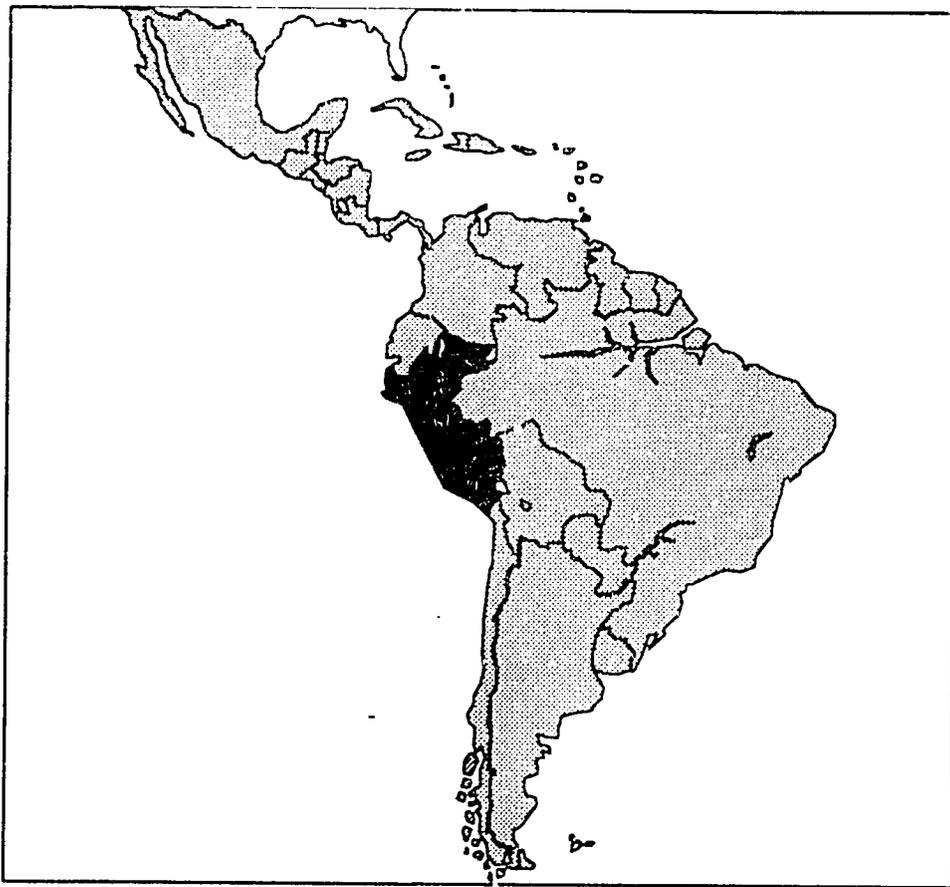


Country Health Profile

PERU

Health Situation & Statistics Report 1994



Center for International Health Information
1601 N. Kent Street, Suite 1014
Arlington, VA 22209

The Center for International Health Information (CIHI), a project managed by Information Management Consultants, Inc. (IMC), prepared this document under the Data for Decision Making Project, #936-5991.05 (CIHI-II), contract number HRN-5991-C-00-3041-00, with the Office of Health and Nutrition, Center for Population, Health and Nutrition, Bureau for Global Programs, Field Support and Research, U.S. Agency for International Development (USAID).

**The Center for International Health Information
1601 N. Kent Street, Suite 1014
Arlington, VA 22209
(703) 524 - 5225
FAX (703) 243 - 4669
E-Mail address: cihi@gaia.info.usaid.gov**

PERU

USAID Health Profile

This is one of a series of USAID Health Profiles produced by the Center for International Health Information/ISTI (CIHI). Each profile contains descriptive information, tables, and graphs about the country's health and demographic conditions, health indicators and trends, and the health care system when available. The profile also provides an overview of USAID health assistance and descriptions of USAID-supported health activities. Profile information is compiled from CIHI's databases and reference library, as well as through analysis from additional data sources and reports.

The profiles are intended to provide current and trend data in a concise format to policy makers, consultants, evaluation teams, and other interested individuals and organizations. They are not intended to provide a comprehensive description of the total health sector of a country. Contact CIHI for information on the availability of other health profiles and standard reports.

This profile contains national level health and demographic statistics available in CIHI's databases as of the date noted in each section. In order to enable CIHI to report the most current health and demographic statistics, please provide any more recent or more accurate data by contacting the center at the address on the previous pages or through USAID, Bureau for Research and Development, Office of Health.

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I: COUNTRY OVERVIEW

DECEMBER 1993

Peru, the fourth largest country in Latin America, boasts the majestic Andes Mountains and a vast supply of natural resources. The Sierra, or upland plateau, is at an average elevation of 13,000 feet; it occupies one-fourth of Peru's surface and contains more than 60 percent of its population. (LAC9301)* However, there has been a continuing trend of migration from depressed rural zones of the Sierra to coastal cities and now nearly one-third of the nation's population resides in or around the capital city of Lima. (AID9300) Climate varies with altitude in Peru -- it is tropical in the lowlands and cold with bitter frost at the highest peaks. (LAC9301)

Peruvian history dates back to the early 1500s when the Inca Empire had its base in southern Peru and represented the most advanced level of indigenous Indian culture in South America. The Inca Empire instituted elaborate systems for agriculture and irrigation and built substantial cities without the benefit of the wheel. However, hearing of great wealth, a Spanish expedition conquered Peru in 1535 and founded the city of Lima. Spanish rule continued until 1821 when Peru declared its independence with the help of General de san Martin of Argentina. (LAC9301)

Currently in Peru, four distinct cultures exist. The Pacific shelf region is mostly European Catholic and is as cosmopolitan as Paris or Rome. The mestizo culture of mixed Spanish and Indian blood tends to center in urban areas. The chofo consists of people who may be coastal urban or inland mountain inhabitants. Finally, the pure Indians of the high Andes still use the Quechua and Aymara dialects and customs with a slight Roman Catholic influence. (LAC9301)

In the century or more following independence, Peru has vacillated between various forms of government, including democracy and dictatorship. In June 1978, for the first time in 11 years, representatives were elected to a 100-seat Constituent Assembly. Their tasks included drafting a new constitution and laying the foundation for a new president and congress to begin governing the country in 1980. Elections did take place in 1980 with former president Fernando Belaunde Terry an easy winner. (LAC9301) This form of democracy in Peru lasted until April 5, 1992 when President Alberto Fujimori, who was elected in 1990, dissolved the legislature, closed down the courts and suspended parts of the constitution in a autogolpe or a coup by the president's own directive. Fujimori's move was supported by most of Peru's citizens, if not its political and intellectual leaders, because in the past decade Peru had seen living standards decline while political violence continued to escalate. (PER9301)

As the political climate changes in Peru, so does the economic outlook. Since August 1990, the government has implemented reforms designed to free the economy of state controls and attract foreign investment. In December 1991, the Framework Law of Private Investment was enacted to permit investors to negotiate agreements with the government of Peru, guaranteeing stable economic and tax conditions for investment. Peru most desires investments in mining, petroleum and agriculture. President Fujimori encouraged domestic competition with a December 1991 law aimed at preventing unfair trade practices by eliminating activities restricting competition in domestic production. (PER9201)

* Sources in this profile are referred to by a seven-digit code. Generally, the first three letters refer to an organization, agency, etc., and the first two numbers indicate the year of the publication or other source document. A complete list of sources appears at the end of the profile.

II: HEALTH & DEMOGRAPHIC OVERVIEW

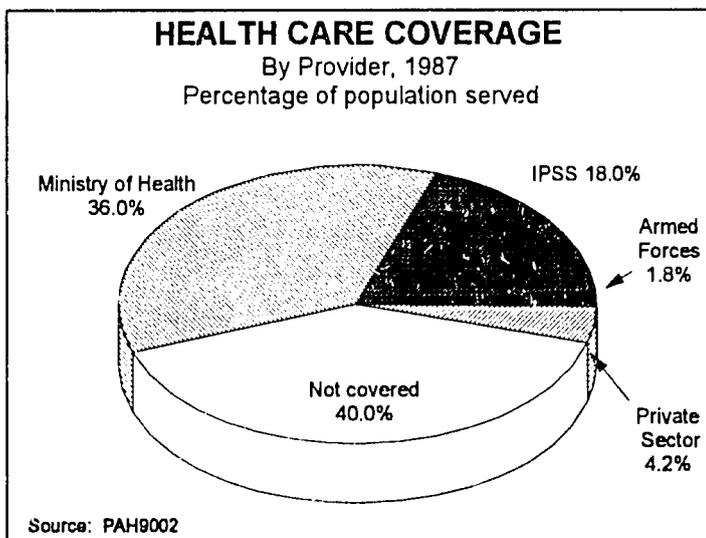
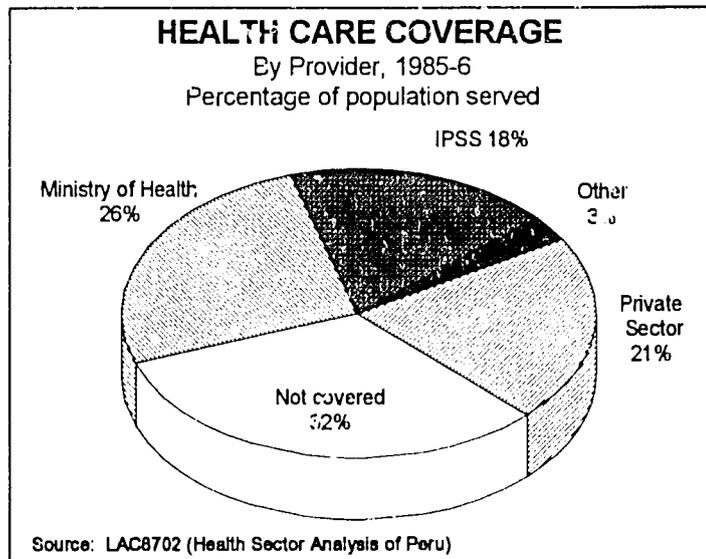
Health Sector Description

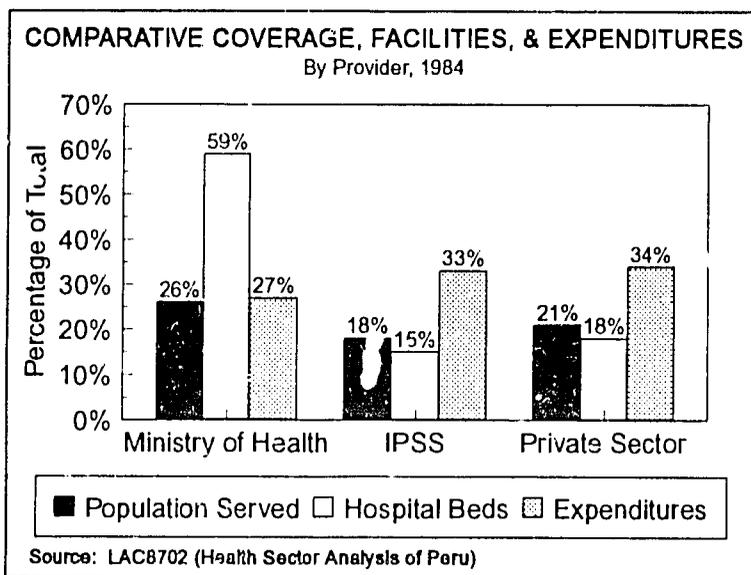
DECEMBER 1993

Peru's health sector consists primarily of services under the Ministry of Health (MOH), the Peruvian Social Security Institute (IPSS), and a diverse private sector. An estimated five million critically poor Peruvians lack any kind of formal health care and four million more can afford only a minimal amount of care on occasion, according to a 1992 health services evaluation by the Pan American Health Organization (PAHO). Drawing on data from 1984, the evaluation estimated that between 53 and 68 percent of rural residents still lack access to health care. (PAH9200) Traditional medicine practiced by *curanderos* plays a significant role in health care provision, particularly among the rural population.

The Health Sector Analysis of Peru (HSA-Peru), a sector-wide, USAID-funded study conducted by the State University of New York in 1985-86, assessed each major subsector's share in coverage, resources, and expenditures. The results of this study and an estimate by PAHO for 1987 appear in the figures on these two pages. HSA-Peru estimated that 32 percent of the national population, mostly in rural and marginal urban areas, and one-sixth of the residents of Lima and Callao lack access to modern health services. (LAC8702)

Between 1980 and 1987, the total number of health centers and health posts increased by 53 percent and 85 percent, respectively. (PAH9002) Human and physical resources are overwhelmingly concentrated in the metropolitan area of Lima. With 73 percent of the nation's physicians, Lima's ratio of 21.3 phy-





sicians per 10,000 residents is 50 times higher than that of the Departments of Apurímac and Amazonas. (PAH9002) The World Bank reports that the likelihood of obtaining medical services when sick is three times higher in Lima than in some other areas. While a survey cited by the bank found that only 36 percent of self-declared sick lived in or around Lima, the capital area accounted for 53 percent of MOH ambulatory

consultations, 41 percent of hospital admissions, and 47 percent of public expenditure for individual care. (WBK9303)

Public Sector

Efforts to integrate the health care services of the two major public providers, the MOH and IPSS, into departmental health units began in 1986. The National Institute for Health Development was established in 1987 to coordinate the various public and private bodies conducting health activities. Formal integration of MOH and IPSS services reportedly occurred in eight areas, (PAH9002) but according to the 1992 PAHO assessment, political, financial and administrative obstacles halted the process in 1988. (PAH9200) Subsequent efforts to establish integrated health services under regional authorities have continued under the National Regionalization Law. (LAC9105)

The armed forces, police and some state-owned firms operate their own facilities supported by health insurance funds which remain separate from the IPSS. Municipal governments, public charities (Sociedades de Beneficencia Pública) and other public institutions also operate a relatively small number of hospitals, health centers and sanitary posts, serving roughly four percent of total population in 1983-84. (WBK8702) Decentralized public health agencies include the National Committee on Food and Drugs, the National Council on Environmental Health Protection, and the National Population Council. (PAH9002)

Ministry of Health

In 1984, the MOH was serving a target population of 11 million uninsured poor, but real coverage for that year has been estimated at five million, or 26 percent of the national population, including roughly two million urban residents and three million rural residents. (PAH9200) In 1990, PAHO reported that the MOH administered 54 percent of the nation's hospital beds, 71.6 percent of its health centers, and 94 percent of health posts. (PAH9002)

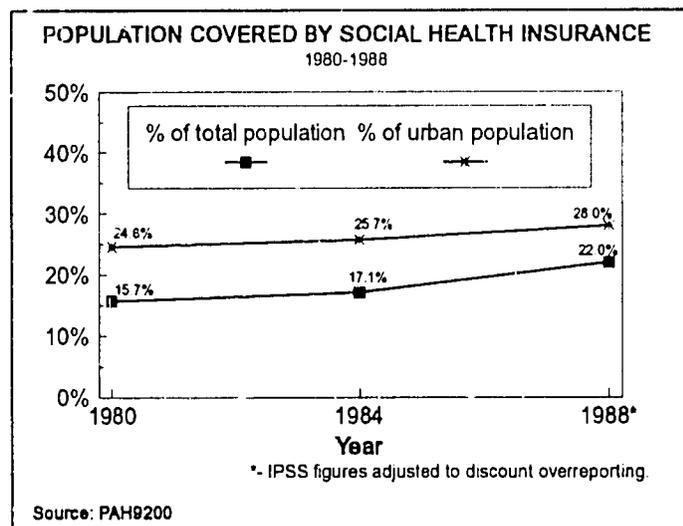
A 1987 study by the World Bank found that MOH hospital services suffer underfunding, poor maintenance, and shortages of drugs and other supplies.(WBK8702) With a bed occupancy rate of only 56.5 percent, the MOH operated 105 hospitals in 1986, of which a total of 38 (accounting for over half of MOH beds) had been in operation for over 35 years.(PAH9002) Nearly 50 percent of installed MOH hospital equipment was no longer functional in the late 1980s, according to PAHO.(PAH9200) Primary health care (PHC) is provided at MOH health centers and posts, respectively numbering 451 and 1402 in 1984.(WBK8702) Services are offered at little or no cost to users; some modest fees are charged primarily for supplies and drugs which facilities otherwise would not be able to provide.(LAC9105)

Social Security

Various social insurance funds were integrated between 1973 and 1980 to create the Instituto Peruano de Seguridad Social (IPSS). Funds for the armed forces and police remain separate. In addition to providing pension coverage for old age, death and unemployment, IPSS administers sickness-maternity and employment injury programs. The sickness-maternity program primarily covers urban workers with formal employment. In 1988, 92.4 percent of IPSS-insured workers were salaried and 58 percent of the total insured lived in metropolitan Lima.(PAH9200) Since 1985, full coverage has been extended to dependent spouses and children up to 18 years of age. Due to lack of funds, the IPSS was forced to suspend implementation of a law extending coverage to informal and agricultural workers.(IDB9101) The work injury program covers some wage earners, including domestic workers and fishermen, who are not covered under sickness-maternity.(IDB9101)

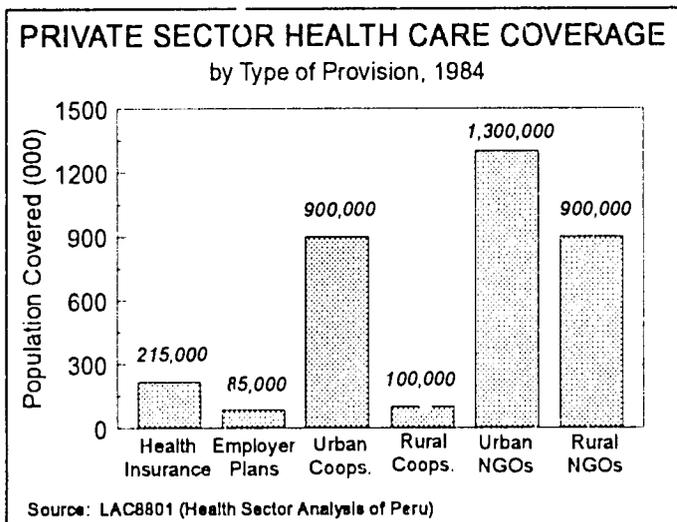
The figure at right illustrates the gradual expansion of social insurance coverage in the 1980s. HSA-Peru estimated in 1986 that 28 percent of the labor force and 18.6 percent of the total population were entitled to IPSS coverage, but found that not all have access to or even choose to use the system.(LAC8702) Another source indicates that real coverage by IPSS health services had dropped to nine percent of the national population by 1989.(LAC9106) PAHO's 1992

evaluation estimates coverage by the IPSS along with other public health insurance funds at 22 per cent of the total population and 28 percent of the urban population for 1988. Estimates of IPSS coverage in various rural departments ranged from 2.5 to 4.7 percent.(PAH9200)



While some chronic care is arranged through providers under contract, the IPSS provides most health care services directly to enrollees through its own hospitals and health centers. Voluntary enrollees can theoretically utilize private services, but low levels of reimbursement and administrative complications have made this option impractical. (LAC8702) IPSS health services are predominantly urban and curative; a special rural program which was to emphasize PHC never materialized. (PAH9200) According to PAHO, in 1987 IPSS administered 15 percent of Peru's hospital beds with occupancy rates exceeding 70 percent. (PAH9002) Expansion of population coverage in the late 1980s coincided with an increase in ambulatory facilities in the provinces, but most of these were eliminated after IPSS policy reverted to a strictly urban curative orientation in 1989. (PAH9002, LAC9105)

Private Sector



The private health sector includes independent hospitals and health centers, individual practitioners, cooperatives, pharmacies, insurance carriers and private voluntary organizations (PVOs). The figure at left illustrates the estimated population coverage in 1984 of various types of prepaid and non-profit providers. Dissatisfaction with deteriorating public medical services led to increased use of the

private sector by middle- and lower-income Peruvians in the late 1980s. (LAC8900) Dissatisfaction with IPSS services in particular is thought to have contributed greatly to growth in the private health insurance industry. The Health Care Financing in Latin America and the Caribbean (HCF/LAC) project found in 1987 that about 25 general insurance companies were offering group and individual health policies in Lima/Callao. (LAC8702) The project found that of four million Peruvians who rely on the private sector for health care, over half (2.2 million) use facilities of private voluntary organizations, a half-million have prepaid health plans (mostly in the Lima/Callao area), and the rest make direct payments to for-profit providers. (LAC8900)

Health Situation Analysis

DECEMBER 1993

Since the early to mid 1980s, levels of infant and under-five mortality in Peru have fallen by approximately 25 percent. The 1991-1992 Demographic and Health Survey (ENDES 1991-1992) reports that infant mortality declined from 73 deaths per thousand live births during the 1982-86 period to 55 deaths during the 1987-91 period. The rate of reduction has been similar in rural and urban areas, 24 and 27 percent, respectively. Viewed separately, however, the level of rural infant mortality is nearly twice that of urban areas: 78 deaths per thousand live births compared to 40 deaths.(DHS9207)

During the 1991-92 period, the total fertility rate was 3.5 children per woman, down from 5.3 during the 1977-78 period. In rural areas, women can expect an average of six children, while in urban areas the expected number is under three children. Fifty-six percent of births are characterized as high-risk, with 11 percent occurring less than 24 months from the previous birth.(DHS9207)

Since the mid 1980s, vaccination coverage rates have steadily increased for children aged 12 to 23 months. From 1988 to 1992, DPT3 coverage rose from 60 to 78 percent, Polio3 coverage increased from 62 to 80 percent, and measles coverage climbed from 50 to 79 percent.(AID9007, AID9202) The ENDES 1991-1992 reports that 58 percent of children ages 12 to 23 months were fully vaccinated.(DHS9207)

In Latin America, diarrhea is the most common cause of death for children under five years of age, and by 1991, the situation was worsened by the reappearance of cholera in Peru. The ENDES 1991-1992 reports that of children with diarrheal episodes, 20 percent received oral rehydration solution packets and 11 percent received a home solution. A full 62 percent received increased fluids during the episode.(DHS9207)

The survey also reports that nearly one child in four surveyed had a respiratory infection and of those, 50 percent were taken to a health care provider or facility. Of children under four months of age, 41 percent are exclusively breastfed. For children under five years of age, 37 percent are chronically malnourished (stunted) and 11 percent are underweight. Twice the proportion of rural children suffer malnutrition by these measures than do children in urban areas.(DHS9207)

The government has finalized a National Program of Action to guide its efforts in achieving basic World Summit for Children goals.(UNI9312) For the period 1990-95, the government of Peru has established a set of principle health objectives which include: reducing infant mortality by 50 percent by 1995, increasing vaccination rates to 85 percent, eradicating polio, eliminating neonatal tetanus by 1995, and reducing maternal mortality to 10 deaths per 10,000 live births.(DHS9207)

Current Demographic and Health Indicators

DECEMBER 1993

Demographic Indicators			
INDICATOR	VALUE	YEAR	SOURCE
Total Population	22,932,400	1993	UNP9200
Urban Population	16,353,200	1991	DHS9207
Women Ages 15-49	5,822,000	1993	UNP9200
Infant Mortality Rate	55	1989	DHS9207
Under 5 Mortality	78	1989	DHS9207
Maternal Mortality	300	1983	WHM9106
Life Expectancy At Birth	65	1993	UNP9200
Children Under Age 1	612,976	1993	CALXX01
Annual Infant Deaths	35,064	1993	CALXX01
Total Fertility Rate	3.5	1993	UNP9200

Child Survival Indicators			
INDICATOR	PERCENT	YEAR	SOURCE
Vaccination Coverage			
RCG	88	1992	DHS9207
DPT 3	78	1992	AID9202
Measles	79	1992	AID9202
Polio 3	80	1992	AID9202
Tetanus 2	20	1992	DHS9207
DPT Drop Out	32	1992	DHS9207
Oral Rehydration Therapy			
ORS Access Rate	28.0	1992	WHD9300
ORT Use Rate	32.1	1992	DHS9207
Contraceptive Prevalence			
Modern Methods (15-49 yrs.)	32.8	1992	DHS9207
All Methods (15-49 yrs.)	59.0	1992	DHS9207
Nutrition			
Adequate Nutritional Status	83.9	1992	DHS9207
Appropriate Infant Feeding	NA		
Exclusive Breastfeeding	40.5	1992	DHS9207
Complementary Feeding	61.7	1992	DHS9207
Continued Breastfeeding	67.7	1992	DHS9207

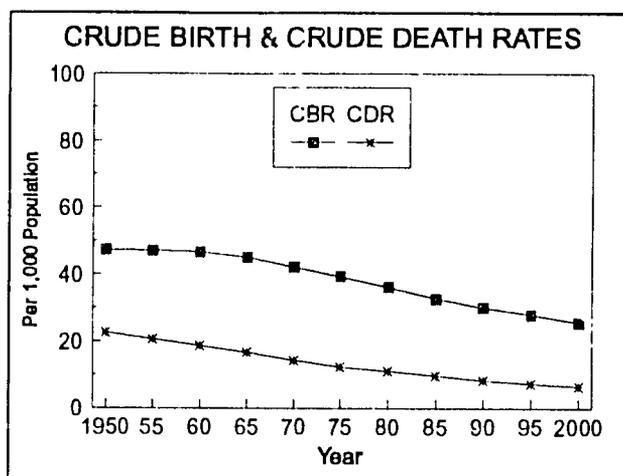
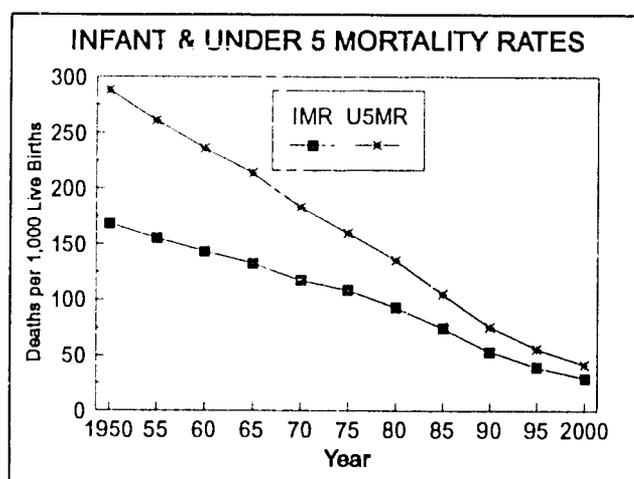
Other Health Indicators			
INDICATOR	PERCENT	YEAR	SOURCE
HIV-1 Seroprevalence			
Urban	0.1	1991	BUC9103
Rural	NA		
Access to Improved Water			
Urban	68.0	1990	WHO9200
Rural	24.0	1990	WHO9200
Access to Sanitation			
Urban	76.0	1990	WHO9200
Rural	20.0	1990	WHO9200
Deliveries/Trained Attendants	52.5	1992	DHS9207

NA = Not available

Trends in Selected Demographic and Health Indicators

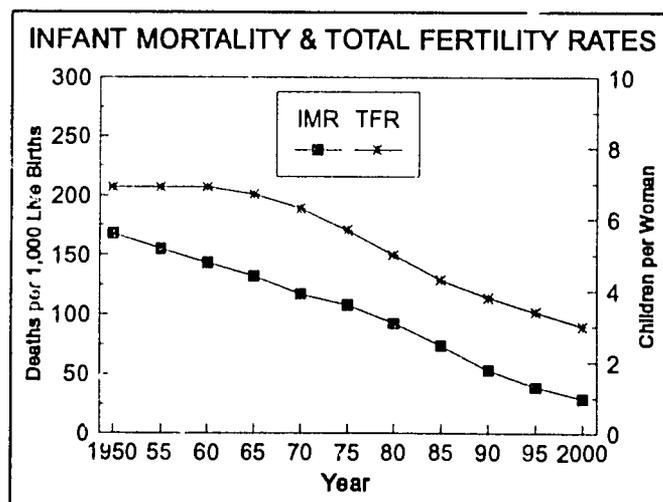
DECEMBER 1993

INDICATOR	1950	1955	1960	1965	1970	1975	1980	1985	1990	1995	2000	SOURCE
Infant Mortality	168.0	155.0	143.1	132.2	117.3	108.1	92.7	74.1	53.2	39.0	29.2	WBK9302
Under Five Mortality	287.8	260.4	235.7	213.5	182.6	159.3	135.0	104.7	75.5	55.4	41.4	WBK9302
Crude Birth Rate	47.2	46.9	46.5	44.9	42.1	39.3	36.1	32.6	30.0	27.9	25.5	UNP9200
Crude Death Rate	22.5	20.6	18.6	16.6	14.2	12.2	11.1	9.7	8.3	7.2	6.5	UNP9200
Avg. Annual Growth Rate	2.5	2.6	2.8	2.8	2.8	2.7	2.5	2.2	2.1	2.0	1.9	UNP9200
Total Fertility Rate	6.9	6.9	6.9	6.7	6.3	5.7	5.0	4.3	3.8	3.4	3.0	UNP9200



IMR and TFR

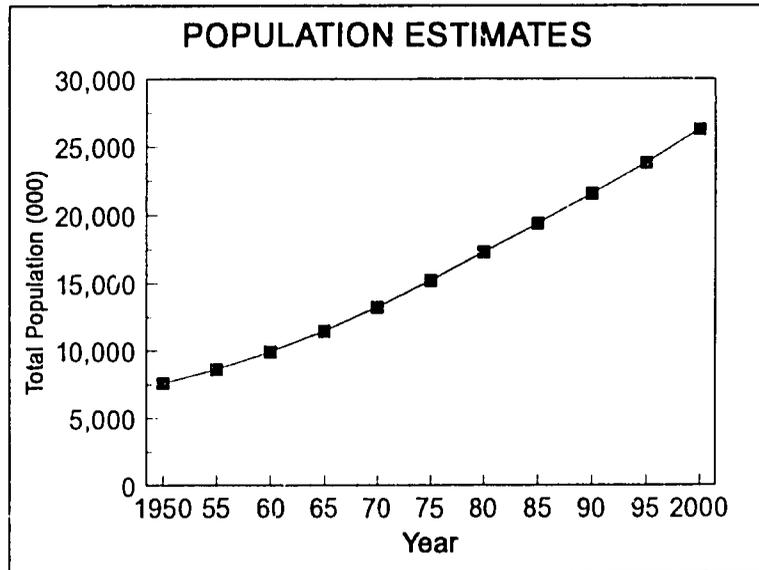
The relationship between IMR and TFR is currently a subject under review by the scientific community. While there is not conclusive evidence that the IMR and TFR are causally linked and necessarily decline together, there is empirical evidence for suspecting that such a reinforcing relationship exists as the pattern is observable in most countries.



Population Estimates/Pyramid

DECEMBER 1993

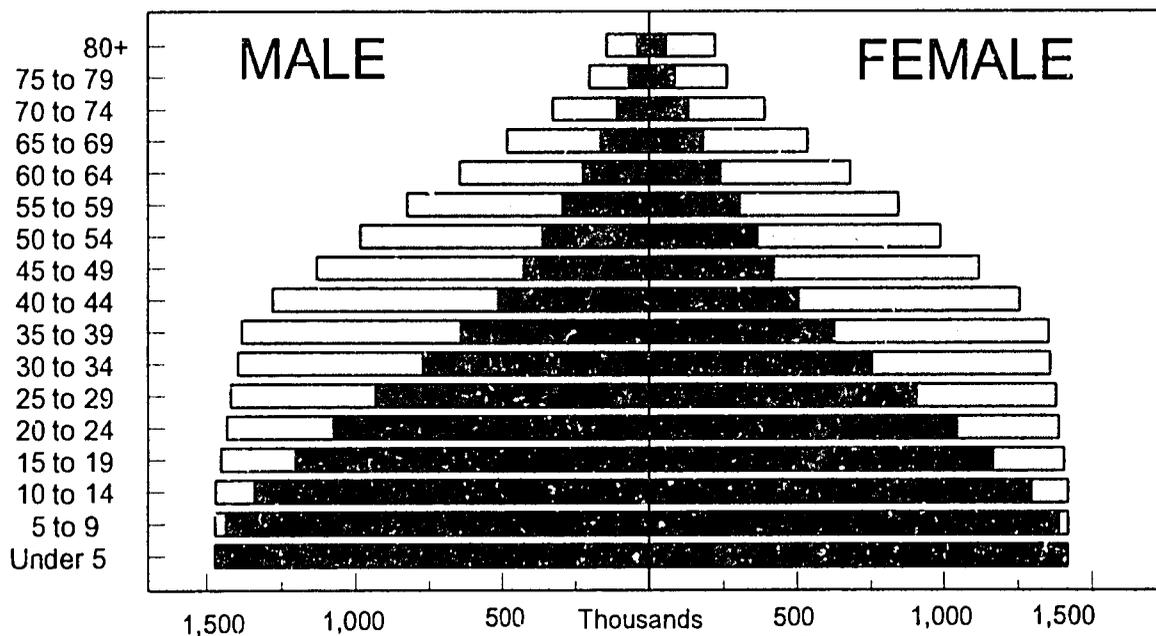
POPULATION ESTIMATES (000s)		
YEAR	VALUE	SOURCE
1950	7,632	UNP9200
1955	8,672	UNP9200
1960	9,931	UNP9200
1965	11,467	UNP9200
1970	13,193	UNP9200
1975	15,161	UNP9200
1980	17,295	UNP9200
1985	19,417	UNP9200
1990	21,550	UNP9200
1995	23,854	UNP9200
2000	26,276	UNP9200



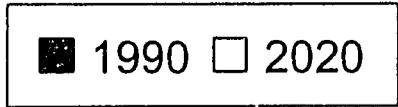
CURRENT & PROJECTED POPULATION

By Age & Gender: 1990 - 2020

Total Population 1990: 21,905,605 Total Population 2020: 35,055,330



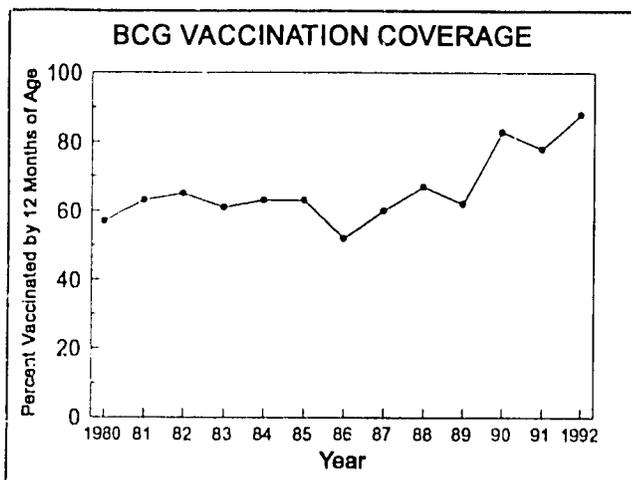
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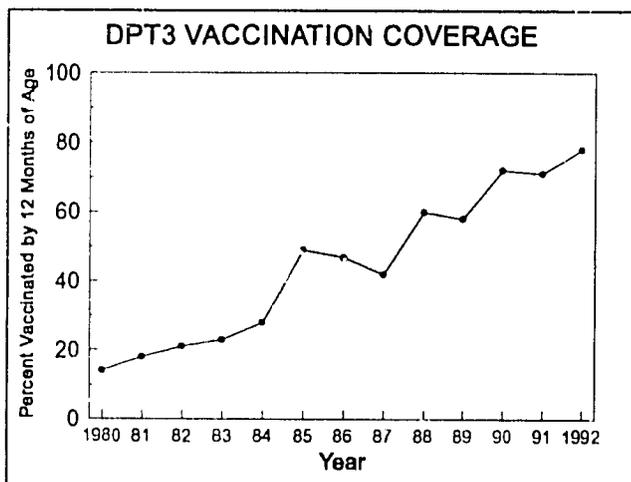
Trends in Selected Health and Child Survival Indicators

Vaccination Coverage Rates

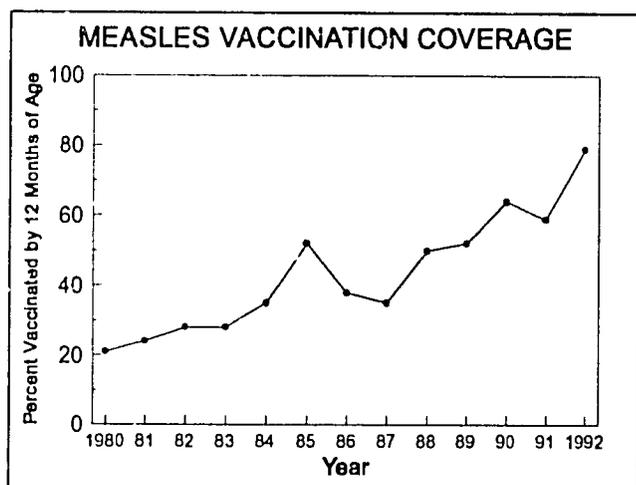
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BCG COVERAGE		
YEAR	PERCENT	SOURCE
1980	57	WHE8700
1981	63	WHE8700
1982	65	WHE8700
1983	61	WHE8900
1984	63	WHE8700
1985	63	AID9007
1986	52	AID9007
1987	60	AID9007
1988	67	AID9007
1989	62	AID9002
1990	83	WHE9100
1991	78	WHE9200
1992	88	DHS9207

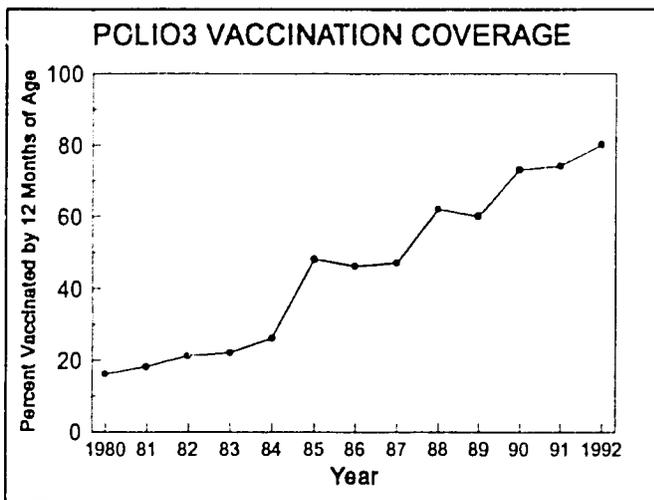


DPT3 COVERAGE		
YEAR	PERCENT	SOURCE
1980	14	WHE8700
1981	18	WHE8700
1982	21	WHE8700
1983	23	WHE8900
1984	28	WHE8700
1985	49	AID9007
1986	47	AID9007
1987	42	AID9007
1988	60	AID9007
1989	58	AID9002
1990	72	WHE9100
1991	71	WHE9200
1992	78	AID9202

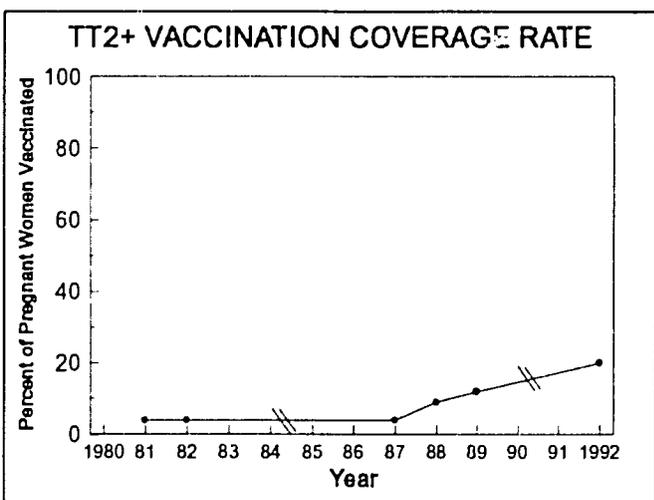


MEASLES COVERAGE		
YEAR	PERCENT	SOURCE
1980	21	WHE8700
1981	24	WHE8700
1982	28	WHE8700
1983	28	WHE8700
1984	35	WHE8700
1985	52	AID9007
1986	38	AID9007
1987	35	AID9007
1988	50	AID9007
1989	52	AID9002
1990	64	WHE9100
1991	59	WHE9200
1992	79	AID9202

Vaccination Coverage Rates, continued



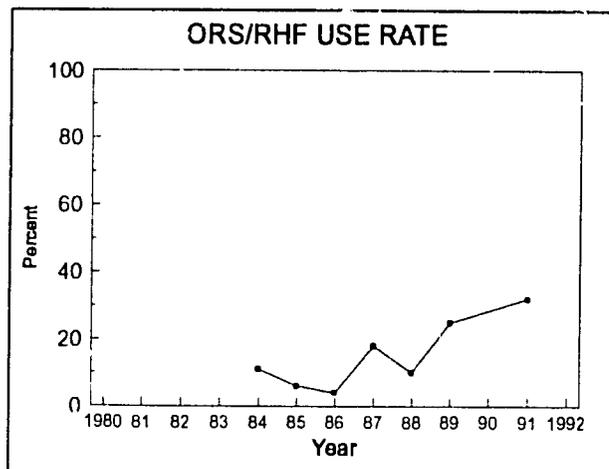
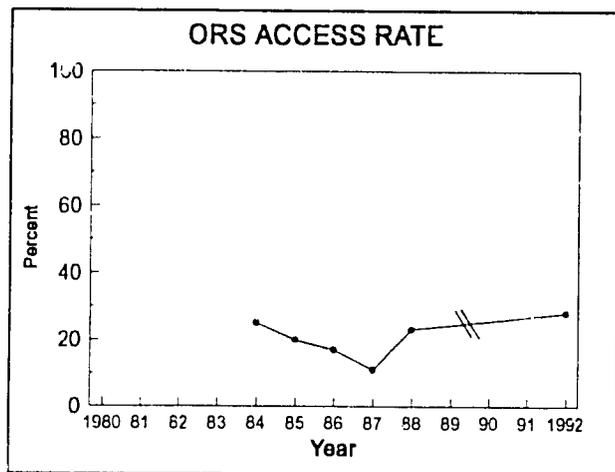
POLIO3 COVERAGE		
YEAR	PERCENT	SOURCE
1980	16	WHE8801
1981	18	WHE8700
1982	21	WHE8700
1983	22	WHE8900
1984	26	WHE8700
1985	48	AID9007
1986	46	AID9007
1987	47	AID9007
1988	62	AID9007
1989	60	AID9002
1990	73	WHE9100
1991	74	WHE9200
1992	80	AID9202



TT2+ COVERAGE		
YEAR	PERCENT	SOURCE
1980		
1981	4	WHE8700
1982	4	WHE8700
1983		
1984		
1985		
1986		
1987	4	WHE8900
1988	9	MRF8901
1989	12	WHE9200
1990		
1991		
1992	20	DHS9207

ORS Access, ORS and/or RHF Use Rates

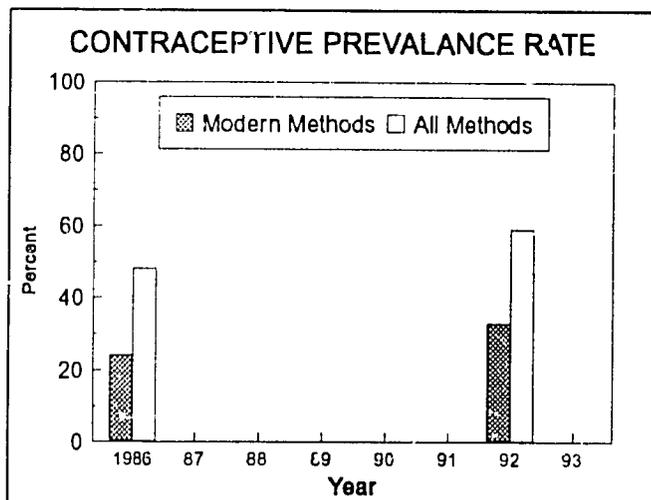
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INDICATOR	1984	1985	1986	1987	1988	1989	1990	1991	1992
ORS Access	25	20	17	11	23				28
Source	WHD8601	WHD8700	WHD8300	WHD8900	WHD9000				WHD9300
ORS/RHF Use	11	6	4	18	10	25		32	
Source	WHD8601	WHD8700	DHS8805	WHD8900	WHD9000	WHD9100		DHS9207	

Contraceptive Prevalence Rate

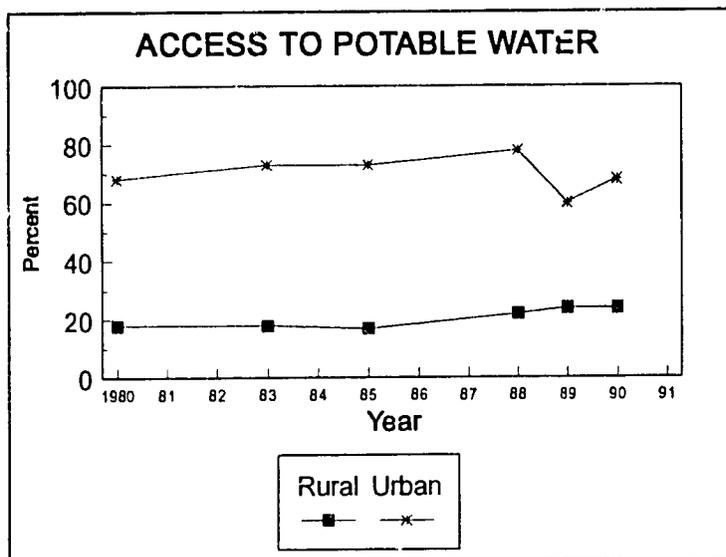
DECEMBER 1993



YEAR	MODERN METHODS	SOURCE	ALL METHODS	SOURCE
1986	24.0	DHS8805	48.0	DHS8805
1987				
1988				
1989				
1990				
1991				
1992	33.0	DHS9207	59.0	DHS9207
1993				

Access to Potable Water

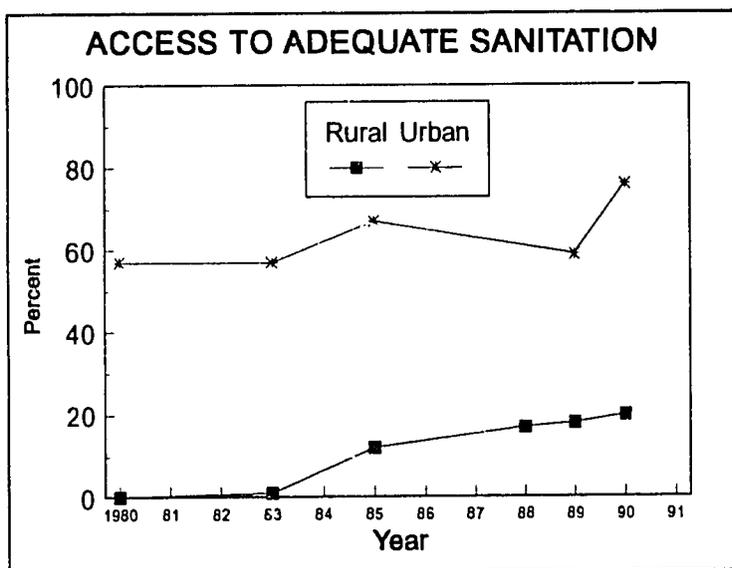
DECEMBER 1993



YEAR	RURAL	SOURCE	URBAN	SOURCE
1980	18	AID9001	68	AID9001
1981				
1982				
1983	18	WHO9101	73	WHO9101
1984				
1985	17	WHO9101	73	WHO9101
1986				
1987				
1988	22	WHO9101	78	WHO9101
1989	24	AID9001	60	AID9001
1990	24	WHO9200	68	WHO9200
1991				

Access to Adequate Sanitation

DECEMBER 1993

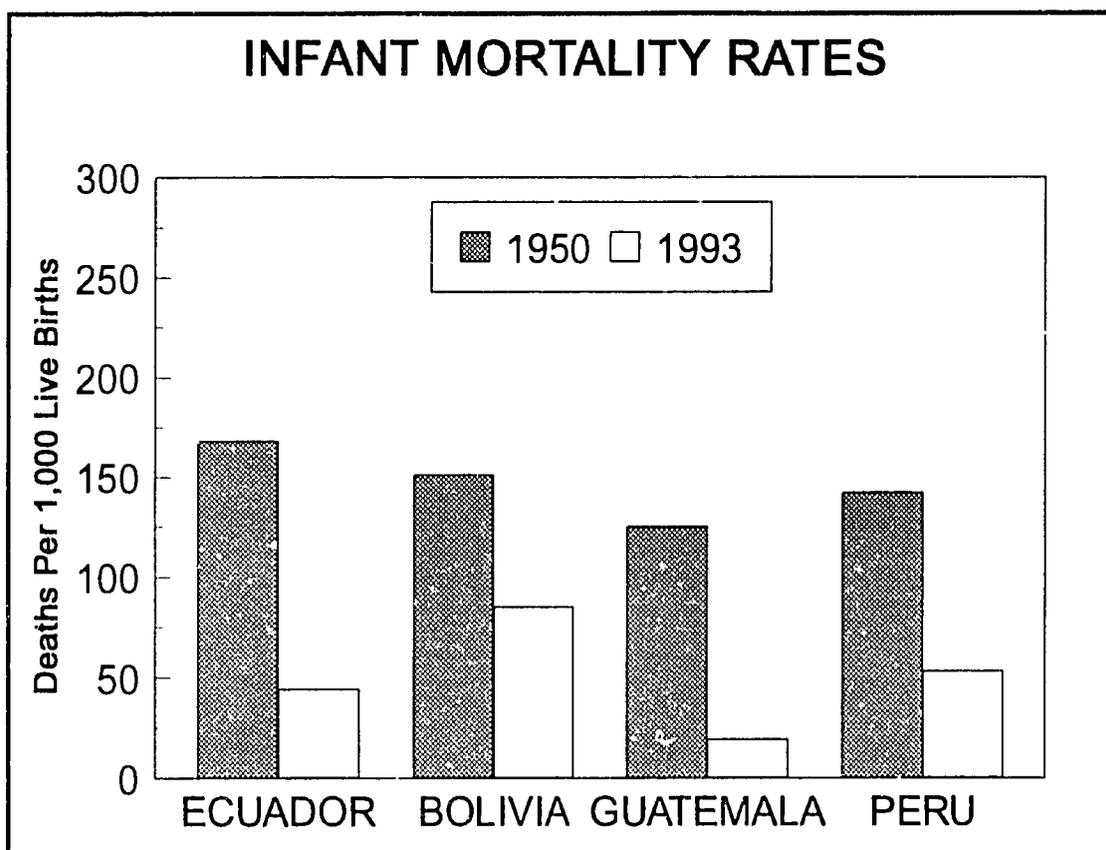


YEAR	RURAL	SOURCE	URBAN	SOURCE
1980	0	AID9001	57	AID9001
1981				
1982				
1983	1	WHO9101	57	WHO9101
1984				
1985	12	WHO9101	67	WHO9101
1986				
1987				
1988	17	WHO9101	59	AID9001
1989	18	AID9001	59	AID9001
1990	20	WHO9200	76	WHO9200
1991				

Comparative Indicators

Comparative IMR Rates

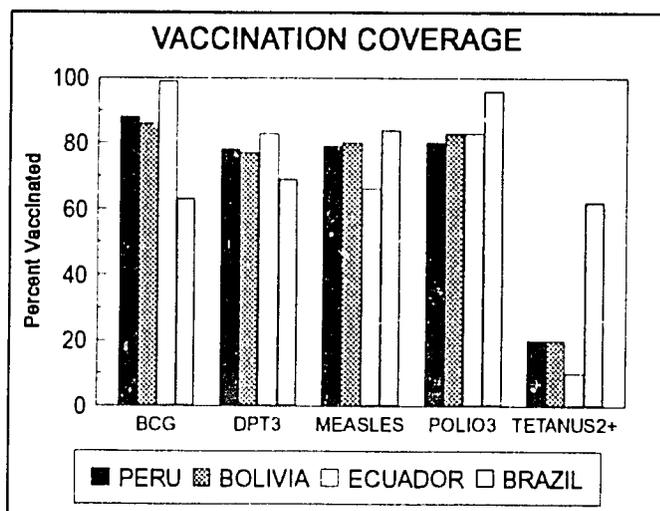
DECEMBER 1993



COUNTRY	1950	SOURCE	1993	SOURCE
PERU	168	WBK9302	44	WBK9302
BOLIVIA	151	WBK9302	85	WBK9302
ECUADOR	125	WBK9302	19	WBK9302
BRAZIL	142	WBK9302	53	WBK9302

Comparative Vaccination Coverage Rates

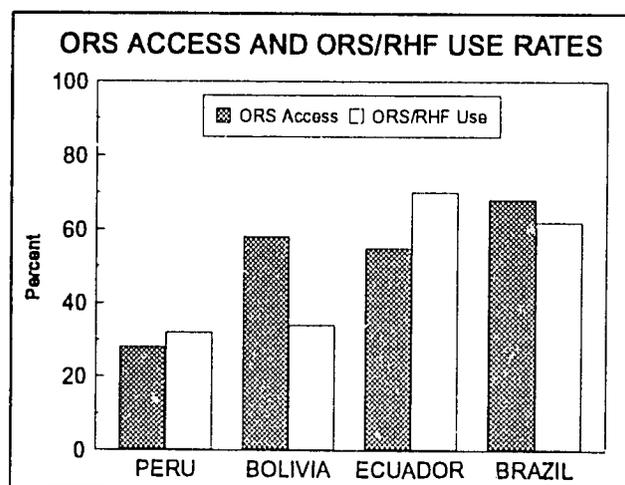
DECEMBER 1993



COUNTRY	INDICATOR	YEAR	VALUE	SOURCE
PERU	BCG	1991	88	DHS9207
	DPT3	1992	78	AID9202
	Measles	1992	79	AID9202
	Polio 3	1992	80	AID9202
	Tetanus 2	1991	20	DHS9207
BOLIVIA	BCG	1992	86	WHE9301
	DPT3	1992	77	WHE9301
	Measles	1992	80	WHE9301
	Polio 3	1992	83	WHE9301
	Tetanus 2	1989	20	WHE9301
ECUADOR	BCG	1992	99	WHE9301
	DPT3	1992	83	WHE9301
	Measles	1992	66	WHE9301
	Polio 3	1992	83	WHE9301
	Tetanus 2	1991	10	WHE9301
BRAZIL	BCG	1992	63	WHE9301
	DPT3	1992	69	WHE9301
	Measles	1992	84	WHE9301
	Polio 3	1992	96	WHE9301
	Tetanus 2	1987	62	WHE8900

Comparative ORS Access, ORS and/or RHF Use Rates

DECEMBER 1993



COUNTRY	INDICATOR	YEAR	VALUE	SOURCE
PERU	ORS Access	1992	28	WHD9300
	ORS/RHF Use	1991	32	DHS9207
BOLIVIA	ORS Access	1991	58	WHD9201
	ORS/RHF Use	1989	34	DHS9001
ECUADOR	ORS Access	1991	55	WHD9201
	ORS/RHF Use	1991	70	WHD9201
BRAZIL	ORS Access	1991	68	WHD9201
	ORS/RHF Use	1991	62	WHD9201

III: HIV / AIDS

DECEMBER 1993

Although Peru's annual incidence rate has steadily risen since 1987 and is higher than those of neighboring Ecuador and Bolivia, the 1992 rate of 10.2 cases per million Peruvians was still well below the Latin American regional rate of 32.9. (PAH9320) An estimated 70 percent of AIDS cases reported to the World Health Organization (WHO) in Peru are homosexual or bisexual men residing primarily in Lima. (AID0002) Actual cases reported represent only a fraction of the full impact of AIDS: in August, 1993, the head of Peru's National AIDS Program reported that the nation had had a total of 4,000 certified cases of AIDS and more than 1,200 deaths due to AIDS since the early 1980s, far more than the totals reported to the WHO. The number of individuals with HIV infection was estimated at an alarming 250,000. (CAB9306) Peruvian non-governmental organizations (NGOs) have been working not only to help the government promote AIDS awareness and protection but also to combat discrimination against at-risk populations by the state, public and private health services, and society as a whole. (PAN9000)

National AIDS Control Program

Programa Especial de Control de SIDA (PECOS), Ministry of Health, Lima. PECOS promotes increased awareness of the social impact of HIV/AIDS, the empowerment of women to protect themselves and collaboration with NGOs. Under the program, *Proyecto SIDA* has employed mass-media campaigns to promote condom use for AIDS protection since 1988. (PAH9316) With external support, PECOS and the President's AIDS Commission have also conducted limited behavioral and educational research. In 1993, the program's new director declared one of his greatest priorities to be the establishment of AIDS committees in hospitals, clinics and medical centers throughout the nation. (CAB9306)

The information below is based on reports to WHO through June 30, 1993: (PAH9318)

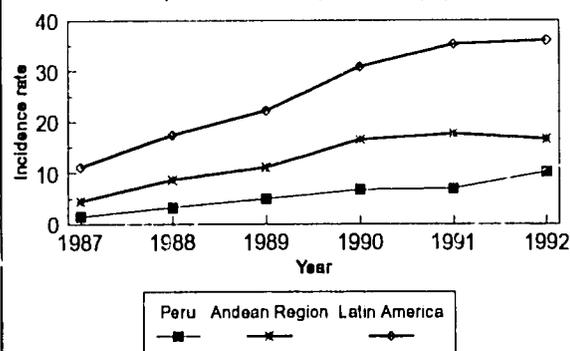
Total reported AIDS cases	883
Deaths attributed to AIDS	270
1992 Incidence rate (per 1 million population)	10.2
Male/female ratio (1992)	9.8:1
Pediatric cases	12 (1.4% of total)
Perinatal cases	11 (1.2% of total)

AIDS: New cases and incidence rates (PAH9318, PAH9320)

Year	New cases	Comparative incidence rates (per million)		
		Peru	Andean Region	Latin America
Through 1986	31			
1987	32	1.5	4.5	11.1
1988	67	3.2	8.6	17.4
1989	110	5	11.1	22.2
1990	149	6.7	16.5	30.8
1991	152	6.9	17.7	35.3
1992	230	10.2	16.6	36.0

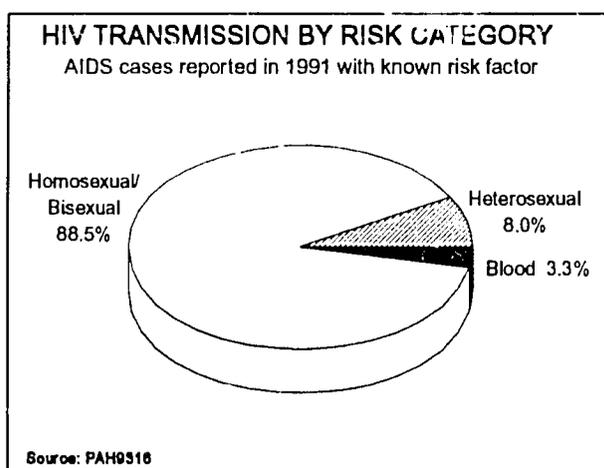
COMPARATIVE AIDS INCIDENCE RATES

Cases reported to WHO, per million population



Sources: PAH9318, PAH9320

HIV-1 Seroprevalence from selected studies (BUC9301)				
Population sampled	Sex	Year	% HIV-positive	Sample
Adults Seeking Health Certification, Lima	M	1991-92	0.40%	285
Adults Seeking Health Certification, Lima	F	1991-92	0.00%	205
Blood Donors (Volunteers)	B	1987-88	0.10%	32,616
Homosexuals	M	1987-88	4.40%	2,788
Prostitutes	F	1987-88	0.30%	2,335
Prostitutes, Callao	F	1988-89	0.60%	630
Haemophiliacs	B	1987-88	5.20%	249



Local Non-Governmental Organizations with HIV/AIDS Activities

(PAH9316, AID0002, AID0003, IPP9001, PER8802)

Flora Tristan Centro de la Mujer Peruana has worked with the AIDSCOM project to educate women about AIDS.

Generación has conducted AIDS education activities, including training teachers to promote awareness among students about HIV and other STDs.

Germinal provides outreach services and communications materials to help at-risk street children protect themselves against HIV. The group receives funding from "Save the Children"/Sweden.

Movimiento Homosexual de Lima (MHOL) has produced educational materials, conducted behavioral research, promoted condom supply and partner number reduction, and established AIDS outreach and information hotline services.

PRISMA (Asociación Benéfica Prisma), collaborates with government, universities and local PVOs to promote HIV/AIDS research, education, counselling and prevention. As the main implementer of USAID's HIV/AIDS Education and Prevention project (completed in 1992), PRISMA provided testing and counselling services and educational workshops for health workers and members of high-risk groups.

Unión Peruana Contra las Enfermedades de Transmisión Sexual (UPCETS) has sponsored workshops and disseminated information on AIDS in Peru.

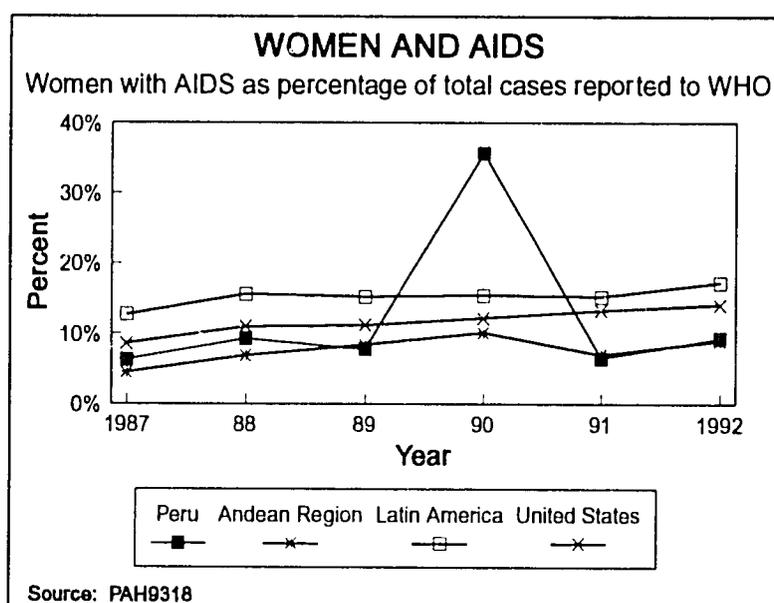
Vía Libre provides counselling and support to HIV-positive people. Vía Libre worked with USAID's AIDSTECH and AIDSCAP projects to recruit and train HIV-positive peer educators who provide communication training to at-risk individuals in the gay and bisexual community of Lima.

International NGOs with AIDS activities in Peru (NCI9201,WHO9102)

- American Red Cross
- Centro Italiano di Solidarieta, Rome
- Corporación FIASAR, Bogotá, Colombia
- Danish Save the Children
- International Planned Parenthood Federation (IPPF)
- Jerusalem AIDS Project, Israel
- Johns Hopkins University, Center for Communication Programs
- Marie Stopes International, London
- Medical Mission Institute of Würzburg, Germany
- Partners of the Americas
- Rädda Barnen (Save the Children), Sweden
- Terre des Hommes Deutschland

International Donors supporting AIDS activities in Peru (PAH9316,UNI0000)

- Canadian International Development Agency (CIDA)
- European Economic Community (EEC)
- Swedish International Development Agency (SIDA)
- United Nations International Children's Educational Fund (UNICEF)
- United States Agency for International Development (USAID)

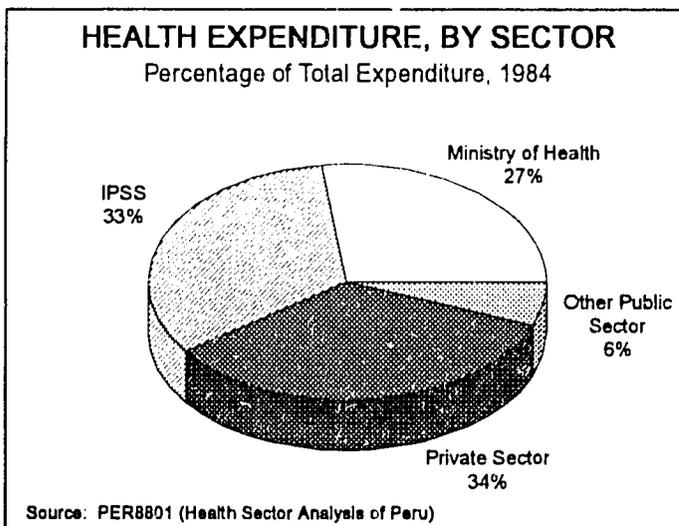


Year	Peru	Andean Region	Latin America	United States
1987	6.3%	4.5%	12.7%	8.6%
1988	9.3%	6.9%	15.6%	11.0%
1989	7.8%	8.4%	15.2%	11.2%
1990	35.7%	10.1%	15.4%	12.2%
1991	6.5%	7.0%	15.2%	13.3%
1992	9.3%	9.0%	17.2%	14.1%

IV: HEALTH CARE FINANCING

DECEMBER 1993

According to the World Bank, total health expenditures amounted to 3.2 percent of Peru's Gross Domestic Product (GDP) in 1990, (WBK9303) one of the lowest levels in the Latin America and Caribbean (LAC) region and down considerably from an earlier estimate of 4.5 percent for 1984. (LAC8702) At \$49 per person, per-capita spending was nearly twice neighboring Bolivia's but less than half the Latin America and Caribbean (LAC) regional average of \$105 per person. (WBK9303) A shrinking Ministry of Health (MOH) budget and a rising deficit at the Peruvian Social Security Institute (IPSS) have resulted in the deterioration of public medical services and an increased need for affordable private health care alternatives. The figure below depicts relative shares of expenditure on health by subsector in 1984.

**Public Sector**

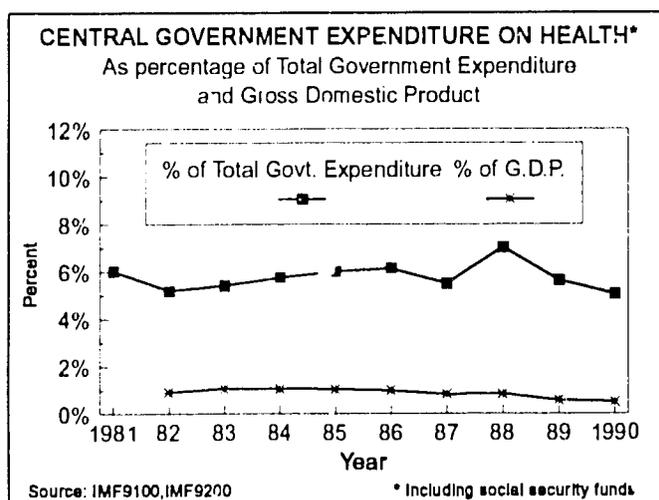
The World Bank estimates that public expenditures, including social security outlays, amounted to just under 60 percent of total health spending in 1990. (WBK9303) Ninety percent of funds for the public health subsector serve to finance the MOH and IPSS programs. (PAH9002) The armed forces, police, and some state-owned firms operate their own facilities supported by health insurance funds

which remain separate from the IPSS. Other recipients of public health funds include local governments and public benefit societies.

While the health sector's share of central government spending gradually increased through the mid-1980s, the two main sources of revenue -- IPSS contributions and public treasury allocations to the MOH -- declined due to worsening recession and inflation, particularly after mid-1988. (PAH9002) The figures on the following pages illustrate levels of public spending on health in the 1980s measured per-capita and as a percentage of total government spending and GDP. A third source of public health financing, official foreign aid flows, amounted to 2.7 percent of total health expenditures in 1990, according to the World Bank. (WBK9303)

Ministry of Health

According to findings by the Health Sector Analysis of Peru (HSA-Peru), spending by the MOH amounted to 27 percent of total health expenditures in 1984. (PER8801) In 1988, over



EXPENDITURES ON HEALTH		
As percent of:		
Year	Total Govt. Expenditure	G.D.P.
1981	6.02%	0.91%
1982	5.18%	1.06%
1983	5.41%	1.06%
1984	5.76%	1.03%
1985	6.01%	1.00%
1986	6.15%	0.83%
1987	5.50%	0.84%
1988	7.03%	0.58%
1989	5.64%	0.50%
1990	5.06%	0.50%

95 percent of MOH funding was provided from outlays from the public treasury.(PAH9002) Other sources of income include foreign borrowing and direct grants. User fees provide a negligible share of revenues: a 1986 survey revealed that 35 percent of MOH clients paid nothing and 85 percent paid less than twenty-five cents per consultation.(LAC9106)

Recurrent costs accounted for roughly 90 percent of total MOH expenditures in the 1980s and nearly 50 percent of overall spending was concentrated in Lima.(PER8801,PAH9002) The MOH spent more than twice as much per person in urban areas than in rural areas in the 1980s, but overall per-capita expenditure by the MOH was only one-eighth the level of IPSS spending in 1987, according to a 1992 evaluation under the Pan American Health Organization (PAHO).(PAH9200)

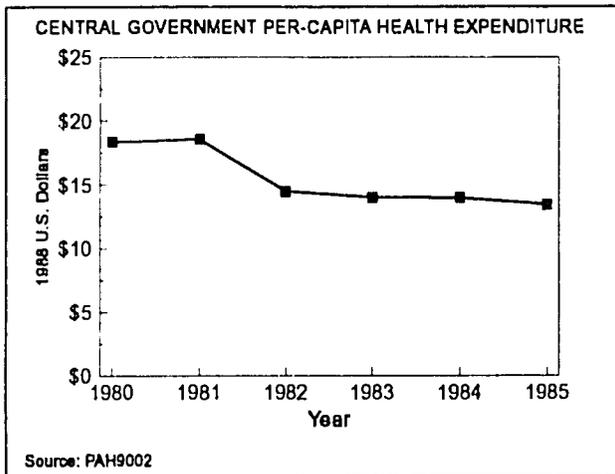
A study in the Arequipa region by USAID's Health Financing and Sustainability (HFS) project revealed a downward trend in MOH spending in the late 1980s. By 1989, the regional office of the MOH was spending about \$1.89 per person, about 66 percent of which was for hospital services. Personnel expenditures alone represented 95 percent of total spending.(LAC9105)

Social Security

Although the IPSS covers the needs of less than one-fifth of the population, the Health Sector Analysis of Peru (HSA-Peru) found that health spending by the IPSS amounted to one-third of total expenditure on health in 1984.(LAC8702) The institute's sickness-maternity program is financed primarily by mandatory contributions of nine percent of salaries and wages (three percent by the insured, six percent by employer; self-employed pay nine percent). The employment injury program draws on employers' contributions ranging from one to 12.2 percent of payroll, depending on the risk involved and the employer's past record.(IDB9101) Returns on investments provide roughly ten percent of IPSS revenues.(WBK9000)

Sickness-maternity outlays, comprising 50 to 60 percent of total IPSS expenditures each year from 1983-1987,(PAH9002) were largely responsible for overall deficits in the 1980s. These were in turn covered through the pension program, which required only 34 percent

IV: Health Care Financing

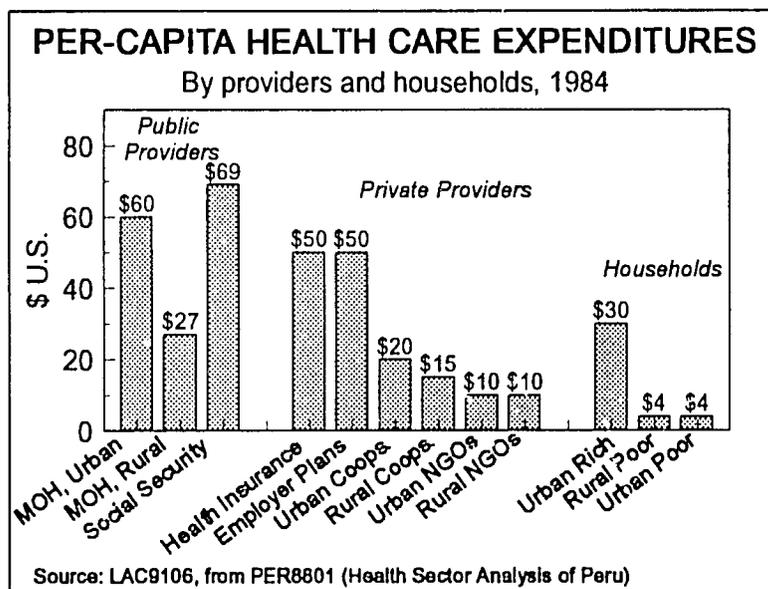


Year	1988 U.S. DOLLARS
1980	\$18.38
1981	\$18.59
1982	\$14.48
1983	\$14.02
1984	\$13.99
1985	\$13.44

of total expenditures in 1983. (WBK9100) In 1988, 2000 percent inflation, evasion estimated at 35 percent of employers (including the Peruvian government itself for much of the 1980s), expansion of coverage and facilities, and related increases in pensions and salaries produced a severe financial crisis for the system. As the cumulative deficit grew and reserves were being depleted, recurrent expenditures represented 85-96 percent of total expenditures and were rising in 1988, according to PAHO. (PAH9002)

Private Sector

Private hospitals, health centers, and individual practitioners are funded through direct payments by health care recipients and by third-party payments arranged through employer and provider plans, risk-sharing mechanisms, cooperatives, and private voluntary organizations (PVOs). (PER8801) The World Bank estimates that private revenues accounted for just over 40 percent of total health spending in 1990. (WBK9303) At just 1.3 percent of GDP, private spending on health in Peru is the lowest relative to GDP of the 17 LAC region nations listed in the bank's World Development Report. (WBK9303) In the late 1980s, the HCF/LAC Project found that of 4 million Peruvians who rely on the private sector for health care, over half (2.2 million) use PVO facilities, a half-million have prepaid health



plans (mostly in the Lima/Callao area), and the rest make direct payments to for-profit providers. (LAC8900)

Per-capita expenditures under private insurance and employer plans amounted to an estimated \$50 in 1984, 10 dollars above MOH per-capita spending but well below the IPSS's level of \$69 per beneficiary. (PER8801) (see figure at left, Since the crisis in

public health care in the 1980s, several initiatives have been experimenting with private financing mechanisms for informal workers and their families and other excluded groups. These efforts have tended to emphasize community- and individually financed PHC services and offer less curative care than do health plans targeting wealthier groups. Examples include a "peoples' mortgage," whereby urban squatters in Lima can borrow against their claimed land and home in order to access life and health insurance.(PAH9200) USAID's Strengthening Health Institutes Project (SHIP) has sought to draw from the model of "PROSALUD," a Bolivian non-governmental organization, to facilitate community-financed health care in Puno, Chiclayo and Arequipa.(LAC9107)

V: USAID PROJECT ASSISTANCE

TIMELINE: USAID Activities Related to Health & Population

DECEMBER 1993

Project Information					Fiscal Year																	
Project #	Project Name	Life-of-Project	Begin FY	PACD	Pre 85	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000	
527-0000	Program Development and Support	*	1974	1993**	█	█	█	█	█	█	█	█	█	█	█	█						
527-9999	Private and Voluntary Organizations (OPG)	*	1978	***	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
527-0178	Integrated Regional Development (Nutrition)	\$13,765,000	1979	1988	█	█	█	█	█	█												
527-0219	Extension of Integrated Primary Health	\$7,700,000	1979	1986	█	█	█	█	█													
527-0160	National Responsible Parenthood Program (Population)	\$650,000	1979	1982	█																	
527-0182	Education for Responsible Parenthood (Population)	\$486,000	1979	1981	█																	
527-0206	Reforestation Food for Work (OPG)	\$490,000	1979	1981	█																	
527-0221	Rural Water Systems and Environmental Sanitation	\$11,000,000	1980	1939	█	█	█	█	█	█	█											
527-0186	CARE Urban Feeding Program (Nutrition)	\$793,000	1980	1982	█																	
527-0196	Expanded Improved Feeding Program-OPG (Nutrition)	\$150,000	1980	1982	█																	

(Timeline continued on next page)

This chart contains USAID-funded projects active since 1980 known to contain a child survival, HIV/AIDS, other health, or population component. The Life-of-Project (LOP) column indicates total authorized funding planned for all project activities from the beginning until the conclusion of the project, and not an amount allocated to a specific project component. The project beginning year and project completion date (PACD) appear after the LOP. OPG is the abbreviation for Operational Program Grant. Please see Data Notes.

* Total LOP is not available

** Fiscal year of final obligation

*** Project is ongoing

Source: AID0000



Project Information					Fiscal Year																	
Project #	Project Name	Life-of-Project	Begin FY	PACD	Pre 85	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000	
527-0224	Sur-Medio Health and Family Planning (Nutrition)	\$800,000	1980	1981	█																	
527-0228	Family Planning Consulting Service - OPG	\$150,000	1980	1981	█																	
527-0244	Upper Huallaga Area Development (Health)	\$27,900,000	1981	1991	█	█	█	█	█	█	█	█	█	█	█	█						
527-0230	Integrated Family Planning/Health	\$13,765,000	1981	1990	█	█	█	█	█	█	█	█	█	█	█	█						
527-0245	AIPOLITO UNANUE - OPG (Population)	\$100,000	1981	1981	█																	
527-0240	Central Selva and Resources Management (Nutrition)	\$12,890,000	1982	1988	█	█	█	█	█	█	█											
527-0231	Expanded Reforestation Program - OPG (Nutrition)	\$1,300,000	1982	1987	█	█	█	█	█	█												
527-0247	Expanded Feeding Program - OPG (Nutrition)	\$1,445,000	1982	1987	█	█	█	█	█	█												
527-0277	Disaster Relief and Rehabilitation Expanded Reforestation	\$2,000,000	1983	1987	█	█	█	█	█	█												
527-0210	Nutrition Policy and Planning (Nutrition)	\$1,200,000	1983	1986	█	█	█	█														
527-0248	Caritas Feeding Program -OPG (Health)	\$10,650,000	1984	1989	█	█	█	█	█	█	█											
527-0261	Basic Infrastructure for Pueblos Jovenes (Health)	\$975,000	1984	1989	█	█	█	█	█	█	█											

(Timeline continued on next page)

Project Information					Fiscal Year																
Project #	Project Name	Life-of-Project	Begin FY	PACD	Pre 85	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000
527-0288	Narcotics Education & Public Awareness	\$6,000,000	1985	1992		█	█	█	█	█	█	█	█	█							
527-0294	Peruvian PVO Health Promotion Network	\$960,000	1985	1988		█	█	█	█												
527-0280	Private Sector Health Care Financing	\$2,500,000	1985	1987		█	█	█													
527-0297	CARE Community Health Program - OPG	\$77,000	1985	1987		█	█	█													
527-0271	Health Policy Planning/Human Resources Development	\$2,000,000	1985	1986		█	█														
527-0269	Private Sector Family Planning	\$13,000,000	1986	1992			█	█	█	█	█	█	█	█							
527-0308	Private Sector Nutrition/Child Survival	\$914,000	1986	1991			█	█	█	█	█	█	█								
527-0311	Identification of High Risk Families (Child Survival)	\$980,000	1986	1989			█	█	█	█											
527-0309	Training Physicians and Nurses	\$161,000	1986	1989			█	█	█	█											
527-0285	Child Survival Action Program	\$19,000,000	1987	1994				█	█	█	█	█	█	█	█						
527-0282	Agricultural Technology Transfer (Nutrition)	\$25,000,000	1987	1992				█	█	█	█	█	█								
527-0313	Andean Peace Scholarships	\$6,358,000	1987	1991				█	█	█	█	█									

(Timeline continued on next page)



Project Information					Fiscal Year																
Project #	Project Name	Life-of-Project	Begin FY	PACD	Pre 85	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000
527-0316	Ninos Child Survival Journal - OPG	\$213,000	1987	1989				■	■	■											
527-0323	PRISMA Supplemental Feeding - OPG	\$712,000	1988	1992				■	■	■	■	■	■								
527-0330	Food Assisted Integrated Development - OPG(Nutrition)	\$665,000	1988	1992				■	■	■	■	■	■								
527-0328	ADRA/VOFASA Nutrition and Food for Work - OPG	\$1,182,000	1988	1992				■	■	■	■	■	■								
527-0327	AIDS Prevention	\$100,000	1988	1992				■	■	■	■	■	■								
527-0320	Reforestation Care - OPG(Nutrition)	\$230,000	1988	1991				■	■	■	■										
527-0331	Decentralized Population and Development Policies	\$200,000	1988	1990				■	■	■											
527-0321	Central Selva Resource Mgmt.Phase II (HLTH,CS,NUT)	\$3,910,000	1988	1988**				■													
527-0335	Private Voluntary Sector Family Planning Service Expansion	\$9,980,000	1989	1993					■	■	■	■	■	■							
527-0333	HIV/AIDS Education and Prevention	\$500,000	1989	1993					■	■	■	■	■	■							
527-0329	CARITAS Food Relief, Nutrition and Development - OPG	\$497,000	1989	1991					■	■	■										
527-0326	Private Commercial Family Planning Development - OPG	\$2,400,000	1991	1995								■	■	■	■	■					

(Timeline continued on next page)

Project Information					Fiscal Year																
Project #	Project Name	Life-of-Project	Begin FY	PACD	Pre 85	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000
527-0319	Strengthening Private Sector Health Institutions	\$18,000,000	1991	1996																	
527-0353	PVO PL480 Title II Program Support (Health)	\$8,000,000	1992	1998																	
527-0347	Narcotics Education & Community Initiatives	*	1992	1994																	
527-0366	Sustaining Child Survival Program	\$60,000,000	1993	1994**																	

Fiscal Year Obligations for USAID-funded Projects Related to Health

DECEMBER 1993

Project #	Project Name	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
527-0000	Program Development and Support (PD&S)	1,970	889	253	120	50	446	139	0
527-0219	Extension of Integrated Primary Health	1,100	0	0	0	0	0	0	0
527-0221	Rural Water System and Environment San.	200	0	0	0	0	0	0	0
527-0230	Integrated Health/Family Planning	3,783	0	0	0	0	0	0	0
527-0231	Expanded Reforestation Program	0	75	0	0	0	0	0	0
527-0244	Upper Hualaga Area Development	0	0	0	0	130	30	0	0
527-0247	Expanded Feeding Program	0	600	100	0	0	0	0	0
527-0248	Caritas Feeding Program	0	272	100	0	0	0	0	0
527-0261	Basic Infrastructure for Pueblos Jovenes	0	300	75	0	0	0	0	0
527-0285	Child Survival Action Project	0	0	2,600	5,114	3,268	0	0	4,016
527-0288	Narcotics Education and Public Awareness	0	0	0	0	0	210	160	0
527-0294	Peruvian PVO Health Promotion Network	660	300	0	0	0	0	0	0
527-0297	Nutrition for Child Survival Program	35	42	0	0	0	0	0	0
527-0308	CS:Private Sector Nutrition	0	1,050	0	0	0	0	0	0
527-0309	Training Physicians and Nurses	0	150	11	0	0	0	0	0
527-0311	Reduction in Child Mortality	0	358	622	0	0	0	0	0
527-0313	Andean Peace Scholarships	0	0	100	100	100	0	0	0
527-0316	OPG:Ninos Child Survival Journal	0	0	213	0	0	0	0	0
527-0319	Strengthening Private Sector Health Institutions	0	0	0	0	0	0	3,025	1,748
527-0321	Central Selva Resource Management Phase II	0	0	0	3,910	0	0	0	0
527-0323	PRISMA Supplemental Feeding OPG	0	0	0	388	150	212	0	0
527-0327	AIDS Prevention	0	0	0	100	0	0	0	0
527-0328	OPG:ADRA/OFASA Nutrition and Food For Work	0	0	0	348	240	662	0	0
527-0329	OPG CARITAS Food Relief and Development	0	0	0	0	497	0	0	0
527-0330	OPG:Food Assisted Integrated Development	0	0	0	178	63	328	0	0
527-0333	HIV/AIDS Education & Prevention	0	0	0	0	150	150	69	132
527-0335	Private Voluntary Sector FP Services Expansion	0	0	0	0	0	1,985	0	0
527-0353	PVO PL 480 Title II Support	0	0	0	0	0	0	0	735
Total (000s):		\$7,748	\$4,036	\$4,074	\$10,268	\$4,648	\$4,023	\$3,399	\$6,631

Funding is based on reported attributions for child survival, HIV/AIDS and other health activities from all funding accounts, except population account funding in FY 1985-91. FY 1985-92 funding figures are actual. Please see Data Notes.

Source: AID0000, AID9308

USAID-Funded Health Projects Active During Fiscal Year 1992

DECEMBER 1993

Project #	Project Name	U.S. Contractor/Grantee
527-0285	Child Survival Action Project	Ministry of Health, Instituto Peruano de Seguridad Social
527-0288	Narcotics Education and Public Awareness	Centro de Informacion y Educacion para la Prevencion del Abuso de Drogas, Ministry of Education & Culture
527-0308	Child Survival:Private Sector Nutrition	Nutrition Research Institute
527-0319	Strengthening Private Sector Health Institutions	CARE/Peru
527-0323	OPG:PRISMA Supplemental Feeding	PRISMA
527-0328	OPG:ADRA/OFASA Nutrition and Food for Work	Adventist Development and Relief Agency/Obra Filantropica Asistencia Social Adventista
527-0330	OPG:Food Assisted Integrated Development	CARE
527-0333	HIV/AIDS Education & Prevention	PRISMA
527-0335	Private Voluntary Sector Family Planning Services Expansion	PRISMA
527-0353	PVO PL480 Title II Program Support	Private Agencies Collaborating Together (PACT)

Please see Data Notes.

Source: CIH0001

Descriptions of USAID-Funded Child Survival, HIV/AIDS, and Other Health Projects

DECEMBER 1993

Bilateral Projects

Project Number: 527-0285
Project Title: Child Survival Action Project
Country: Peru
Project Area: Entire country
Project Duration: FY 1987 - 12/31/94
Implementing Organization(s):
 Host Country: Ministry of Health (MOH), Instituto Peruano de Seguridad Social
 U.S.: PRISM Group, Centers for Disease Control, Alpha Consult S.A.

Project Overview:

The Child Survival Action Project, designed to support Peru's five-year child survival strategy, provides child survival services through the Ministry of Health (MOH) and the Social Security Institute. The project works to expand child survival services and strengthen decentralized support systems for sustainable delivery of child survival services through the public health sector. Project assistance is provided for activities in diarrheal disease control, nutrition, immunization, family planning and management of acute respiratory infections. During a two-year expansion period (January 1, 1993 - December 31, 1994) the project is concentrating grant funds on five components: Field Epidemiology Training Program; completion of a national computerized health information system; immunizations; clinical training in diarrheal disease case management and lactation management/weaning; and, health/nutrition communications.

Project Highlights:

- Although attention to child survival activities was often diverted in 1991 as government attention turned to the cholera epidemic, existing project infrastructure and funds provided valuable support to the effort to track and respond to the epidemic. The nationwide computerized health information system, designed and implemented with assistance from this project, has served almost exclusively as the MOH's cholera surveillance system. Project-supported training in oral rehydration therapy and production of oral rehydration salts (ORS) have also contributed to low cholera case fatality rates.
- Ten MOH physicians completed a two-year Field Epidemiology Training Program with technical assistance from CDC. These trainees played an important role in epidemiologic reporting during the 1991 cholera epidemic in Peru. Approximately 20,000 MOH employees were trained as computer center administrators; HIS/MIS trainers; and HIS/MIS users. In addition, project PL480 funds supported the national Diarrheal Disease Control Program, local ORS procurement, and the MOH's General Directorate of Epidemiology in investigation and documentation of the cholera epidemic in FY 91.
- In FY 92 scales for growth monitoring and cold chain equipment were provided with PL480 funds for child survival activities. PL480 funds also served as major support to the MOH national immunization program which emphasized polio eradication and control of measles outbreaks throughout the country in 1992. Project grant funds were used to purchase refrigerators and cold chain equipment for the MOH.

Sources:

AID0001, LAC9108, QUE9100, QUE9200

No Longer Funded

Project Number: 527-0323
Project Title: OPG: PRISMA Supplemental Feeding
Country: Peru
Project Area: Entire country
Project Duration: FY 1988 - 9/30/92
Implementing Organization(s):
Host Country: PRISMA, Ministry of Health
U.S.: No organizations

Project Overview:

The PRISMA OPG: Integrated Food, Nutrition and Child Survival Project is a joint program of the Ministry of Health (MOH) and PRISMA, a local private voluntary organization, working to integrate the MOH's supplementary feeding program with maternal and child health care services, and to improve the distribution and targeting of PL480 Title II food. The program uses a strategy of high-risk targeting developed by USAID-funded research to extend food and child survival interventions to families which have the greatest risk of child mortality or malnutrition.

Project Highlights:

■ The successful use of the risk targeting strategy is being replicated with the MOH in all departments of Peru. In 1991 a new project component was added in six cities in Peru. Trained health promoters detect all acutely malnourished children and provide rehabilitation with Title II foods, as well as with child survival interventions. This new component is called "kusiayllu" or "happy community" in Quechua. A manual has been developed by the project to instruct health professionals in identifying high risk families and in managing the distribution of Title II food. The manual has been distributed to over 500 health professionals. A total of 191 health professionals in 28 departmental health areas have received training in the use of risk evaluation cards.

■ Based on project-funded research in high risk targeting, the MOH has developed a new national nutrition and child survival program, Food and Nutrition for High Risk Families, to extend child survival interventions to families with children at high risk of malnutrition.

■ The "Kusiayllu" (happy community) program has proved to be very successful in detecting and rehabilitating malnourished children. It has allowed full community participation in a private/public sector program as well as provided invaluable nutritional information. The data collected from the six cities is used as a "sentinel surveillance system". Decisions for the allocation of resources and new programs are made based on the severity of nutritional status. This program is expected to form the base-line for evaluation of development projects, enabling projects to include and evaluate nutritional objectives.

Sources:

AID0001, AID9014, AID9105, LAC9108, QUE9100, QUE9200

No Longer Funded

Project Number: 527-0328
Project Title: OPG: ADRA/OFASA Nutrition and Food for Work
Country: Peru
Project Area: 20 Provinces of the following Departments: Lima, Arequipa, Lambayeque, Puno, Junin, Tacna, Cajamarca, Piura and La Libertad
Project Duration: FY 1988 - 12/31/92
Implementing Organization(s):
Host Country: Local NGO organizations
U.S.: Adventist Development and Relief Agency

Project Overview:

The Nutrition and Food for Work Project, implemented by the Adventist Development and Relief Agency, works with local private voluntary organizations in nine departments to provide health and nutrition-related services to women and children under the age of six. The project, partially supported by PL 480 funds, reaches its beneficiaries through community-based mother-child centers. Local health promoters provide health and nutrition education, promote community gardens and offer supplemental feeding programs. Other project activities include the provision of agricultural credit and equipment to farmers to increase food yield, and the establishment of group-operated micro-enterprises to increase family income.

Project Highlights:

- In 1991, project activities included a public march to promote community awareness of the causes and prevention of diarrheal disease, particularly cholera.
- The primary focus of the project is education-based prevention. Important project components include the training of ADRA health specialists, local volunteer health promoters and mothers. One indicator of the success of this focus is that in 1992, only 1.4 percent of babies born to participating mothers were below normal weight, a fraction of the national average of 10 percent.
- At the end of the fiscal year 1992, an internal evaluation was completed. A sampling was done of 38 of the 262 MCH centers, visiting 186 mothers in their homes. This sampling revealed that more than 90 percent of project mothers can interpret the nutritional status of their children from the growth monitoring control card. 96 percent of the mothers are practicing exclusive breast feeding until six months and are providing adequate nutrition to the baby during weaning. 95 percent of the mothers are able to provide appropriate care during episodes of diarrhea, and can use oral rehydration therapy on their child when needed. In 1988, 68 percent of all children in the MCH centers were showing a positive growth curve. At the end of FY 92, 75 percent of all children in the program are showing a positive growth curve. This was accomplished in spite of the severe economic conditions and the third year of drought conditions.
- With the experience gained during the four years of the project, ADRA/OFASA refined and focused its health and child survival activities. Home based, mother implemented health interventions proved to be the most effective and lasting. Best results were obtained by focusing consistently on training the ADRA health specialists, the community based volunteer health promoter for the local project, and mothers.

Sources:

AID9105, LAC9108, QUE9100, QUE9200

No Longer Funded

Project Number: 527-0308
Project Title: CS: Private Sector Nutrition
Country: Peru
Project Area: Lima, Arequipa, Ayacucho, Huancayo, Ancash, Lambayeque, Piura, Cuzco, Puno, Cajamarca, Junin, Tacna, Apurimac, and Moquegua Departments
Project Duration: FY 1986 - 12/31/91
Implementing Organization(s):
Host country: Nutrition Research Institute
U.S.: No Organizations

Project Overview:

The project helped to improve the nutritional and health status of children in urban and rural areas through improvements in the effectiveness and delivery of child survival interventions, particularly those related to the treatment of diarrhea. The project supported research on the causes and control of diarrhea, including studies pertaining to traditional beliefs and feeding practices affecting the dietary management of diarrhea and oral rehydration therapy programs. The project also supported the training of nutritionists and other health workers in growth monitoring and nutrition education to increase the impact of Title II feeding programs on populations at high risk of malnutrition.

Project Highlights:

■ Using a simplified methodology developed by the project, Ministry of Health (MOH) personnel in two regions designed culturally-acceptable, nutrient-rich, low-cost weaning diets made of locally available foods. The project also designed appropriate diets for use in the management of diarrhea at oral rehydration units. A pilot project at the oral rehydration unit of Hospital del Nino tested the feasibility of establishing a component in the MOH's oral rehydration units which would focus on the dietary management of diarrhea. Cloth flip charts depicting various nutrition themes were developed and distributed to nutrition educators. Upon completion of the project in FY 1992, the project had provided nutritional training to over 3,000 health professionals and community leaders and placed approximately 35,000 children in 15 departments of Peru on monthly surveillance.

■ In the Dietary Management of Diarrhea component, a pilot program intervention was carried out in an Andean valley. Cultural beliefs, traditional practices on infants' feeding and care, and local available foods were studied. A recipe was designed and field tested. A pilot mass media intervention was carried out in which 82 percent of the population received the messages. In Lima, a survey and ethnographic studies were completed and 10 recipes were designed. These were tested in the oral rehydration unit of Hospital del Nino. A manual including recipes and messages on feeding children during diarrhea was designed and distributed. A total of 3,155 health professional and mothers' club leaders were trained in the dietary management of diarrhea.

Sources:

LAC9108, QUE9100

No Longer Funded

Project Number: 527-0333
Project Title: HIV/AIDS Education and Prevention
Country: Peru
Project Area: Entire country
Project Duration: FY 1989 - 1/31/93
Primary Implementing Organization(s):
Host Country: Ministry of Health (MOH), PRISMA, Movmiento Homosexual do Lima, San Marcos University
U.S.: No organizations

Project Overview:

The HIV/AIDS Education and Prevention Project was designed to reduce the sexual transmission of HIV through educational interventions designed to encourage risk-reducing behaviors. The project collaborated with three local institutions: the special Program of the Ministry of Health for control of AIDS, the Institute of Tropical Medicine of San Marcos University, and the Movmiento Homosexual do Lima (MHOL), a local homosexual community services organization. The project ran an AIDS information hotline and a series of workshops designed to educate homosexual and bisexual men on AIDS prevention. The project also provided confidential HIV testing and counseling services.

Project Highlights:

■ The project helped develop HIV/AIDS prevention strategies targeting adolescent girls and prostitute clientele. The project sponsored a workshop focusing on the methodological process of developing AIDS information and education materials. Information campaigns supported by the project have contributed to more open discussions on AIDS.

■ The organizations which have worked together in the project have been strengthened by their collaboration and have formed a base for a coalition of Peruvian organizations working in AIDS. The public/private sector collaboration is especially important. The project has strengthened the Office of the "Programma Especial de Control de SIDA" in the Ministry of Health to the point where PRISMA has been able to obtain EEC funding to continue support for an AIDS Education and Prevention Program in Peru.



Sources:

LAC9108, QUE9100, QUE9200

Project Number: 527-0319
Project Title: Strengthening Health Institutions (SHIP)
Country: Peru
Project Area: Region of Arequipa and sub-region of Puno
Project Duration: FY 1991-FY 1995

Implementing Organization(s):

Host Country: Instituto Pervano de Paternidad Responsable, Centro Promocion y Desarrollo, Union de Comunidades Aymaras, Multicomunal Winay Marca, Farmacias de Apoyo Social Urbana-Rural, Accion Social y Desarrollo, Centro Apoyo y Promocional Desarrollo, CARITAS Arequiipa, Centro de Comunicacion Amakella, Prelatura de Carveli, Centro de Estudios Para Desarrollo Regional, Vicria San Jose Trabaya y Pampas Nuevas
U.S.: CARE/Peru

Project Overview:

The project has been designed to establish and evaluate models of private primary health care delivery systems in target areas of Peru. Child Survival interventions are the primary focus of activities within the traditional primary care context. In the Puno area, the major number of targeted beneficiaries live in rural communities. In Arequipo, the majority are new urban residents in shanty town neighborhoods called "pueblos jovenes". Basic services are to include vaccinations, diarrheal disease control, nutrition interventions, family planning, treatment of acute respiratory infections, pregnancy care and emergency care. CARE is serving as an implementing agency. Sub-grants are provided to organizations that deliver health services and/or health education, including PVO's, universities, associations, church agencies, private clinics, and community organizations. Operations research and technical studies will provide baseline information and feedback on project activities which will contribute to health policy dialogue in Peru regarding options for health care financing and health care delivery.

Project Highlights:

- In FY 1992, twelve proposals had been tentatively approved for sub-grant funding; seven for Arequipa region and five for Puno. From May to September 1992, the project carried out the following training activities:
- * 2 health sector briefing conferences for regional institutions interested in submitting proposals for sub-grants
- * 3 project design and proposal development workshops
- * 2 sub-grant accounting and management workshops
- * 2 workshops for development of operational plans
- * Visit of project team to PROSALUD/Bolivia operations

Sources:

AID0001, QUE9200

Project Number: 527-0353
Project Title: PVO Support Project
Country: Peru
Project Area: Selected as sub-grants are awarded
Project Duration: FY 1992 - 09/30/98
Implementing Organization(s):
Host Country: Ministry of the Presidency
U.S.: Private Agencies Collaborating Together (P.A.C.T.)

Project Overview:

The purpose of this new project is to expand the amount and increase the development impact of PVO's/NGO's food-assisted programs in the key sectors of health, agriculture, and enterprise development. It is implemented through a cooperative agreement with P.A.C.T. In most instances, U.S. PVO's will work in collaboration with a Peruvian NGO, providing on-the-job training and technical assistance. Up to 18 Peruvian PVO's are to receive Institutional Development Grants (IDG's), designed for smaller, newer NGO's which need organizational or programming skills to manage their resources. It is planned that the project will also make annual microgrants for community-level projects. The project is expected to improve the impact and management of USAID's P.L. 480 Food for Peace Project by establishing a monitoring system for Title II commodity distribution and monetization.

Project Highlights:

- This is a new project. There are no significant highlights to report.

Sources:

AID0001,QUE9200

No Longer Funded

Project Number: 527-0330
Project Title: OPG: Food Assisted Integrated Development
Country: Peru
Project Area: Departments of Piura, La Libertad, Cajamarca, Lima/Callao, Ancash, Junin, Apurimac, Huancavelica, Ayachucho, Cusoo, Puno
Project Duration: FY 1988 - 12/31/92
Implementing Organization(s):
Host Country: National Office for Food Assistance (PRONRA); Ministry of Health (MOH)
U.S.: CARE

Project Overview:

This project was implemented through an Operational Program Grant to CARE for development activities in the peri-urban areas (pueblos juvenes) of Peru, using P.L. 480 Title II food support. The project had seven components focusing on community development, income generation, child survival, nutrition improvement, disaster management, and physical protection of "pueblos Jovenes" located on river floodplains or unstable hillsides. CARE organized women into groups centered around community eating centers (comedores). These centers offered health, family planning, child survival, and nutrition education, along with P.L. 480 feeding programs. Care provided business training and guaranteed bank loans to enable some of the women to establish profitmaking businesses. The project targeted families in the "comedores" in the urban shanty town; homes for abandoned or mentally retarded children and for the indigent elderly, rural children under the age of six years from rural communities; and "campesino" families in the rural sierra.

Project Highlights:

- No significant highlights were available.

Sources:

AID0001,QUE9200

Project Number: 527-0366
Project Title: Sustaining Child Survival Programs
Country: Peru
Project Area: Nationwide
Project Duration: FY 1993 - FY 2000
Implementing Organization(s):
 Host Country: Ministry of Health
 U.S.: To be selected

Project Overview:

This is a new project to improve the health status, particularly of young children and mothers, through improved coverage and quality of child survival programs. It will support decentralized management to improve the delivery of health services, strengthen primary health care services and improve Ministry of Health budget support for child survival programs through expansion of cost-recovery and other resource mobilization schemes. The project supports two strategies: 1) Reduce the burden on the MOH to finance hospitals through restructuring of cost-recovery schemes and privatization models and 2) Increase quality and efficiency of primary care services at the peripheral level, through improved MOH allocation of resources and budget levels for child survival programs, particularly at subregional levels.

Project Highlights:

- This is a new project. There are no significant highlights to report.

Source:

CAB9307

USAID/Washington Support (AID9300)

■ **Regional Projects**

Applied Diarrheal Disease Research supported research on diarrheal diseases and treatment methods and facilitated technical assistance visits by cholera experts from Bangladesh.

■ **Short-term technical assistance and support**

Data for Decision-Making contributed to health policy and systems analysis.

Demographic and Health Surveys II completed a national survey in cooperation with Asociacion Benefica PRISMA.

Diarrheal and Respiratory Disease Research and Coordination provided technical assistance to MOH efforts to control cholera.

HEALTHCOM II (Communications and Marketing for Child Survival) conducted policy and communication workshops for MOH and PVO health personnel.

Health Financing and Sustainability assessed health systems and health financing in the Arequipa Region.

HealthTech (Technology for Child Health) conducted research on cholera detection.

MotherCare and Wellstart (Breastfeeding and Maternal and Neonatal Health) conducted a country assessment of breastfeeding practices.

Nutrition Education and Social Marketing conducted research on educational materials to help CARE expand the Peru Breastfeeding Project.

WASH (Water and Sanitation for Health) supported urban sanitation efforts and assessed overall costs of the 1991 cholera epidemic.

Wellstart (Women and Infant Nutrition) strengthened lactation management education and breastfeeding programs.

VI: DATA NOTES

DECEMBER 1993

Notes On Mortality Estimation

Throughout this profile, references are made to infant and under 5 mortality rates for individual countries or groups of countries. In past years, the primary source of data on infant mortality was the World Population Prospects, a set of estimates updated every two years by the Estimates and Projections Section of the Population Division of the Department of International Economic and Social Affairs, United Nations. The primary source of data on under 5 mortality was a special report published in 1988 by the same group. Where another source, such as a recent Demographic and Health Survey or a national census, was available for a given country, the reported values from that source were cited in place of the United Nations estimates if the technical staff of USAID in the Country Mission and/or the appropriate regional bureaus confirmed the validity of the alternative source.

Known as indirect estimates, those of the United Nations are generated from accepted demographic models which combine the results of all available surveys and censuses in a given country to produce a single time series of estimates and projections. When new empirical data becomes available for a given country, the entire time series of estimates and projections is updated. Thus, using conventional demographic approaches, a survey done in 1990 may generate a new estimate of a mortality rate for 1970 or 1980.

During 1993, a new set of estimates for mortality was generated for 82 countries for publication in the World

Development Report 1993 and a forthcoming UNICEF publication entitled The Progress of Nations. Based on a curve-fitting model, the methodology applied to generate these new estimates purports to depict more accurately the trend derived from all available data sources for a country. Like the estimates generated using conventional demographic models, the entire time series might change upon the addition of a new empirical source. These estimates were made available to USAID through the courtesy of the World Development Report of the World Bank and UNICEF.

The selection of the mortality rates was done through a consultative process involving representatives of the Office of Health in USAID's Research and Development Bureau, USAID's Regional Bureaus and, in many cases, the USAID Country Missions. The source determined to best reflect the reality in a country for the current values of infant and under 5 mortality was identified and one of a number of a computation procedures, depending on the source selected for the current value, was applied to estimate the longitudinal rates. The consideration of the additional source of data developed for the World Development Report and UNICEF during the consultative process has prompted some changes in the reporting of mortality rates from those reported in recent years.

Definitions

Demographic Indicators

Total Population: The mid-year estimate of the total number of individuals in a country.

Average Annual Rate of Growth: An estimate of the rate at which a population is increasing (or decreasing) in a given year.

Infant Mortality Rate: The estimated number of deaths in infants (children under age one) in a given year per 1,000 live births in that same year. This rate may be calculated by direct methods (counting births and deaths) or by indirect methods (applying well-established demographic models).

Under 5 Mortality Rate: The estimated number of children born in a given year who will die before reaching age five per thousand live births in that same year. This rate may also be calculated by direct or indirect methods.

Maternal Mortality Ratio: The estimated number of maternal deaths per 100,000 live births where a maternal death is one which occurs when a woman is pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management. Although sometimes referred to as a rate, this measure is actually a ratio because the unit of measurement of the numerator (maternal deaths) is different than that of the denominator (live births). The measure would be a rate if the units were the same. Extremely difficult to measure, maternal mortality can be derived from vital registration systems (usually underestimated), community studies and surveys (requires very large sample sizes) or hospital registration (usually overestimated).

Crude Birth Rate: An estimate of the number of live births per 1,000 population in a given year.

Crude Death Rate: An estimate of the number of deaths per 1,000 population in a given year.

Life Expectancy At Birth: An estimate of the average number of years a newborn can expect to live. Life expectancy is computed from age-specific death rates for a given year. It should be noted that low life expectancies in developing countries are, in large part, due to high infant mortality.

Children Under Age 1: Mid-year estimate of the total number of children under age one.

Annual Infant Deaths: An estimate of the number of deaths occurring to children under age one in a given year.

Total Fertility Rate: An estimate of the average number of children a woman would bear during her lifetime given current age-specific fertility rates.

Child Survival Indicators

Vaccination Coverage In Children: An estimate of the proportion of living children between the ages of 12 and 23 months who have been vaccinated before their first birthday -- three times in the cases of polio and DPT and once for both measles and BCG. Vaccination coverage rates are calculated in two ways. Administrative estimates are based on reports of the number of inoculations of an antigen given during a year to children who have not yet reached their first birthday divided by an estimate of the pool of children under one year of age eligible for vaccination. Survey estimates are based on samples of children between the ages of 12 and 23 months.

Vaccination Coverage In Mothers: An estimate of the proportion of women in a given time period who have received two doses of tetanus toxoid during their pregnancies. This indicator is being changed in many

countries to account for the cumulative effect of tetanus toxoid boosters. A woman and her baby are protected against tetanus when a mother has had only one or, perhaps, no boosters during a given pregnancy so long as the woman had received the appropriate number of boosters in the years preceding the pregnancy in question. (The appropriate number of boosters required during any given pregnancy varies with number received previously and the time elapsed.) The revised indicator is referred to as TT2+. Rates are computed using administrative methods or surveys.

DPT Drop-out Rate: An estimate of the proportion of living children between the ages of 12 and 23 months who received at least one DPT vaccination but who did not receive the entire series of three vaccinations before their first birthdays.

Oral Rehydration Salts (ORS) Access Rate: An estimate of the proportion of the population under age five with reasonable access to a trained provider of oral rehydration salts who receives adequate supplies. This is a particularly difficult indicator to measure and, therefore, it may fluctuate dramatically from year to year as improved methods of estimation are devised.

ORS and/or Recommended Home Fluid (RHF) Use Rate: An estimate of the proportion of all cases of diarrhea in children under age five treated with ORS and/or a recommended home fluid. ORT use may be determined using administrative means or surveys. In general, administrative estimates are based on estimates of the number of episodes of diarrhea in the target population for a given year and the quantity of ORS available. Thus, changes in the estimates of the frequency of diarrhea episodes can alter the ORT use rate as well as "real" changes in the pattern of use.

Surveys are more precise in that they focus on the actual behavior of mothers in treating diarrhea in the two-week period prior to the survey.

Contraceptive Prevalence Rate: An estimate of the proportion of women, aged 15 through 44 (or, in some countries, 15 through 49), in union or married, currently using a modern method of contraception. Where sources fail to distinguish modern and traditional methods, the combined rate is shown.

Adequate Nutritional Status: An individual child of a certain age is said to be adequately nourished if his/her weight is greater than the weight corresponding to "two Z-scores" (two standard deviations) below the median weight achieved by children of that age. The median weight and the distribution of weights around that median in a healthy population are taken from a standard established by the National Center for Health Statistics, endorsed by the World Health Organization (WHO). The indicator for the population as a whole is the proportion of children 12 through 23 months of age who are adequately nourished.

Appropriate Infant Feeding: A composite estimate of the proportion of infants (children under age one) being breastfed and receiving other foods at an appropriate age according to the following criteria: breastfed through infancy with no bottle-feeding, exclusively breastfed through four months (120 days) of age, and receiving other foods if over six months of age (181 days). Water is not acceptable in the first four months (120 days). ORS is considered acceptable at any age. Surveys are the only source of data to form this indicator. Surveys yield an estimate of how many infants are being fed correctly at the moment of the survey. They do not give an indication of the proportion of individual children fed appropriately throughout their first year of life. A number of sub-

indicators may be calculated from the data used to form the composite, of which two are presented in this report.

Exclusive Breastfeeding: An estimate of the proportion of infants less than four months (120 days) of age who receive no foods or liquids other than breast milk.

Complementary Feeding: An estimate of the proportion of infants six to nine months of age (181 days to 299 days) still breastfeeding but also receiving complementary weaning foods.

Continued Breastfeeding: An estimate of the proportion of children breastfed for at least one year. In this report, all values presented for this indicator are the proportion of children 12 to 15 months of age at the time of the survey still receiving breast milk.

Other Health Indicators

HIV-1 Seroprevalence, Urban: An estimate of the proportion of all persons (pregnant women, blood donors, and other persons with no known risk factors) living in urban areas infected with HIV-1, the most virulent and globally prevalent strain of the human immunodeficiency virus.

HIV-1 Seroprevalence, Rural: An estimate of the proportion of all persons living in rural areas infected with HIV-1.

Access to Improved Water, Urban: An estimate of the proportion of all persons living in urban areas (defined roughly as population centers of 2,000 or more persons) who live within 200 meters of a stand pipe or fountain source of water.

Access to Improved Water, Rural: An estimate of the proportion of all persons not living in urban areas with a source of water close enough to home that family members do not spend a disproportionate amount of time fetching water.

Access to Sanitation, Urban: An estimate of the proportion of all persons living in urban areas with sanitation service provided through sewer systems or individual in-house or in-compound excreta disposal facilities (latrines).

Access to Sanitation, Rural: An estimate of the proportion of all persons not living in urban areas with sanitation coverage provided through individual in-house or in-compound excreta disposal facilities (latrines).

Deliveries By Trained Attendants: An estimate of the proportion of deliveries attended by at least one physician, nurse, midwife, or trained traditional birth attendant.

Notes on Project Information

The primary source for information related to USAID projects is the USAID Health Projects Database (HPD) operated by the Center for International Health Information/ISTI.

The HPD tracks bilateral, regional and centrally-funded USAID projects and sub-projects with a health component, including child survival, HIV/AIDS, nutrition, water supply and sanitation, and other health related activities. Projects are identified for the HPD through the annual USAID Health and Child Survival Project Questionnaire, Annual Budget Submissions (ABS), Congressional Presentations (CP), and the Activity Code/Special Interest (AC/SI) System. Information on project activities, organizations implementing these activities, and project assistance completion dates is also taken from other official USAID documents such as project reports.

In the **Timeline: USAID Activities Related to Health and Population** table, Life-of-Project (LOP) funding indicates the total authorized funding

planned for all project activities from the beginning until the conclusion of the project. Projects may contain components which are not directly related to health, and therefore, LOP totals reported here may not be used to describe funding for health activities specifically. Please refer to the Fiscal Year Obligations for USAID-funded Projects Related to Health table to determine funding attributed to health activities. Where project assistance completion dates are not available, the timeline reports the planned final year of funding for the project and notes this with **. Project activities may extend beyond this reported final year of funding.

The **Fiscal Year Obligations for USAID-funded Projects Related to Health** table does not include total project obligations; it includes only totals for health, child survival and HIV/AIDS activities. These funding totals are based on calculations of annual obligations reported in the USAID Congressional Presentation and on reported attributions for health activities. These attributions are reported through the annual USAID Health and Child Survival Project Questionnaires for Fiscal Year (FY) 1985-91, and the AC/SI System for FY 1992, with the exception of the Child Survival and Vitamin A grants as reported from FDC/PVC for all years. Reported obligations include all accounts except population account funds for FY 1985-91. Public Law 480 funding is not included in this report.

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- AID0000 Data for the timelines is a consolidation of data from: a) annual USAID Health and Child Survival Project Questionnaires, b) USAID Congressional Presentations (CPs), and c) the USAID Office of Private Voluntary Cooperation/Bureau for Food and Humanitarian Assistance.
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Peru



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Lambert Conformal Projection
Standard parallels 3°00' and 15°20'
Scale 1:10,000,000

— Railroad
- - - Road
↑ Airport

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