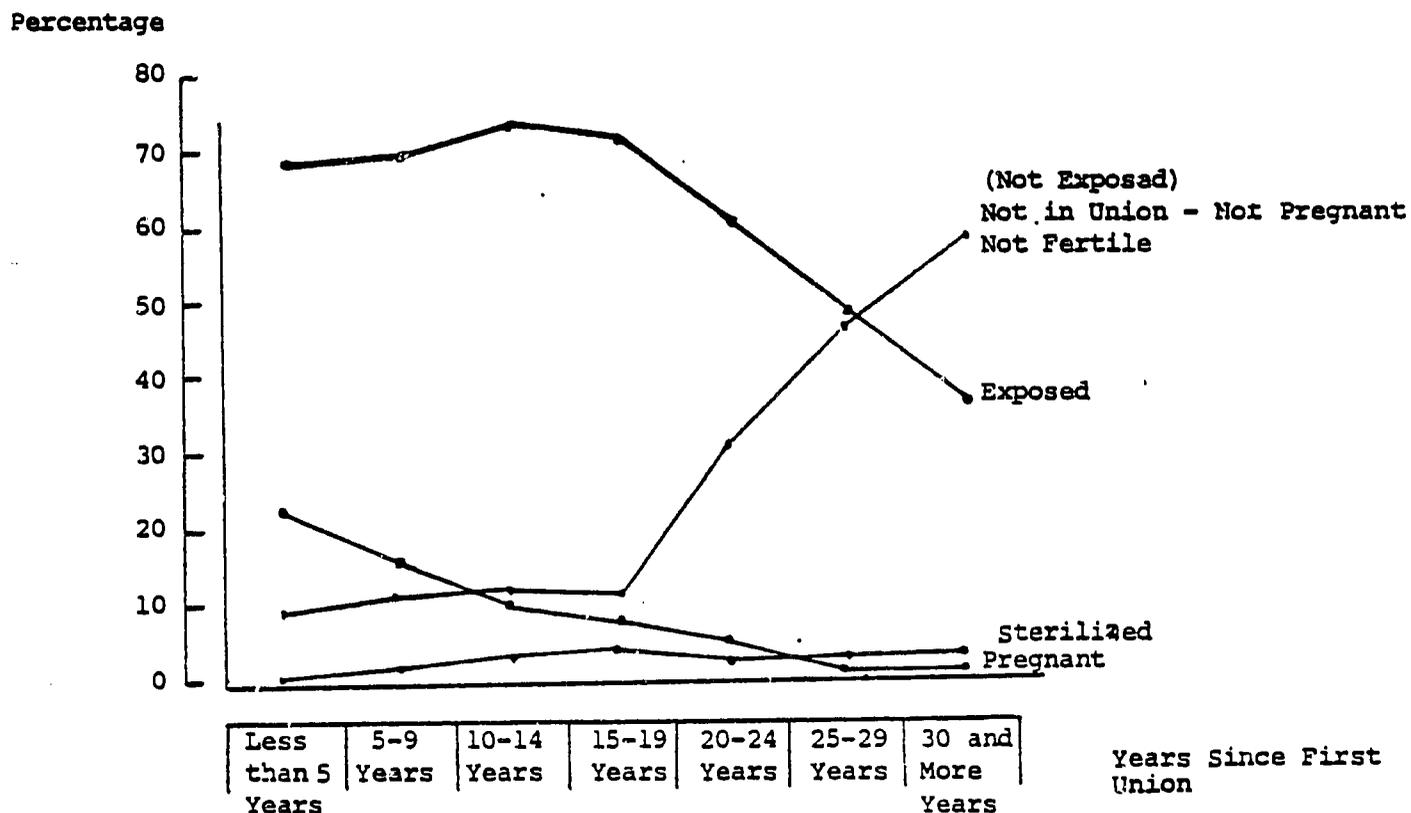
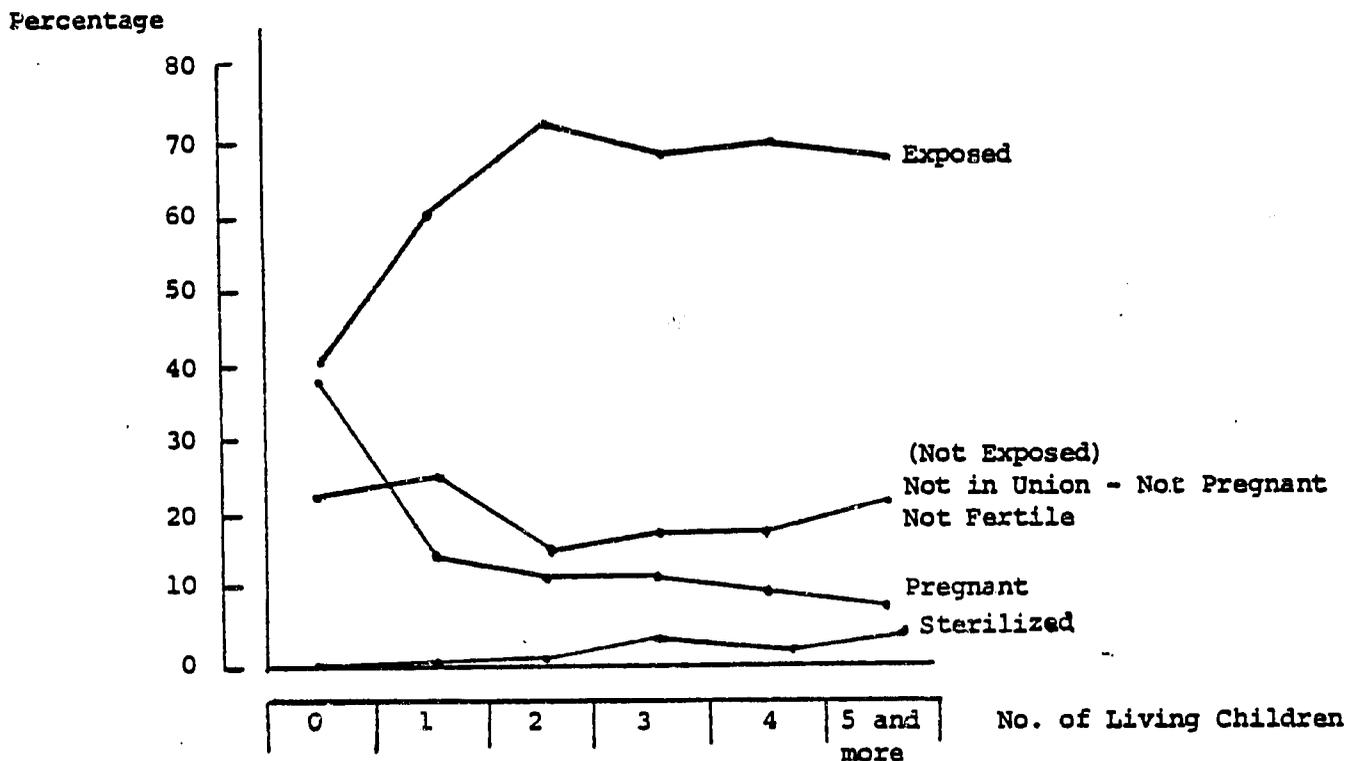
N° - 17'293.1
 0-14 years - 43.3%
 15-64 years - 53.3%
 65 and older - 3.4%



GRAPHIC II-2

EXPOSURE TO PREGNANCY RISK: EVER-MARRIED WOMEN AGED 15-49
BY NUMBER OF LIVING CHILDREN AND YEARS SINCE FIRST UNION

ENAF-PERU 1977-78



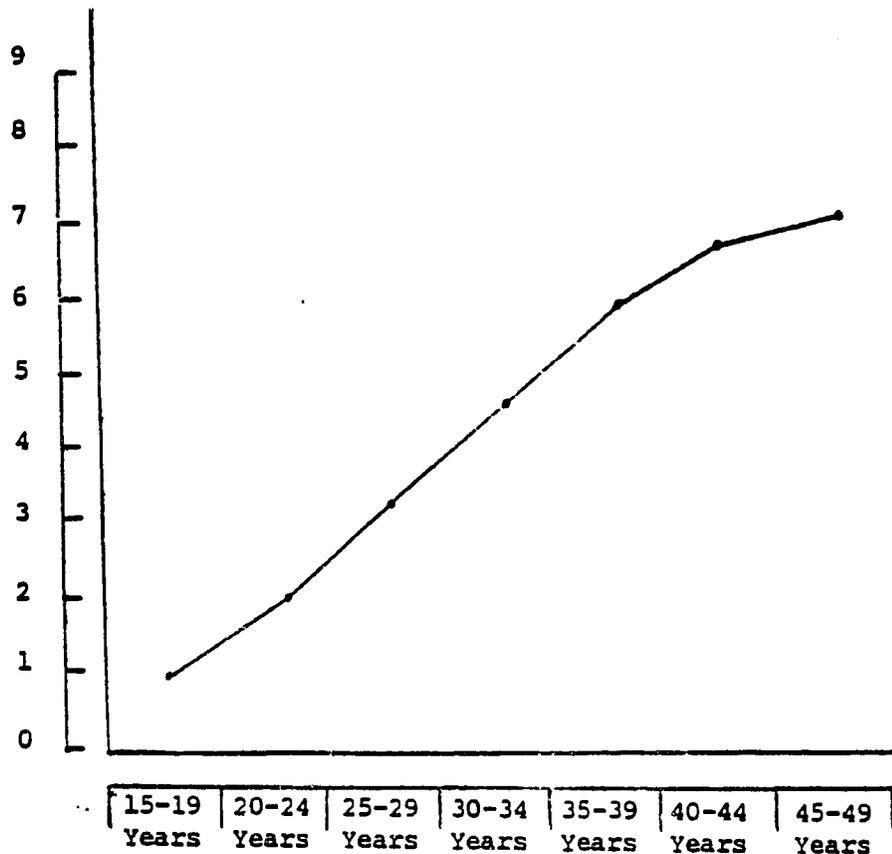
GRAPHIC II-3

AVERAGE NUMBER OF CHILDREN PER CURRENTLY MARRIED
WOMAN AGED 15-49 BY CURRENT AGE (BORN ALIVE CHILDREN)

ENAF-PERU 1977-78

Current Age	Average number of born alive children
15 - 19 Years	1.03
20 - 24 Years	2.04
25 - 29 Years	3.31
30 - 34 Years	4.62
35 - 39 Years	6.02
40 - 44 Years	6.76
45 - 49 Years	7.18
Total Average	4.59

Average



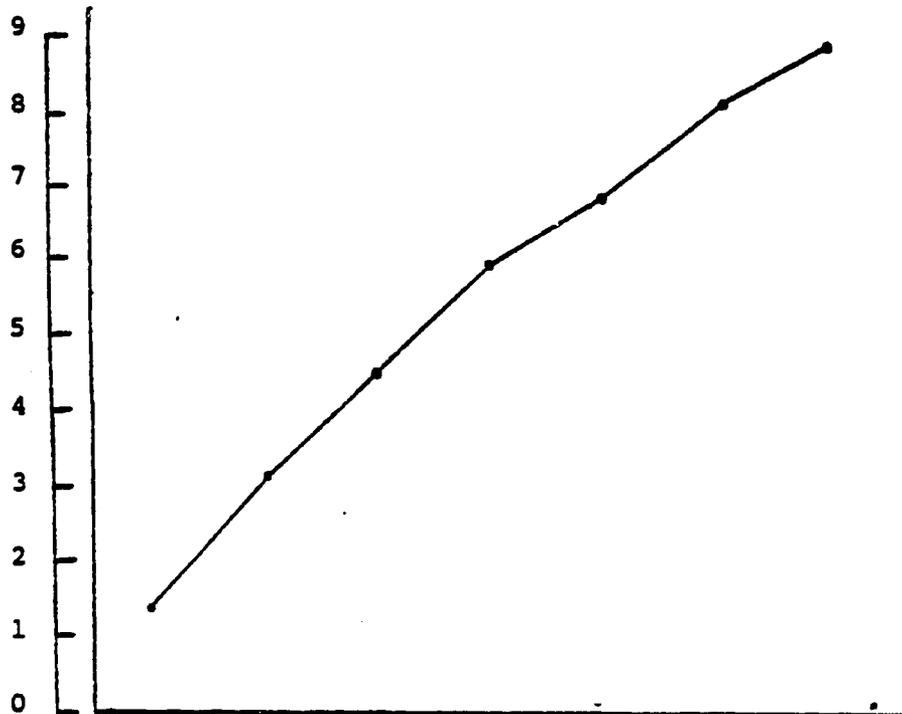
Current age

AVERAGE NUMBER OF CHILDREN PER CURRENTLY MARRIED WOMAN
AGED 15-49 BY YEARS SINCE FIRST UNION

ENAF-PERU 1977-78

Years Since First Union	Average Number of Children
Less than 5 Years	1.31
5 - 9 Years	3.06
10 - 14 Years	4.55
15 - 19 Years	5.95
20 - 24 Years	6.93
25 - 29 Years	8.02
30 Years	8.73
Average of Total	4.59

Average

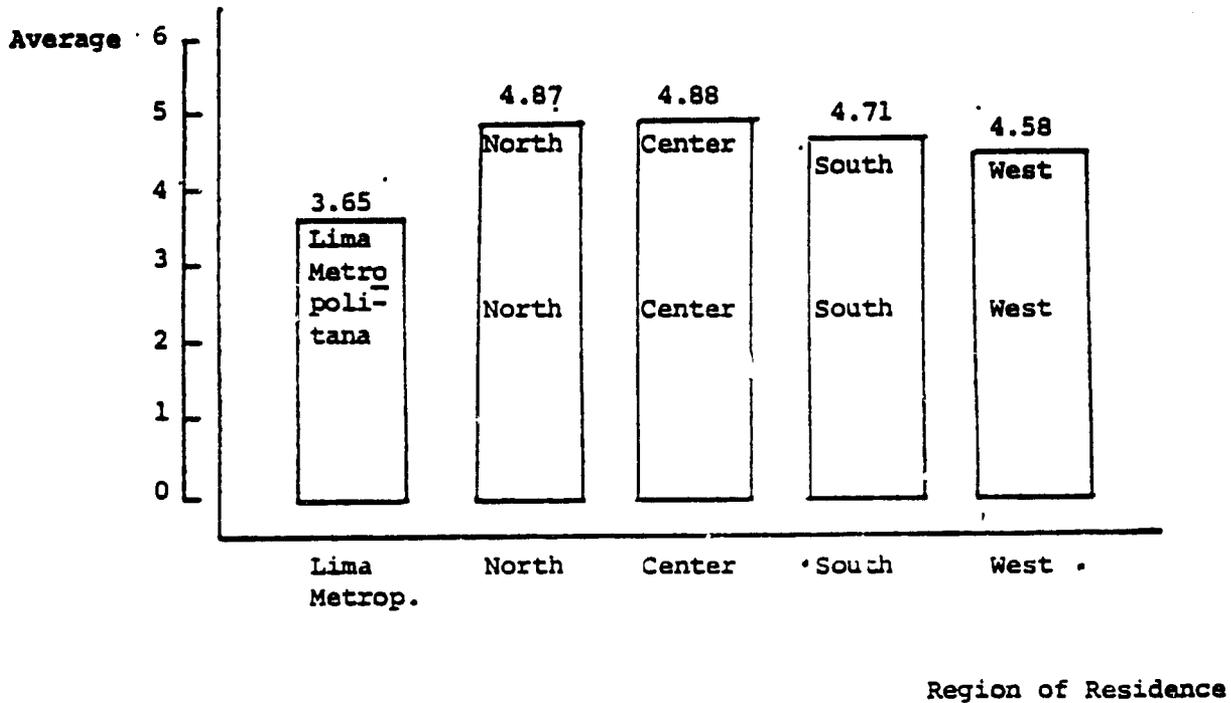
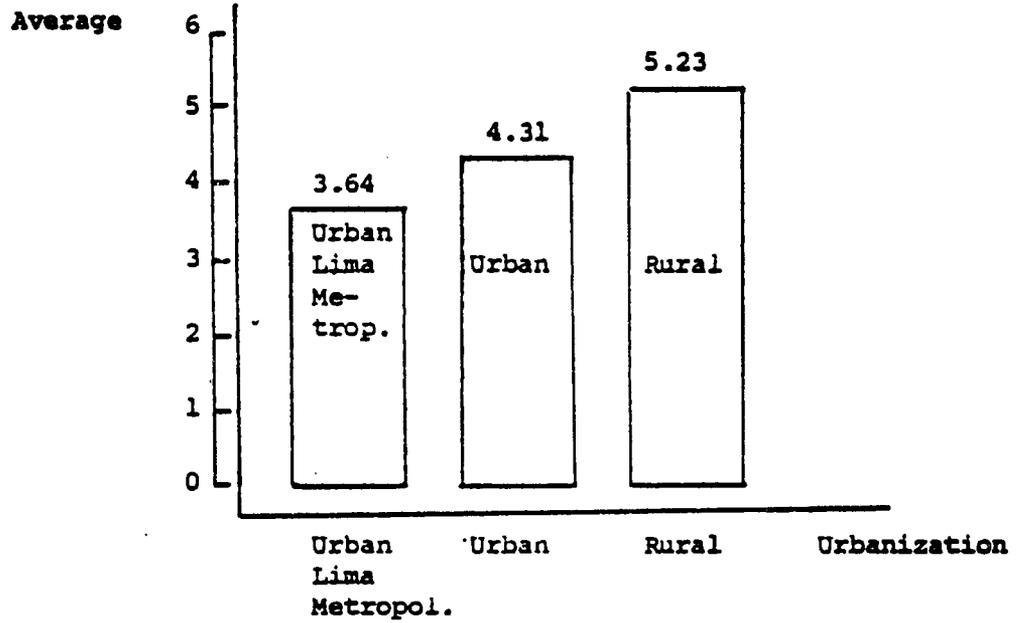


Less than 5 Years	5-9 Years	10-14 Years	15-19 Years	20-24 Years	25-29 Years	30 Years
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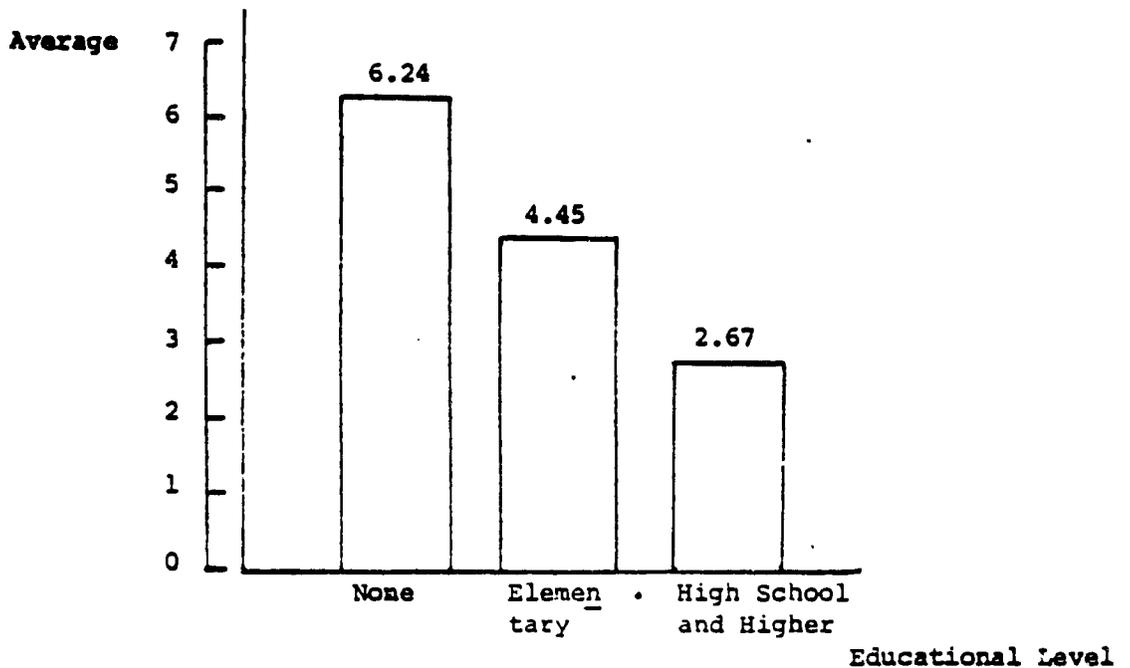
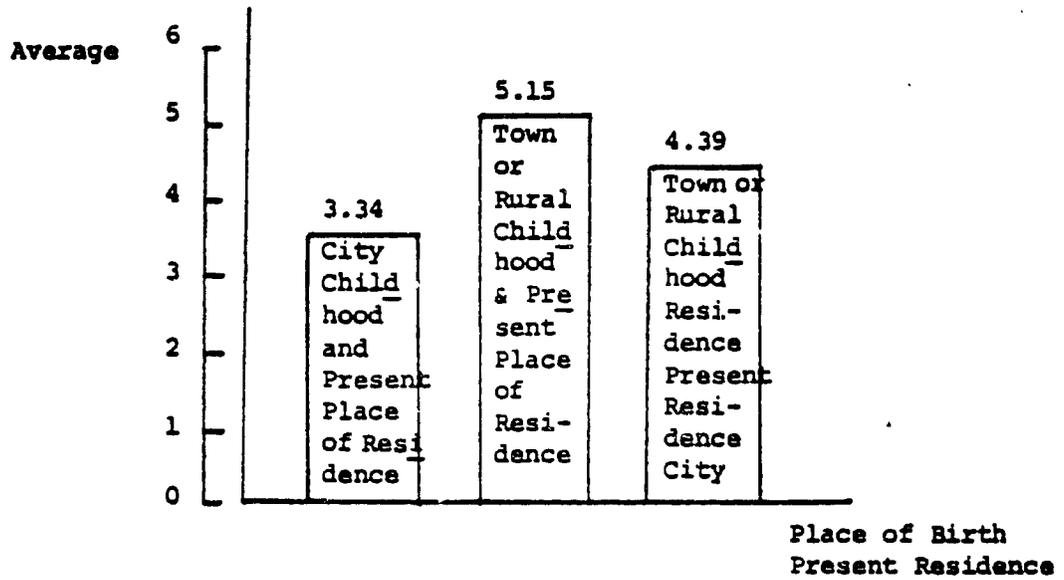
Years since first union

AVERAGE NUMBER OF BORN ALIVE CHILDREN PER EVER MARRIED
WOMAN AGED 15-49 BY URBANIZATION AND REGION OF RESIDENCE

ENAF-PERU 1977-78



AVERAGE NUMBER OF BORN ALIVE CHILDREN PER EVER MARRIED WOMAN
 AGED 15-49 BY PLACE OF BIRTH - PRESENT RESIDENCE, AND
 EDUCATIONAL LEVEL
 ENAF-PERU 1977-78



ANNEX III - CHARTS ON THE HEALTH SYSTEM IN PERU

CHART III-1
 STRUCTURAL ORGANIZATION CHART OF THE
 MINISTRY OF HEALTH
 PERU - 1979

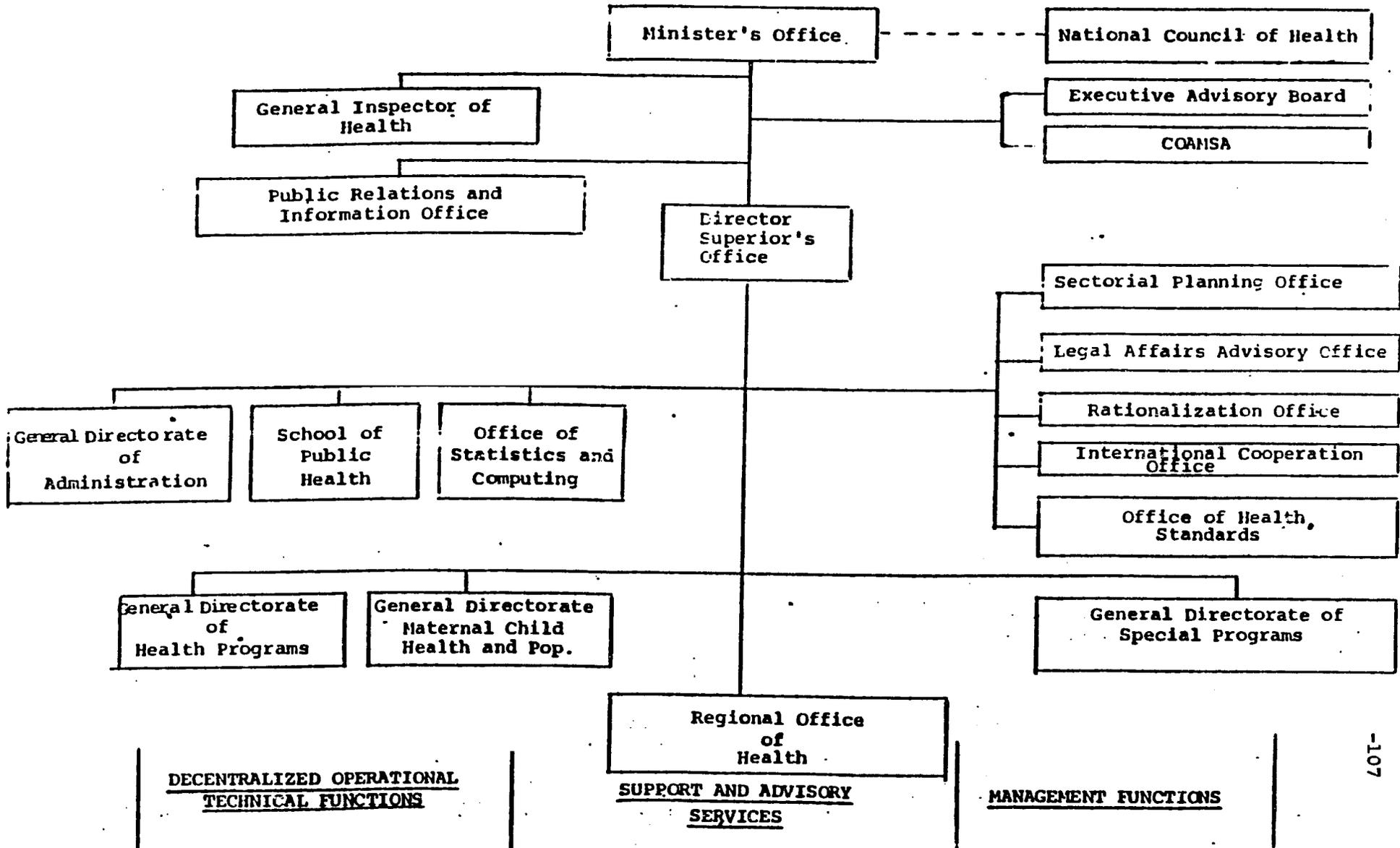


CHART III-2

HEALTH INFRASTRUCTURE - February 1979

ADMINISTRATIVE SCOPE	Place	Territorial Responsibility	Areas	Hosp.	N.C.	S.P.			
CRCE-MORKE	Piura	Tumbes and Piura Departments	PIURA	2	15	42			
			Sullana	1	9	15			
			Tumbes	1	5	9			
			TOTAL	4	29	66			
ORDE-MOR CENTRO	Huancayo	Amazon Department Marañon Province (Huancayo)	SANTA	3	8	15			
			Huancayo	7	14	23			
			TOTAL	10	22	38			
ORDE-TAM	Tacna	Tacna and Moquegua Departments	Tacna	1	7	12			
			Moquegua	2	4	15			
			TOTAL	3	11	27			
CDESO	Cusco	Cusco, Madre de Dios and Apurimac Departments	Cusco II Regional	1	4	23			
			Cusco I Lorena	1	8	25			
			Cancha	1	4	23			
			La Convención	1	-	27			
			Madre de Dios	2	1	9			
			Apurimac	2	6	47			
			TOTAL	8	25	154			
ORDE-PUNO	Puno	Puno Department	Puno	1	4	37			
			Assumpcion-Sandia	1	4	12			
			Juliana	2	3	21			
			Malgar-Cayash	1	2	22			
			TOTAL	5	13	93			
ORDE LORETO	Iquitos	Loreto Department Boma district and Puerto Inca	Iquitos	1	7	31			
			Yurimaguas	1	2	15			
			Pucallpa	2	2	31			
			TOTAL	4	11	77			
ORDE-AREQUIPA	Arequipa	Arequipa Department	Arequipa	2	11	32			
			Islay	1	2	5			
			Cama	2	7	14			
			TOTAL	5	20	51			
ORDE-LIBERTAD	Trujillo	La Libertad Department	Pacasmayo	3	3	3			
			Trujillo	5	19	19			
			Huancabamba	1	2	15			
			TOTAL	9	24	37			
ORDE-ICA	Ica	Ica Department Lucanas Province and Parícutas (Ayacucho) Castrovirreyes Province (Huancavelica)	Ica-Palpa	4	14	17			
			Chincha-Pisco	2	8	14			
			Lucanas	2	1	27			
			Parícutas	3	2	28			
			TOTAL	11	25	66			
CENTRO-MEDIO REGION	Huancayo	Junin Department Huancavelica (Castrovirreyes) Ayacucho (Lucanas-Parícutas)	Huancayo	1	14	30			
			Jaya	1	3	21			
			Tarma	1	3	10			
			Chamambayo	3	-	25			
			Ayacucho	3	12	23			
			Huancavelica	1	4	23			
			TOTAL	10	43	132			
CENTRO-ORIENTAL REGION	Huancayo	Pasco Department, Huancayo Boma district and Puerto Inca	Huancayo	1	2	19			
			Tingo Maria	1	2	14			
			La Unión	1	-	42			
			Cerro de Pasco	-	8	25			
			TOTAL	3	12	100			
LIMA METROPOLITANA REGION	Lima	Lima Department	Rimac	2	20	-			
			Barrios Altos	2	10	-			
			La Victoria	1	7	3			
			Brera	1	3	-			
			Magdalena	1	4	-			
			Callao	2	10	5			
			Callique	1	4	-			
			Jose Lar	2	28	-			
			Chosila	1	12	12			
			Caracas-Puente	4	-	11			
			Chancay-Tarapoto	2	-	11			
			TOTAL	10	109	52			
			LAMBAYEQUE CAJAMARCA AREAS	Chiclayo	Cajamarca and Lambayeque Departments	Chota	1	3	21
						Cajamarca	2	12	25
Lambayeque	1	17				25			
TOTAL	4	32				71			
SAN MARTIN-VAUCANAS AREAS	Tarma	San Martin and Amazonas Departments	Tarapoto	2	5	23			
			Noyocoma	2	-	13			
			Hualaya	1	5	12			
			Uchire	1	5	15			
			TOTAL	6	15	63			
				22	130	1,132			

CHART III-3

THE HEALTH REGION SERVICE SYSTEM

- | | |
|--|---|
| <p>LEVEL III - <u>Regional Hospital</u></p> | <ul style="list-style-type: none">- Diagnosis and Integral Assistance- Hospitalization- Especialization Services- Auxiliary Services- Preventive - Promotional |
| <p><u>General Hospital</u></p> | <ul style="list-style-type: none">- Diagnosis and Integral Assistance- Hospitalization- Auxiliary Services- All those services related to the Health Center- Preventive - Promotional |
| <p>LEVEL II - <u>Health Center</u></p> | <ul style="list-style-type: none">- Diagnosis and Treatment- All those services related to the Health Center- Nutrition- Treatment- Medical Examination and Notification |
| <p><u>Health Post</u></p> | <ul style="list-style-type: none">- Preventive and Promotional- Medical Examinations and Notification.- Mother, Child, Adult Services- Medical Examination- Sample Collection |
| <p>Sanitary Education
Community Work
First AID
Case Detection
Follow-Up Treatment
Case Reports</p> | <p>Primary Health Post
Promotor, Empirical Midwife

Community
Committee</p> |

CHART III-4

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

MINISTRY OF HEALTH - PERU 1978

HEALTH REGIONS	HOSPITALS		HEALTH CENTERS		SANITARY STATIONS N°	OTHERS N°
	N°	BEDS	N°	BEDS		
	107	15,327	403	625	1,154	6
NORTH WESTERN	11	797	70	58	232	1
NORTH EASTERN	23	1,610	55	74	107	2
CHICLAYO	3	411	10	49	78	
NORTH EASTERN	3	350	6	36	57	
CENTER	10	916	28	76	150	
NORTH SOUTH	7	613	20	-	58	1
SOUTH WESTERN	8	1,767	26	51	98	
SOUTH EASTERN	8	1,131	25	63	155	
SOUTHERN PLATEAU	5	344	15	124	90	
SAN MARTIN	4	216	10	-	98	
LIMA	25	7,172	100	94	31	

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

CHART III-5

PERSONNEL BY HEALTH REGIONS ACCORDING TO ITS TYPE

MINISTRY OF HEALTH - PERU 1976

<u>HEALTH REGIONS</u>	<u>TOTAL</u>	<u>PHYSICIANS</u>	<u>OBSTETRICIANS</u>	<u>NURSES</u>	<u>NURSE- AIDES</u>	<u>OTHERS</u>
T O T A L	27,682	2,013	546	2,164	6,344	14,615
North Western	2,264	151	37	93	828	1,155
Mid Northern	2,627	153	46	147	795	1,485
Center	1,653	86	31	113	523	900
Mid Eastern	574	29	9	25	194	317
Mid South	1,137	100	25	92	320	600
South Western	2,604	216	39	225	827	1,297
South Eastern	1,472	93	15	62	556	746
Southern Plateau	780	33	11	45	303	388
East	1,461	68	12	35	563	783
Lima	13,110	1,084	321	1,327	3,435	6,943

PHYSICIANS PER STATE

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	5.46
Junín	196	4,457	2.24
La Libertad	498	1,958	5.11
Lambayeque	272	2,532	3.95
Lima (Provincia)	216	1,530	6.53
Lima Metropolitana	6,588	693	14.42
Loreto	131	5,015	1.99
Madre de Dios	5	5,025	1.98
Moquegua	68	1,473	6.79
Pasco	37	5,660	1.77
Piura	286	3,639	2.74
Puno	87	10,210	0.97
		//

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

ANNEX IV - CHARTS ON DONOR/GRANTEE ORGANIZATIONS
AND INSTITUTIONS

INTERNATIONAL ORGANIZATIONS

	DAI	both/under	PRIA	John Hopkins	Population Council Journal	Seattle	Ford Foundation	DMH/National Center for Health/Stat.	ITPP	U.S. Census Bureau	AVS (ITP)	ITTT	UNFPA/PANO	U.S.S.I.
	Training Technical Assistance	Services/ supplies Training Tech. Assist.	Services/ supplies equipment Inf. Ed. Com Tech. Assist.	Training Equipment Tech. Assist.	Research Tech. Assist. Services/ supplies Training	Pop. Policy Research Training Tech. Assist.	Training Research Tech. Assist.	Research Training Tech. Assist.	Research Training Tech. Assist.	Training Tech. Assist. Data	Training Serv./supplies Equipment Tech. Assist. Inf. Ed. Com.	Services/ supplies Inf. Ed. Com. Technical Assistance	Serv./supplies equipment Training Research - Inf. Ed. Com - Tech. As	Serv./supplies equipment Training Research - Inf. Ed. Com - Tech. As.
A. Public Institutions														
1. Ministry of Health														Extension of Integrated Primary Health (Int. Proj.) (O.G.)
a. Maternal Child Health and Population Directorate		Supplies (O.G.)	Supplies (O.G.)										Maternal child and Population Project (O.G.)	Research Services Equip. (O.G.)
b. Information					Information System (C)									
c. Health Region - Line San Juan de Dios, Maternidad, Sop. Cayusa	Training (O.G.) Maternidad de Line - Training (O.G.)	Services/ supplies equipment (O.G.)								Maternidad IUD post partum (IP) San Juan de Dios IUD post part. (O.G.)				Primary Health (Col/Yagu Project) (O.G.)
d. Health Region - Centro Médico (Huancayo)	Training (P)													
2. Health Region ONDEICA (Sur medio)	Training (O.G.)	Supp. Equip. (O.G.)	Supp. Equip. (O.G.)											Maternal child Health & Family Planning Proj. (O.G.)
3. Health Region - ONDEHORTE (Piura)	Training (O.G.)		Services/ supplies (O.G.)	Training equipment (O.G.)						High Tech research (I.P.)				
4. Health Region - ONDELIB (Trajillo)	Training (O.G.)		Educational materials supplies (O.G.)											
5. Health Region - ONDESO (Cuzco)	Training (C)	Services/ supplies Tech. Assist. (P)		Training equipment (C)										
6. Health Region - ONDEPUNO (Puno)				Training (P)										Services/ supplies (P)
7. Health Region - ONDEAREQUIPA (Arequipa)				Training (O.G.)										Services/ supplies (P)
8. Health Region - ONDELORETO (Iquitos)				Training (O.G.)										Services/ supplies (P)
9. Ministry of Labor					Tech. Assist. to otome (C)								Technical Assistance (C)	
10. Social Security	Training (IP)	Training Supplies (O.G.)		Training equipment (O.G.)	Training Tech. Assist. (O.G.)				Training Research (I.P.)		Services/ supplies equipment (I.P.)			Training Services/ supplies (O.G.)
11. Ministry of Education	Training (C) San Educ.													Technical Assistance (P)
12. Ministry of War		Inf. Ed. Com. (IP)												
13. National Planning Institute (INP)														Training (C)
14. National Statistics Office (ONE)						Pop. Policy Seminars (O.G.)	Pop. Policy Seminars (O.G.)	Victim Project (O.G.) Andean Pact (P)		Tech. Assist. see for Census (O.G.)			World Fertility Survey (C) Tech. Ass. (O.G.) Computer (P)	Census Training (O.G.)
15. INAPRODEF	Orientation Seminars on Pop/Fam. Plan. (C)													

	DAI	Pathfinder	FFIA	John Bushing	Population Council Journal	Detelle	Ford Foundation	Smith/National Center for Health Statist.	ITSP	U.S. Census Bureau	S.V.S.	IFFY	USFPA/PMO	U.S.S.I.P.
	Training Technical Assistance		Serv./supplies equipment Inf. Ed. Com. Technical Assistance			Pop. Policy Research Training Tech. Assist.						Servicos/ supplies Inf. Ed. Com Tech. Assist.		
B. Private Institutions														
1. Instituto Marcelino		Priv. Physicians Supplies (I.P.) Pop. Res. (O.G.) Trng. Center (O.G.)			Research (O.G.)									Surgical Center Equip. (I.P.) Chiclayo-Arequipa Serv./supplies (O.G.)
2. ALAFARU	Training C.S.D. Workshop (I.P.)	Servicos/ supplies (O.G.)												Ed. materials Training (O.G.)
3. ANIDEP	CASH Training (C)					Research Population Seminars (O.G.)	Research Population Seminars (O.G.)							Training Abortion Study (P)
4. ADIFAM	Training (C)	Choice Com. Distrib. Drugstore training (O.G.)	Comm. Distrib. Inf. ed. Com. equip. Trng. Sup. Tech. Assit. (O.G.)											
5. Lima Market Women Project (O.G.)		Servicos/ supplies O.G.												
6. Nelson Santó													Equipment Training Serv./supplies (I.P.)	
7. Chimbote Clinic Service		Servicos/ supplies												
8. Peruvian Studies Institute					Sugar Cooperative Research	Research (O.G.)								
9. CEPD					Male Information (I.P.)	Pop. Library (O.G.)							Law Pop. Monograph (C)	
10. PALP			Serv./supplies Inf. Ed. Com. Tech. Assist. (O.G.)											
11. Ch/Cyn Society		Ch/Cyn Conference (C)												
12. Asociación Peruana de Obstetrias	Training (O.G.)													
13. Carmen de la Lopez			Servicos (C) Supplies (O.G.)											Special Project Health Services (I.P.)
14. Women Rights Movement		Women Rights Seminars (C)												
15. SUPVUZS												Ventanilla Service/ supplies (O.G.)		Training (C)
16. Regio Americana Clinica				Training (O.G.)									Equipment (O.G.)	

	NSI	Pathfinder	FRS	John Haring	Population Council Council	Settle	Ford Foundation	UNR/National Center for Health Statist.	ITP	U.S. Census Bureau	A.T.S.	ITP	WFAA/FAO	U.S.S.I.P.
	Training Tech. Assist.		Serv./supplies Equip. Inf. M. Com. Tech. Assist.			Pop. Policy Research Training Tech. Assist.								
C. Universities														
1. ASOFAM	Training (C)	Workshops (C)			Services- Training (O.G.)									Training
2. Cayetano Heredia (Lima)	Coop. Loans Training (O.G.)	Coop. Loans Fertility Cen- ter for Coop. (O.G.)	Training supplies (O.G.)											Training
3. San Marcos (Lima)	Training (O.G.)	Training (O.G.)									Training (I.P.)			Training
4. Villavieja (Lima)		Training (O.G.)												
5. Catholic University (Lima)					Research Pop/Gen. (C)									
6. University of Trujillo			training equip. supplies, Tech. Assist. (O.G.)		Training Services									
7. University of Arequipa						Research								
8. University of Ica														Research (O.G.)
D. Other Institutions														
1. Lima Cerro Cooperative		Services/ supplies												
2. Municipalidad de Lima (San Juan de Los Rios)			Serv./supplies Inf. M. Com. equip. Tech. Asst. (O.G.)											
3. Central de Cooperativas Agrarias de Producción Aucarcara No. 69					Serv./supplies Training Research (I.P.)									
4. Contronía			Training Supplies/ services (?)											

INTERNATIONAL DONORS IN THE HEALTH SECTOR

<u>FINANCIAL AGENCY</u>	<u>NAME OF PROJECT</u>	<u>PLACE</u>	<u>DURATION</u>	<u>TOTAL AMOUNT</u>
CNPPA	Maternal-Child Health Population	PERU	4 years	\$ 5'331.112
AID	Project for Maternal and Child Health and Population	SUR MEDIO REGION	3 years	1'900,000
HOLLAND	Extension of Health Services Program	ORDESO	2.1/2 years	521,500
UNDP	Dev. & Ext. Health Ser. Prog.	ORDELORETO	2 years	176,501
UNICEF	Development & Extension Health Service Program	ORDE PUNO	2 years	179,305
POPULATION COUNCIL	Project Support for Health Professionals in Maternal Health, Family Planning & Responsible Parenthood	ASPEFAM	2 years	100,000
POPULATION COUNCIL	Project Support for Informatics-Information System	INFORMATICA	2 years	27,000
WORLD FOOD PROGRAM	Food Assistance Program for Mothers and Infants	PERU	3 years	
A.I.S.	School Feeding Program (PAE)	PERU		
GENERAL FEDERAL REPUBLIC	Lupinus Project	INTERNATIONAL HEALTH INSTITUTIONS		
GERMAN FEDERAL REPUBLIC	Applied Nutrition	ORDEPUNO		
DENMARK	Medical Care Extension	ORDE LORETO		
SWEDISH ASSOCIATION FOR DEVELOPMENT TRAINING	Survey on Family Participation in Multiple Programs	RSLN (Lima)		
SWISS EVANGELIC MISSION	Voluntary Services	ORDESO ORDEPUNO		
SWISS TECHNICAL COOPERATION	Extension of Medical Services	ORDEPUNO		
TERRE DES HOMES	Voluntary Services	ORDEPUNO		
AMAZONIC MEDICAL SOCIAL FOUNDATION	Tarinacocha Hospital	ORDEPUNO		
HOSPICE INTERNATIONAL	Small Hospitals' Construction	R.S.C. MEDIO		
INTERNATIONAL FOSTER PLAN	Protection & Medical Care	R.S.C. CENTRO MEDIC		
INTERNATIONAL PHYSICIAN	Development/Health Services in Central Huallaga	R.S.C. ORIENTAL		
EYE INTERNATIONAL FOUNDATION	Ophthalmological Training	ORDESO		
UN FUNDS FOR DISEASE CONTROL	Epidemiology Studies on Drug Abuse	PERU		
PAEC	Special Health Projects: Chagas disease, environmental health, vaccines, etc., more than 100 projects; technical assistance	PERU - ongoing		\$1,300,300