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DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PERU

PROGRAM TO STRENGTHEN HEALTH SERVICES

(PE-0030)

LOAN PROPOSAL

FEBRUARY 1993

PERU

PROGRAM TO STRENGTHEN HEALTH SERVICES

(PE-0030)

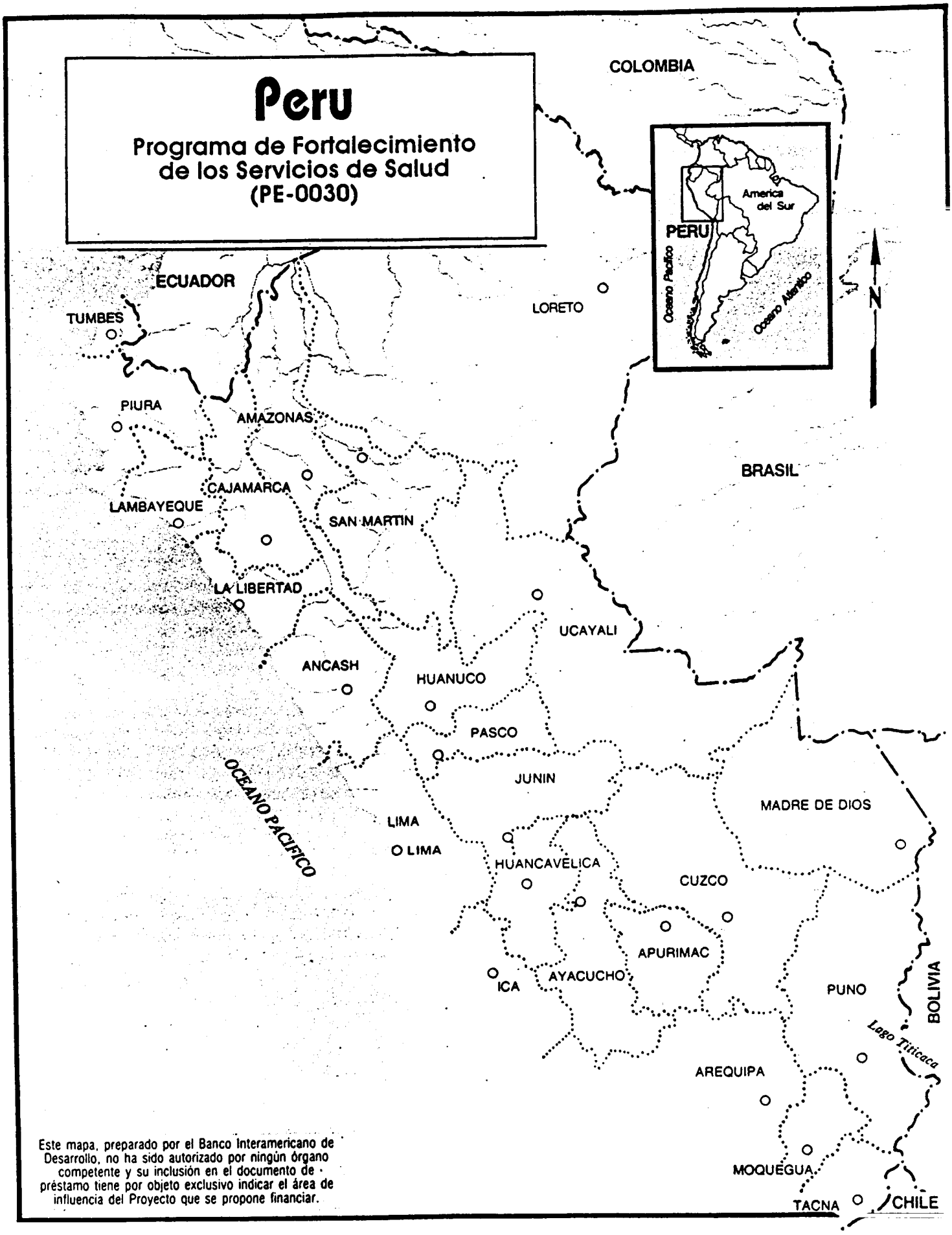
CONTENTS

LIST OF ANNEXES

LIST OF APPENDICES

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CEPIS	Pan American Center for Sanitary Engineering, a specialized center within PAHO/WHO, headquartered in Lima.
DRS	Subregional Health Directorates. These are decentralized bodies responsible for implementing the standards issued by the technical/administrative bodies, which regulate, supervise, monitor and promote health activities, coordinating the public and private sectors with the participation of the community, cooperating agencies and other sectors within their jurisdiction.
IPSS	Peruvian Social Security Administration. This is an autonomous entity with legal personality, entrusted with administering public health, pension and social benefits.
MINSA	Ministry of Health
NGO	Nongovernmental organizations, These are private non-profit institutions dedicated to health activities generally of a preventive or educational nature, as well as other social development activities at the local and community level.
OECF	Overseas Economic Cooperation Fund of Japan
PAHO/WHO	Pan American Health Organization/World Health Organization
PCU	Project Coordinating Unit. This is the unit especially established to coordinate execution of the program with the participation of the specialized bodies of MINSA.
UDES	Departmental Health Units. These are decentralized agencies of the Ministry of Health, which as of August 1992 were only operating in Lima and Callao. Now replaced by the Subregional Health Directorates in the process of being set up in Lima and Callao, established by Supreme Decree 002-92-SA of August 20, 1992.
UNDP	United Nations Development Program
USAID	United States Agency for International Development
UTES	Regional Health Units. These are bodies under the authority of UDES entrusted with coordinating the operation of health posts and centers in Lima and Callao until August of this year.
ZONADIS	Integral Health Development Zones. These are functionally integrated health establishments responsible for the promotion and protection of human and environmental health at the most basic level. Delineation, organization and implementation are the responsibility of the Subregional Health Directorates, which replaced the UDES.


Peru
Programa de Fortalecimiento de los Servicios de Salud (PE-0030)
COLOMBIA
ECUADOR
TUMBES
PIURA
AMAZONAS
LORETO
BRASIL
CAJAMARCA
LAMBAYEQUE
SAN MARTIN
LA LIBERTAD
UCAYALI
ANCASH
HUANUCO
PASCO
JUNIN
OCEANO PACIFICO
LIMA
LIMA
HUANCAVELICA
MADRE DE DIOS
CUZCO
APURIMAC
ICA
AYACUCHO
PUNO
BOLIVIA
Lago Titicaca
AREQUIPA
MOQUEGUA
TACNA
CHILE
PERU
America del Sur
Oceano Pacifico
Oceano Atlantico
N
Este mapa, preparado por el Banco Interamericano de Desarrollo, no ha sido autorizado por ningún órgano competente y su inclusión en el documento de préstamo tiene por objeto exclusivo indicar el área de influencia del Proyecto que se propone financiar.

PERU

Basic Socio-Economic Data
Statistics and Quantitative Analysis
Economic and Social Development Department

Executive Summary

Social Statistics

Land Area (Km2)	1992	1,280,219
Population (Thousands)	1992	22,454
Population (Average Annual Growth Rate)	1983-1992	2.2
Rural (Percent)	1992	28.8
Density (Population per Km2)	1992	17.5
Vital Statistics		
Crude Birth (Rate per 1,000 Population)	1990	30.3
Infant Mortality (Rate per 1,000 Live Births)	1990	69.3
Crude Death (Rate per 1,000 Population)	1990	8.3
Life Expectancy at Birth (Years)	1990	62.7
Illiteracy (Percent)	1990	14.9
Primary School Enrollment Ratio	1990	126.0

Economic Statistics

Market Exchange Rate (New Soles/US$)	11-1992	1.6
GDP per Capita (Average Annual Growth Rate)	1983-1992	-3.6
Labor Force (Thousands)	1990	7,138
Unemployment Rate (Percent)	1991	5.9
Consumer Prices (Twelve Month Variation)	1992	72.5
NF Public Sector Overall Balance (% of GDP)	1991	-2.2
Domestic Credit (% of GDP)	1991	4.2
Balance of Payments (Millions of US$)		
Current Account Balance	1992	-3,166
Trade Balance	1992	-625
Capital Account Balance	1992	3,610
Change in Reserves (- Increase)	1992	-444
Total External Debt (Millions of US$)	1991	20,030
Total Debt Service (Millions of US$)	1991	1,257
Debt to GDP Ratio (Percent)	1991	55.7
Debt Service Ratio (Percent)	1991	29.3

19 January 1993

PERU
Basic Socio-Economic Data

1. Exchange Rates

New Soles/US$, End of Period
Index 1980 = 100

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Market Rate	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	1.0
Real Effective Index	81.6	86.9	86.9	106.0	95.5	84.1	92.2	50.5	36.0	28.8

2. Prices

Average Annual Growth Rates in Percent

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Consumer Price Index	64.4	111.2	110.2	163.4	77.9	85.8	667.1	3398.7	7482.6	409.5
Wholesale Price Index	...	...	...	0.0	60.3	51.1	627.9	2510.3	6737.7	...

3. International Liquidity

Millions of US$

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Reserves	1750	1766	2031	2262	1866	1159	1098	1480	1769	3000
Reserves minus Gold	1350	1366	1631	1842	1407	646	511	808	1040	2443
Special Drawing Rights (SDRs)	33	1	22	...	...	...	...	...	...	...
Reserve Position in the IMF	...	...	...	...	...	...	...	...	...	...
Foreign Exchange	1317	1365	1608	1842	1407	646	511	808	1040	2443
Gold (National Valuation)	400	400	400	420	459	513	587	672	729	557

4. National Accounts

Millions of 1988 US$
1988 US$

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Gross Domestic Product	34074	29409	30719	31219	34750	38296	34849	30317	28904	29755
GDP Per Capita	1878	1584	1617	1608	1751	1890	1685	1436	1341	1353

Annual Growth Rates in Percent - Constant Prices

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
GDP Per Capita	-2.1	-14.6	2.5	0.0	6.9	6.2	-10.2	-13.5	-7.0	0.3
GDP by Type of Expenditure (MP)	0.2	-12.6	4.8	2.3	9.2	8.5	-8.3	-11.7	-5.1	2.4
Consumption	2.5	-8.8	1.0	2.3	13.3	9.3	-8.5	-16.0	-3.3	1.2
Gross Domestic Investment	-7.3	-38.8	-9.9	-11.1	32.8	28.1	-9.4	-32.5	3.0	19.8
Exports of Goods and Services	6.1	-10.3	9.1	4.4	-10.2	-7.3	-7.2	18.7	-5.2	-4.6
Imports of Goods and Services	2.2	-29.6	-18.2	-8.7	20.4	14.9	-9.0	-25.3	12.5	6.3
GDP by Sector of Origin (MP)										
Agriculture, Forestry and Fishing	3.0	-10.8	11.9	3.7	6.2	5.1	7.8	-4.8	-8.2	1.1
Mining and Quarrying	1.2	-9.8	4.8	4.3	-4.5	-3.0	-15.0	-4.9	-4.2	-3.9
Manufacturing	-1.2	-18.1	5.7	4.5	15.6	12.8	-11.2	-15.7	-6.9	5.8
Electricity, Gas and Water	8.2	-16.0	0.3	6.2	17.6	7.7	0.5	-1.3	0.4	9.6
Construction	2.0	-20.8	0.8	-10.5	21.4	17.7	-6.8	-14.7	3.2	-1.6
Wholesale and Retail Trade	0.0	-14.4	2.5	2.2	14.2	9.9	-11.0	-16.0	-4.1	5.9
Transport and Communications	-1.5	-7.1	0.5	2.8	8.4	10.0	-5.4	-9.4	-7.1	4.0
Financial Services	0.3	-13.9	0.3	3.6	3.9	8.0	-6.1	-12.8	4.3	2.8
Government	0.8	6.7	7.6	0.5	8.4	4.8	-9.0	-14.2	-8.3	-8.2
Other Services	-2.4	-11.4	7.1	-1.5	6.6	11.1	-16.5	-7.3	-9.3	4.8

PERU
Basic Socio-Economic Data

4. National Accounts (cont.)

Composition in Percent - Current Prices

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
GDP by Type of Expenditure (MP)										
Consumption	74.4	77.6	74.1	73.7	79.8	80.0	74.6	79.2	78.6	79.9
Gross Domestic Investment	31.3	23.5	22.2	21.6	22.4	22.8	26.1	20.7	20.4	22.3
Exports of Goods and Services	15.7	18.1	18.6	20.0	12.1	9.3	11.4	12.4	10.9	9.5
Imports of Goods and Services	21.4	19.2	14.9	15.3	14.3	12.1	12.2	12.3	9.8	11.7
GDP by Sector of Origin (MP)										
Agriculture, Forestry and Fishing	9.5	10.6	11.0	9.4	11.2	10.3	8.3	8.0	6.8	6.6
Mining and Quarrying	10.5	11.1	10.6	9.9	3.2	2.1	2.2	2.8	2.7	2.4
Manufacturing	18.3	18.3	19.9	24.3	24.2	23.4	29.8	25.3	27.5	25.0
Electricity, Gas and Water	1.1	0.8	1.1	1.2	1.0	0.9	0.5	0.4	0.6	0.6
Construction	8.9	6.7	6.6	7.1	7.6	7.9	9.0	7.8	7.6	8.6
Wholesale and Retail Trade	17.5	18.9	18.3	18.0	20.5	20.4	18.7	19.1	18.7	18.7
Transport and Communications	6.1	5.6	5.9	6.2	5.4	5.4	5.0	5.0	4.8	5.9
Financial Services	7.1	6.7	6.3	6.1	6.0	5.4	4.8	2.9	3.4	4.5
Government	8.7	9.3	8.9	8.1	9.1	10.4	7.6	8.3	6.7	2.7
Other Services	12.3	11.9	11.4	9.8	11.9	13.8	14.1	20.5	21.3	24.9

5. Non-Financial Public Sector

As a Percent of GDP

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Current Revenues	17.3*	16.6	18.0	19.5	15.9	13.3	10.9	9.0	9.9	9.2
Current Expenditures	17.1	18.8	17.4	17.4	16.6	17.0	15.7	14.3	13.7	9.5
Current Savings	0.1	-2.1	0.6	2.1	-0.7	-3.7	-4.7	-5.3	-3.9	-0.3
Capital Expenditure	8.6	8.6	8.1	6.3	5.8	4.9	3.7	4.4	2.4	2.3
Overall Balance (- Deficit)	-7.2	-9.8	-6.7	-3.4	-5.7	-7.9	-8.1	-8.5	-5.9	-2.2
Domestic Financing	1.1	4.2	2.1	-1.6	2.3	5.2	4.1	4.9	2.4	1.7

6. Monetary Survey

As a Percent of GDP

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Domestic Credit	14.0	13.7	17.0	12.8	9.3	11.0	3.7	3.5	1.5	4.2
Public Sector	3.7	3.9	7.4	4.5	2.0	3.9	1.6	1.0	0.8	1.0
Private Sector	10.3	9.8	9.6	8.3	7.4	7.2	2.2	2.5	0.8	3.2
Money (M1)	6.0	6.2	4.8	4.3	8.3	7.4	3.0	2.2	0.7	1.6

7. External Trade

Direction in Percent
Index 1980 = 100

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Exports of Goods (fob)										
Developed Countries	72.4	79.8	72.4	70.9	69.0	67.9	68.5	64.3	69.5	62.4
Developing Countries	27.6	20.2	27.6	29.1	31.0	32.1	31.5	35.7	30.5	37.6
Latin America	15.2	10.4	11.9	14.1	14.5	16.1	14.5	14.9	15.4	16.6
Imports of Goods (cif)										
Developed Countries	77.2	78.7	71.8	69.8	69.5	65.3	66.3	59.6	54.9	55.3
Developing Countries	22.8	21.3	28.2	30.2	30.5	34.7	33.7	40.4	45.1	44.7
Latin America	18.8	17.6	23.0	25.5	26.5	23.4	29.6	25.0	27.4	39.2
Terms of Trade Index	80.4	96.2	93.5	90.1	80.3	85.5	99.6	94.6	81.4	75.0

PERU
Basic Socio-Economic Data

7. External Trade (cont.)

Composition in Percent

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Exports of Goods (fob)										
All Food	12.3	13.1	17.6	16.9	27.9	23.1	25.6	26.4	21.2	...
Agricultural Raw Materials	4.8	4.7	4.2	4.7	5.4	3.9	3.9	4.6	3.3	...
Fuels	27.0	23.2	26.5	24.0	12.7	13.1	6.7	7.1	10.0	...
Ores and Metals	42.2	47.6	40.2	42.7	37.6	43.6	48.3	41.6	47.1	...
Manufactured Goods	13.7	11.5	11.5	11.8	16.4	16.4	15.5	20.3	18.2	..
Chemicals	1.6	1.1	1.3	1.2	1.9	2.4	2.4	2.8	2.2	..
Machinery and Transport Equipment	1.2	1.3	1.5	1.2	1.5	1.2	1.5	1.5	1.0	..
Other Manufactured Goods	10.9	9.0	8.7	9.4	13.0	12.8	11.5	16.0	15.1	..
Imports of Goods (cif)										
Capital Goods	30.3	28.3	24.2	25.2	22.9	27.1	20.1	23.3	...	..
Consumption Goods	15.3	15.3	13.4	10.8	17.3	15.6	12.8	13.6	...	...
Intermediate Goods	49.1	53.5	60.6	61.9	58.1	56.3	66.5	62.9	...	...
Fuels	...	...	...	...	...	...	...	...	...	..
Other	5.3	2.8	1.8	2.1	1.7	0.9	0.5	0.3	...	...

8. Balance of Payments

Millions of US$

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Current Account Balance	-1609	-872	-221	137	-1077	-1481	-1091	362	-949	-1871
Trade Balance	-428	293	1007	1172	-65	-521	-99	1197	340	-165
Exports of Goods (fob)	3293	3015	3147	2978	2531	2661	2691	3488	3231	3329
Imports of Goods (fob)	3721	2722	2140	1806	2596	3182	2790	2291	2891	3494
Service Balance	-1348	-1384	-1386	-1169	-1162	-1140	-1149	-1071	-1536	-2022
Freight and Insurance	-123	-70	-54	-4	-33	-98	-93	-25	-180	-291
Travel	46	19	27	35	4	-20	65	-55	-419	-618
Investment Income	-1034	-1130	-1165	-999	-819	-718	-773	-622	-688	-905
Other Services	-237	-203	-194	-201	-314	-304	-348	-369	-249	-208
Unrequited Transfers	167	219	158	134	150	180	157	236	247	316
Private	0	0	0	0	0	0	0	0	0	0
Official	167	219	158	134	150	180	157	155	...	
Capital Account Balance	1927	718	1037	347	736	867	1215	447	547	1525
Non-Monetary Sector	2206	663	1046	328	724	905	1199	419	572	1530
Private Sector	1221	-834	-403	-451	85	459	188	321	114	194
Direct Investment	48	38	-89	1	22	32	26	59	41	-7
Portfolio Investment	0	0	0	0	0	0	0	0	0	0
Other Long-Term	157	-85	-114	-124	-70	-160	-263	-198	-183	-14
Other Short-Term	1016	-787	-200	-328	133	587	425	460	256	215
Government Sector	985	1497	1449	779	639	446	1011	98	458	1336
Long-Term	931	1284	84	-496	-1139	-1098	-1034	-716	-828	-247
Short-Term	54	213	1365	1275	1778	1544	2045	814	1286	1583
Monetary Sector	-279	55	-9	19	12	-38	16	28	-25	-5
Long-Term	...	...	...	...	...	...	...	...	...	
Short-Term	-279	55	-9	19	12	-38	16	28	-25	-5
Change in Reserves (- Increase)	84	34	-250	-186	295	668	-10	-595	-284	-1376
Errors and Omissions	-402	120	-566	-298	45	-54	-114	-214	687	1722

PERU
Basic Socio-Economic Data

9. External Debt

Millions of US$
Ratios in Percent

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Total Debt	12305	12061	13099	14279	16154	18645	18998	19921	21105	20030
Long-Term Debt	8632	9828	10675	11681	12671	14166	13928	14258	14898	13925
Public and Publicly Guaranteed	6968	8249	9210	10339	11334	12733	12505	12669	13344	13313
Bilateral	2245	2566	2857	3437	3861	4476	4479	4632	4931	5050
Multilateral	837	985	1050	1343	1667	2137	2052	2031	2192	2198
Bond Holders	1	1	1	1	1	1	1	1	1	...
Banks	2244	2946	3607	3765	3871	3958	3914	3914	3968	3933
Suppliers	911	1075	1101	1240	1356	1524	1449	1478	1587	1512
Other Creditors	729	677	593	553	579	636	612	613	666	...
Private Non-Guaranteed	1664	1579	1465	1342	1337	1433	1423	1589	1554	612
Use of IMF Credit	650	698	675	702	728	845	801	758	755	691
Short-Term Debt	3024	1536	1750	1896	2754	3634	4269	4904	5453	5414
Interest Arrears on Debt	8	96	420	804	1461	2243	2878	3426	3873	...
Total Debt Service	2316	1511	1286	1184	839	435	237	311	474	1257
Public and Publicly Guaranteed	1522	761	625	680	534	321	123	198	237	....
Bilateral	404	208	157	262	173	79	46	124	132	239
Multilateral	89	111	134	160	220	156	66	66	51	159
Private Non-Guaranteed	330	354	385	291	133	15	15	20	45	...
IMF Repurchases and Charges	97	146	144	97	71	1	1	38	137	119
Short-Term Debt (Interest only)	367	249	132	117	102	98	99	55	55	55
Debt to GDP Ratio	47	50	50	51	51	52	55	60	67	56
Debt Service Ratio	55	39	32	30	24	12	6	7	11	29

... Not Available
0.0 Indicates that the amount is nil or negligible

PERU
Basic Socio-Economic Data

Sources and Notes

Executive Summary

Social Statistics:

Land Area: Organization of American States (OAS), América en Cifras 1974.

Population: IDB estimates based on data from Latin America Demographic Center (CELADE) and United Nations Population Division.

Vital Statistics:

World Bank, Social Indicators of Development - 1991-92 Edition and Economic Commission for Latin America and the Caribbean (ECLAC), Statistical Yearbook - 1991 Edition.

Economic Statistics:

Labor Force: World Bank, Social Indicators of Development - 1991-92 Edition.

Unemployment: Programa Regional del Empleo para América Latina y El Caribe (PREALC).

1. Exchange Rates:

International Monetary Fund (IMF), International Financial Statistics (IFS).

Real Effective Index: IDB estimates based on data from the Banco Central de Reserva del Perú.

2. Prices:

IMF, IFS.

3. International Liquidity:

IMF, IFS.

4. National Accounts:

GDP in 1988 US Dollars: IDB estimates.

GDP by Type of Expenditure and Sector of Origin: Instituto Nacional de Estadística and Banco Central de Reserva del Perú.

5. Non-Financial Public Sector:

Banco Central de Reserva del Perú and IMF.

6. Monetary Survey:

IMF, IFS (mid-year observations).

7. External Trade:

Trade by Direction: IMF, Direction of Trade Statistics (magnetic tapes).

Terms of Trade: ECLAC, Balance Preliminar de la Economía Latinoamericana, December 1991.

Export Composition: United Nations Statistical Division (UNSTAT) Commodity Trade (COMTRADE) Data Base; Exports include Re-Exports.

Import Composition: Banco Central de Reserva del Perú, Memoria Anual. Fuels include Crude Petroleum.

8. Balance of Payments:

Banco Central de Reserva del Perú and IMF, Balance of Payments Statistics (magnetic tapes).

9. External Debt:

World Bank, World Debt Tables (magnetic tapes).

PERU
OPERATIONS DEPARTMENT
OPS/IRO

IDB LOANS

APPROVED AS OF DECEMBER 31, 1992

	US$Thousand	Percentage
TOTAL APPROVED *	2,434,650	100.0%
DISBURSED	1,959,768	80.5%
CANCELLATIONS	451,220	18.5%
UNDISBURSED BALANCE	474,882	19.5%
PRINCIPAL COLLECTED	902,862	37.1%
APPROVED BY FUND		
ORDINARY CAPITAL	1,820,296	74.8%
FUND FOR SPECIAL OPERATIONS	393,133	16.1%
SOCIAL PROGRESS TRUST FUND	45,108	1.9%
VENEZUELAN TRUST FUND	175,453	7.2%
OTHER FUNDS	660	0.0%
APPROVED BY SECTOR		
AGRICULTURE AND FISHERY	437,201	18.0%
INDUSTRY AND MINING	412,879	17.0%
TOURISM AND MICROENTERPRISE	30,839	1.3%
ENERGY	190,658	7.8%
TRANSPORTATION AND COMMUNICATIONS	364,188	15.0%
EDUCATION SCIENCE AND TECHNOLOGY	9,028	0.4%
PUBLIC AND ENVIRONMENTAL HEALTH	88,065	3.6%
URBAN DEVELOPMENT	56,520	2.3%
PLANNING AND REFORM	659,025	27.1%
EXPORT FINANCING	176,756	7.3%
PREINVESTMENT AND OTHER	9,491	0.4%

* Net of cancellations with monetary adjustments and export financing loan collections.

PERU
OPERATIONS DEPARTMENT
OPS/IRO

TENTATIVE LENDING PROGRAM

1993		US$ Millions
STRENGTHENING OF HEALTH SERVICES PROGRAM		68.0
AGRICULTURAL SECTOR PROGRAM		116.0
REHABILITATION ELECTRIC SUBSECTOR		130.0
WATER AND SEWERAGE PROGRAM		42.0
	TOTAL	356.0
TOTAL PROGRAMMED		356.0
OTHER POSSIBLE PROJECTS		
MICROENTERPRISE CREDIT PROGRAM		10.0
MULTISECTORAL PREINVESTMENT PROGRAM		15.0
	TOTAL	25.0

PROGRAM TO STRENGTHEN HEALTH SERVICES

(PE-0030)

EXECUTIVE SUMMARY

BORROWER:	Republic of Peru	
EXECUTING AGENCY:	Ministry of Health (MINSA)	
TERMS AND CONDITIONS:	IDB:	US$68 million (OC)
	Local contribution:	US$10 million
	Cofinancing:	US$20 million
	Total:	US$98 million
TERMS AND CONDITIONS:	Amortization period:	25 years
	Disbursement period:	4 years
	Interest rate:	variable
	Inspection and supervision:	1%
	Credit fee:	0.75%

COFINANCING: The Overseas Economic Cooperation Fund (OECF) of Japan, under negotiation.

OBJECTIVES: The purpose of the program is to conduct studies and activities permitting the preparation of sector reform programs, taking into account the role of social security and the other public and private entities of the health sector; to strengthen the Ministry of Health, in its role as regulatory entity for the sector, and the regional entities, in their coordinating and regulatory capacities within their respective jurisdictions; and to conduct emergency activities producing an immediate improvement in the quantity and quality of basic preventative and curative care for low-income groups.

DESCRIPTION: The program would include three components that would interact with and complement one another:

a. **Institutional and preinvestment studies (US$12.3 million).** This component consists of the preparation of sector studies to serve as the basis for: (i) reorganizing the sector and making adjustments in sector policy in order to define a new structure and organization of the sector; (ii) laying the groundwork for structural reform of the sector; and (iii) preparing a short- and medium-term priority investment program.

b. Institutional strengthening of the Ministry of Health and of the decentralized bodies (US$11.1 million). This component would consist of the design and implementation of seven technical-administrative systems to strengthen critical areas of MINSA and of the corresponding decentralized health agencies in order to give them the capacity to provide better support for service-providing institutions within their jurisdictions. The systems are as follows: supervision and monitoring, supply of inputs, maintenance, communications, hospital waste management, information and human resource development.

c. Support for the network of establishments (US$57.5 million). This component would consist of financing for basic equipment, medicinal products and other inputs as well as the strengthening of management and training for health posts and centers and MINSA and regional general hospitals, grouped in networks of establishments. This financing would be provided through a health investment fund established especially for this purpose.

ENVIRONMENTAL CLASSIFICATION: The Environmental Management Committee, at its meeting of July 29, 1991, classified this as a Category II operation.

BENEFITS: The main benefits of the program would be as follows:

(1) It would generate the elements necessary for the introduction of sector policies and strategies in the context of regionalization, which would in turn make it possible to channel additional resources to the sector from other international financing sources more efficiently.

(2) It would help to consolidate the process of decentralization and strengthen the administrative capacity of the decentralized bodies and of the health establishments.

(3) It would help to increase the number and quality of skilled health human resources in the health care field through training that would be provided to strengthen MINSA, regional directorates and health establishments.

(4) It would improve the efficiency of health service establishments by promoting their incorporation in functional networks, and would at the same time improve local capacity for treating health problems.

(5) It would develop operating mechanisms to help investments and programs target specific population groups based on their demographic, socioeconomic or epidemiological characteristics.

(6) It would have a direct impact on low-income segments of the population which are served almost solely by the public health subsector to be addressed by the program. In addition, selection criteria would be established to restrict financing to networks located in the most depressed areas with the most adverse socioeconomic conditions. Low-income women and children, who are the main users of the public service, would benefit in particular.

RISKS:

The risks of the program are those inherent in the country's particular set of problems and adjustment processes. The design of the program incorporates measures to control many of the foreseeable risks, but a number remain:

(a) The difficulty of retaining qualified personnel given the extremely low salaries of the public sector. If this situation does not improve, the formation of a professional, stable and qualified public sector work force will be threatened. This problem could be alleviated by carrying out a plan to improve salaries and incentives so as to attract qualified personnel to the new functions, as provided for in the institutional and preinvestment studies component.

(b) Another risk pertains to inadequately defined lines of authority of the regional and municipal governments with respect to services, which could create obstacles to the adoption of decisions to formulate and submit requests for network support.

(c) Finally, despite the well-known good will of the Government of Japan in support of projects in Peru, and in particular the program proposed, there is a certain risk that the proposed amount of cofinancing will not be obtained, in which case the component affected would be network support, whose scale would be substantially reduced.

THE BANK'S COUNTRY STRATEGY:

The operating strategy for Peru for the period 1993-1994 gives priority to helping the country alleviate poverty and promote social progress by means of programs designed directly to improve the living conditions of low-income population groups. Other priority areas are: consolidation of the macroeconomic stabilization and structural reform programs;

strengthening of the country's institutional and preinvestment capacity; privatization of public enterprises and promotion of private sector growth; and rehabilitation of productive sectors and economic infrastructure.

SPECIAL ASPECTS:

(1) The objectives of the program, its design and execution, have been especially adapted to the circumstances currently prevailing in Peru, which are discussed in chapter I, "Frame of Reference". In this context, it is considered that the only means of providing a rapid response to the main problems besetting the sector is to address the most essential aspects first: laying the groundwork for efforts to reform and strengthen the sector; initiating the first stage of that process and introducing an emergency component to improve service in the poorest areas. In this regard, the institutional and preinvestment studies component will play a critical role by generating activities in key areas of the sector; the institutional strengthening component initiates the basic activities to consolidate both MINSA, as the sector's regulatory body, and the decentralized entities in their respective administrative jurisdictions; and the network support component is an emergency measure to avoid total collapse of the health services provided by public health establishments to the lowest-income segments of the population (see paragraphs 1.31-1.34).

(2) Although sufficient technical information has been obtained to begin program execution, the limited availability of resources in proportion to the needs existing in the networks necessitates a number of refinements in the numerical parameters for the allocation of equipment, particularly to hospitals. It is being proposed that these adjustments be made once program execution has begun, on the basis of the analysis of the first five requests from the networks, which would be examined jointly by the Bank and the Program Coordinating Unit (see paragraph 3.23).

(3) It is proposed that the program include from the outset the participation of two international agencies to advise the executing agency on the selection and supervision of consultants and on the public bidding process for the procurement of equipment, medicinal products and other basic inputs. This proposal is justified by MINSA's inadequate installed capacity to contend with the numerous and complex tasks to be performed in these fields.

One of these international agencies is the Pan American Health Organization (PAHO/WHO), which would advise MINSA on the selection and supervision of consulting firms and individual consultants to be hired for the program, as well as on the technical specifications of the equipment to be acquired. The other agency would be the United Nations Development Programme (UNDP), which would advise MINSA on the process for organizing international calls for bids and selecting bidders for the acquisition of equipment, medicinal products and other inputs. In addition, it is being proposed that PAHO/WHO conduct one of the experimental studies, that on water and food disinfection (see paragraphs 3.25-3.31).

I. FRAME OF REFERENCE

A. Introduction

1.1 The context within which the program to strengthen health services in Peru has been formulated and would be executed is characterized, at a sector level, by a worsening of health conditions, particularly among low-income groups, and a virtual collapse of health services and, more generally, by a crisis whose severity and duration is the most profound and prolonged in the country's history. It is an all-encompassing crisis manifested in economic, financial, political and institutional deterioration. The violence produced by terrorism accentuates the crisis and is in turn one of its most visible expressions. The government has been making efforts to overcome this situation, and three different but related processes are under way: macroeconomic adjustment, reform of the State and regionalization.

a. The macroeconomic adjustments began in mid-1990. These adjustments have been rapid and profound and consist essentially of a drastic economic stabilization program that includes strict control of public expenditure and a reorganization of the tax administration, as well as a series of reforms in key areas of commerce and finance designed to lay the groundwork for resumed economic growth.

b. Transformation of the State accelerated in 1992 with the aim of increasing the functional efficiency of the government. It entails a rescaling of the entire public sector and a redefinition of the State's role in the economy, in which, rather than act as a producer of goods and services, it would promote a policy framework favorable to greater participation by the private sector, including a process of privatization.

c. Rationalization of the process of national regionalization is designed to bring about decentralization, on an orderly basis, of the services provided by the central government. This process has been undertaken in pursuance of a constitutional mandate and entails a division of the country into 12 politically and administratively autonomous regions.

1.2 The virtual collapse of health services is a reflection of the national crisis, but also of chronic problems specific to the sector itself, such as: (i) a lack of coordination between the various health care establishments; (ii) institutional weaknesses at central and regional level, which hinder health care operations in the decentralized context; (iii) a lack of sufficient equipment, inputs and basic medicinal products in the health care establishments; and (iv) the financial problems of the country which are curtailing health care spending.

B. The government's policy and strategy in the health sector

1.3 The government's policy and strategy are designed to lay the groundwork for the construction of an integrated, regionalized national health care system in which the various public and private health institutions and establishments participate.

1.4 As a result of its experience over the past two years in implementing the regionalization scheme, the government has established a series of regulatory and coordinating mechanisms to ensure orderly regionalization of the health sector. Within this framework, priority has been given to: (i) defining the institutional operating framework, especially at regional level, where responsibility for providing services lies; (ii) coordinating the delivery of services at all levels; (iii) restoring the capacity of health establishments to provide services; and (iv) re-establishing national information flows in order to facilitate sectorwide planning and thus channel resources to the groups that need them most.

C. Health conditions in Peru and the most significant problems encountered in providing health care services

1. Health conditions

1.5 The average health indicators for the population (life expectancy at birth: 63 years; infant mortality rate: 69.3 per 1,000 live births; maternal mortality rate: 29.1 per 10,000 live births), do not truly reflect the situation within the lowest-income segments of the population. For example, in Huancavelica and Cuzco, which account for the largest proportion of this population, one out of every eight children dies before reaching the age of one year. In recent years, the high rates of infectious disease reflect the impoverishment of a considerable proportion of the population, combined with deterioration in the quality and quantity of health and sanitation services. The incidence of malaria increased fivefold between 1971 and 1989; yellow fever and dengue fever have become endemic; the prevalence of tuberculosis has doubled and there has been a resurgence of leishmaniasis.

1.6 Cholera, a disease not previously recorded in the country during this century, has since 1991 reappeared in the epidemiological profile. The speed at which the epidemic has spread and its proportions reveal grave deficiencies in the supply of water and basic food hygiene. (About 65% of the population does not have running water in the home, and even where they do, the water supply is unsafe because public health authorities do not systematically monitor its quality; in rural areas, approximately 95% of the population does not have access to safe water supplies.) Propagation of the epidemic has revealed the limited response capability of health establishments in the regions affected.

2. Organization of the health sector

1.7 Health services are provided by both public and private sector entities. The public health subsector consists of: (i) the Ministry of Health and its decentralized departments: the Departmental Health Units (UDES) and Regional Health Units (UTES), their posts, centers and hospitals located in Lima and Callao and centers specialized in research and training; (ii) institutions and establishments under the authority of regional governments; (iii) the Peruvian Social Security Administration (IPSS), an autonomous entity whose function is to administer health, pension and social services, to collect and administer the necessary resources and to provide curative and preventive services in its own establishments; (iv) the health care establishments of the armed forces and national police, which provide care to their active and retired personnel, as well as to the inhabitants of border areas and areas declared as emergency zones as a result of terrorism; (v) the health care establishments of State enterprises providing services to their personnel; and (vi) public decentralized agencies endowed with their own legal personality, which are administratively autonomous and conduct activities in research, training and the development of disease prevention technologies.

1.8 The private health subsector consists of profit-making institutions and nonprofit, nongovernmental organizations (NGOs), offering hospital-type services in clinics and in the private-sector equivalent of the health posts and centers. Centralized information is not available on the latter, but the number of such establishments is apparently marginal compared with those in the public sector.

1.9 The breakdown by subsector is as follows:

SUBSECTOR	HOSPITALS		CENTERS		POSTS	
	No.	% Beds	No.	%	No.	%
Public:	181	80.4	1,012	100.0	3,141	100.0
MINSA and regional governments	130	53.2	752	74.0	2,909	92.6
Social security	22	15.6	96	9.5	45	1.4
Armed forces, police and state corp.	14	8.8	74	7.3	72	2.3
Private:	187	19.6	n/d	n/d	n/d	n/d
TOTAL	368	100.0	1,012	100.0	3,141	100.0

1.10 The scope of action of the program proposed is the public subsector, and in particular, the establishments under the authority of MINSA in Lima and Callao and under that of the regional governments.

3. Main problems in the delivery of service

a. Lack of functional coordination between health establishments

1.11 The lack of coordination between the public and private institutions and between those of the IPSS, MINSA and the regions constitutes a serious problem that makes it difficult to increase efficiency in providing services. Although in the sphere of public establishments the concept of "network" exists and its functional interrelations have been defined, in practice coordination between them is very weak or almost nonexistent. This results in unnecessary duplication of services and consequently in less coverage.

b. Human resources

1.12 The visits and surveys conducted in four geographic areas of the country (Cajamarca, Loreto, Tumbes and North Lima), during preparation of the project, revealed a marked deficiency in trained human resources, and in particular administrative personnel, senior nurses and laboratory and radiology technicians. This situation is explained by: a drastic cutback in public sector employment, in line with the policy of downscaling the State; a severe reduction in the remuneration of existing employees in real terms; and deficient personnel management and deployment procedures. The combination of these factors has resulted in a loss of management capacity and inadequate coverage of management posts, which has seriously affected the delivery of health services.

c. Physical resources

1.13 The surveys indicated above also recorded critical gaps within MINSA and the regional establishments in basic equipment in reasonable condition (such as scales, examination tables, stethoscopes, anaesthetic equipment and electrocardiographs) and in pharmaceuticals and other medical inputs, reducing them to virtually nonoperational status. There is unused capacity in the public sector hospitals, which is a result of poor correlation between supply and demand and is manifested in: (i) the excessive scale of some hospitals; and/or (ii) under-utilization because of inadequate equipment, improper siting or insufficient financial resources. The situation is aggravated by a deteriorating physical infrastructure, old equipment and the absence of maintenance programs.

d. Administrative capacity of MINSA and the regional entities

1.14 The abrupt movement towards regionalization has not allowed time to develop administrative systems in areas critical to health care in the regions, and what does exist within MINSA poses serious problems:

a. There is no uniform system for the supervision and monitoring of activities.

b. The accounting and financial information produced within MINSA is too out-of-date and unreliable for purposes of decision-making since it has been assembled by different departments, each with its own system for collecting information.

c. Inputs are purchased without a thorough knowledge of the market, so procurement is planned without solid information on the products, suppliers, sources, substitute products, brands, quality and systems of marketing; there are also significant distortions in the process of storage.

d. In the case of maintenance, there is no clear definition of the functions and levels of responsibility that should be assumed by the central, regional and municipal authorities, so that in reality MINSA continues to carry out maintenance and repair services without a policy establishing clear criteria for the efficient use of available resources.

e. The national communications network, which coordinates the administrative and health care activities of MINSA and its departments, regional governments and health establishments, is limited in coverage and low in quality, and there is an excessive tendency to attend to administrative matters as opposed to the provision of medical assistance itself. Most of the equipment is within MINSA, and is in need of maintenance, standards and personnel qualified to operate it. The restrictions are still greater with regard to the transportation of personnel and patients.

f. Another serious problem concerns the disposal of waste produced by health establishments, which is deposited in open, unmonitored dumpsites. There are various reasons for this, and in particular: deficient systems for incineration; inadequate rules, methodologies and trained personnel for the internal handling and treatment of waste; and the lack of an efficient national hospital administration.

e. Adaptation to regionalization

1.15 Since 1987, Peru has undergone a political process of regionalization and decentralization of operations of the national government. Since the enactment of Law 23,878 (National Regionalization Plan) the country has entered a process in which powers and resources are being transferred to 12 regions.

1.16 The regionalization process is being implemented on the basis of the Basic Regionalization Law (Law 24,650 of March 20, 1987) and a law amending it (Law 24,792 of February 11, 1988), which regulate both the procedures for the creation of regions and their

functions, organizational structure, jurisdiction, and relations with all other governmental institutions. Using this legal framework as a base, 11 organic laws have been enacted establishing regions. The draft legislation creating the Lima/Callao region is now awaiting approval, and in the meantime, the central government continues to exercise responsibility for providing services in that area.

1.17 The regional governments, as decentralized political bodies, are empowered to take regulatory and executive decisions in a number of fields, such as health, housing, education, public works, etc., while the various ministries, as supervisory entities, are responsible for monitoring and supervision within a decentralized and deconcentrated system. In the financial area, the resources allocated to each region are divided into two categories: (i) discretionary resources, which may be used autonomously by the regional governments and which include income generated by their own services, revenues generated by regional taxes, shared income from the exploitation of natural resources, and donations; and (ii) resources transferred by development corporations, decentralized ministerial bodies and from the public sector budget, including funds from external borrowings and resources from the regional equalization fund, established for redistributional purposes.

1.18 Prior to regionalization, MINSA operated through decentralized bodies called Departmental Health Units (UDES), subdivided into Regional Health Units (UTES) which had jurisdiction within delineated geographical areas. Within this framework, the health establishments at national level came under the authority of MINSA. This hierarchical relationship still exists, on a temporary basis, in the Lima and Callao area pending enactment of the law defining it as a region.

1.19 Under the existing legal framework for regionalization, the regional governments and MINSA maintain policy and regulatory relations, with MINSA exercising responsibility for defining sector policy as well as issuing sector regulations. The regional government is responsible for carrying out the policy and adapting the corresponding sector regulations. With regard to services, the regions are responsible for providing second and third level services; hospitals thus come under the authority of the Regional Health Directorates (DRS) and health centers and posts would come under the authority of the municipalities. Technical, political and legal coordination of the regional health directorates with the ministry is provided by a national technical coordinating committee, and coordination of operations with the primary levels of service would be ensured in the so-called integrated health development zones (ZONADIS), whose structure would be based on the "network" concept.

1.20 The constitution endows the municipalities with economic and administrative autonomy and competence in all areas of development planning within their geographical jurisdictions and with regard to all local public services. Nonetheless, with respect to health services, the guidelines for implementation of this mandate still have not been issued, so these services remain under the authority of the regional governments, or under MINSA in the case of Lima and Callao.

1.21 The current difficulties have arisen because the regionalization process was instigated with no transition period during which the operational functions previously administered entirely by the central government could be transferred on an orderly basis. Many regional plans, administered centrally, were abruptly interrupted, leaving the institutions now assigned responsibility for those plans in complete disarray; an example is the regional maintenance program, under which regional workshops had been established which today are closed, so many institutions turn to MINSA for their maintenance activities. This situation has caused a problem in defining the relations between MINSA and the regional directorates, since while the general policy and regulatory relations are defined by law, the transitional operational relations are not, and it is in fact here that the most serious problems arise. The program proposed is designed to support the process of transition towards complete decentralization.

f. Sector financing

1.22 The level of total spending on health in Peru is among the lowest in Latin America. Total public spending on health was between US$7 and US$8 per capita in 1991 (1986 U.S. dollars). This figure includes spending by the central government, the IPSS, the military and police health services. Nonprofit services provided by enterprises, NGOs, religious establishments and other private sector entities are estimated at an additional US$1 or US$2, bringing the total value of health services provided to approximately US$8 to US$10 per person in 1991.

1.23 The current level of public health spending reflects a drastic reduction, necessitated by the fiscal crisis. By way of comparison, in 1987 the combined health spending of the central government and the IPSS amounted to US$27 per capita, and the level in 1980 was US$33. Although most of that reduction resulted from a decline in the real value of wages within the sector, it also reflects a drastic reduction in the real amount of materials, medicinal products, and professional time provided by the public health system to the population. Private spending on medicinal products and medical services was estimated by the national standard of living survey of 1991 at US$24 (half of the amount reported in 1985-86 by a similar survey). Total public and private health spending accounted for barely 1.3% of GDP in 1991, a figure well below that of other countries in the region and those recorded in Peru in previous years.

As a proportion of total spending by the central government, the health sector accounted for between 5% and 6% of the national budget during the past decade.

D. Conclusions drawn from the sector analysis

1.24 The following fundamental conclusions can be drawn from the analysis of current problems in the sector:

a. There is an urgent need to define financing policy for health services that is consistent with the current economic situation and the redefined role of the State.

b. A health human resources policy must be formulated that responds to the needs of the market and to the level and pace of scientific development, and which makes it possible to redistribute and make better use of the various categories of human resources and adapt existing personnel policies, conducting a comprehensive analysis of institutions and programs for the training and refresher training of professionals and technical personnel.

c. Health programs and investments must target the highest risk population groups and critical geographic areas.

d. MINSA, whose growing weakness prevents it from exercising its policy-setting and regulatory function, thus undermining coordination within the sector, must be strengthened.

e. The regional governments must be strengthened in order for them to conduct health programs and administer the establishments within the decentralized regionalization framework.

f. The treatment capabilities of public health establishments must be strengthened, especially in areas whose population depends almost entirely on the public sector for attention to their health needs.

E. Bank strategy in the social sectors

1.25 The Bank's operating strategy in Peru for 1993-1994 includes as one of its priorities activities to alleviate poverty and promote social progress. Priority with respect to investments is given to programs that directly improve living conditions for the poorest groups and meet the most urgent health, nutrition, education and sanitation needs.

1.26 The Bank's most recent experience in the sector was related to efforts to control the cholera epidemic, for which it granted non-reimbursable technical cooperation funding in the amount of US$1 million, with execution by the Pan American Health Organization (PAHO/WHO).

F. Participation of other international entities

1.27 The World Bank is developing a health and nutrition project focusing on specific programs such as maternal and child care and would provide direct support to health establishments in the areas of greatest poverty. This project is being coordinated with the proposed program, within MINSA as well as the IDB and World Bank project teams.

1.28 USAID is executing the following programs: infant survival, with funding in the amount of US$19 million, focusing on immunization, control of diarrhea and respiratory infections, family planning and nutrition; training in field epidemiology; expansion of family planning services in the private sector, executed by NGOs with funding in the amount of US$11.8 million; and prevention and education for the control of AIDS, with funding in the amount of US$500,000, with execution through an NGO. Two grants for the private sector are under negotiation: one in the amount of US$5 million to improve the provision of modern methods for family planning; the other, in the amount of US$15.33 million, with the private sector, for the development of cost recovery and alternative financing experiments for primary care.

1.29 The project team has held conversations on these programs with USAID in order to initiate the necessary coordination. For example, with regard to the private sector experiments, the proposed preinvestment studies would analyze the results of the experiments to be conducted by USAID with the private sector entities and would add other modalities and geographic areas covering public health care and social security institutions with participation from the private sector.

1.30 PAHO/WHO has been contributing its budgetary resources to the strengthening of specific health programs, such as immunization, control of diarrhea and communicable diseases, integrated maternal and child care, etc. At the request of MINSA, it administered social emergency resources in the amount of approximately US$4 million, largely intended for the control of cholera, as well as US$500,000 from the social emergency fund and US$4 million from various grants.

G. Conceptualization of the proposed program

1.31 The objectives, design and execution of the program have been especially conceived as the only means of responding rapidly to the virtual collapse of the health sector, in the midst of the severe economic and financial crisis and the institutional transformations occurring nationwide. In that context it is both urgent and feasible to implement a program that will lay the groundwork for reorganization and strengthening of the sector within the regionalized framework as well as improve the quality and quantity of health services available to the poorest segments of the population.

1.32 The operation has been conceived as a first stage in a process designed to increase the efficiency of the sector. The first step would be to conduct the studies necessary to evaluate the situation in the most critical areas of the sector, such as: (i) its structure and organization, including the public and private sector; (ii) financing of health services; (iii) problems in the area of human resources; and (iv) the physical infrastructure and other studies indispensable to establish the basis for a sector or hybrid operation. At the same time, strengthening of the basic administrative systems of the public health sector would be initiated. Other agencies, including USAID, have expressed substantial interest in supporting the sectoral change, and would be awaiting the results of the studies in order to support the government in this regard. While the studies are under way, work would be conducted to restore health care capacity in geographic areas where health needs are the most critical, through management support, training and the supply of equipment to establishments that have adequate staff, operating budgets, and physical space. The following stages of the preinvestment studies would permit the preparation of physical investment projects to rehabilitate the network of establishments in the areas selected.

1.33 One of the consequences of the weakness of the sector's institutional framework within which the program has been designed is the lack of reliable information on which to base the numerical criteria for quantifying the equipment to be allocated to the hospitals, as well as the scarcity of financial and human resources for obtaining it on a timely basis. The program was prepared on the basis of information obtained through surveys conducted in four geographic areas of the country for the purposes of the program, as well as reasonable estimates based on standardized equipment lists in the health posts and centers. This provided sufficient technical information to begin program execution. However, parameters for the evaluation of equipment requests within the network support component are required in order to optimize the allocation of equipment, particularly in the case of hospitals. In order to introduce these refinements, without causing delays in program startup, it is being proposed that such information be extrapolated from the first five requests from the networks, which would be evaluated jointly by the Bank and the PCU as explained in chapter III.

1.34 Measures have been introduced in the program to minimize the vulnerability of its execution given the institutional weakness of the entities involved and the instability caused by the processes of adjustment indicated above. These measures include the participation of two international agencies with field offices in Peru (PAHO/WHO and UNDP) to advise the executing agency with respect to contracting and supervision of the consulting services necessary for execution of the program, as well as in the acquisition of equipment, medicinal products and other inputs.

II. THE PROGRAM, ITS COST AND FINANCING

A. Objectives

2.1 The program has three fundamental purposes:

a. To conduct the studies and concrete activities necessary to lay the groundwork for the implementation of sector reform programs taking into account the role of social security and of the other entities providing public and private health services.

b. To strengthen the Ministry of Health as policy-setting and regulatory authority for the sector, as well as the decentralized bodies as coordinating and regulatory bodies within the jurisdictions.

c. To create the minimum conditions necessary to satisfy the most urgent needs for public health care in the most depressed areas by strengthening the management capacity of the establishments and providing the basic equipment necessary to restore their capacity to deliver priority health care services.

B. Description

2.2 In order to accomplish its objectives, the program would include three components: institutional and preinvestment studies, institutional strengthening of the Ministry of Health (MINSA) and of the regional directorates of health, and support for the network of establishments. 1/

2.3 The three components of the program would be complementary and would be interrelated in such a way that the institutional and preinvestment studies would play a critical role in generating activities in key areas of the sector; the institutional strengthening component would initiate the main activities necessary to consolidate MINSA, as regulatory body for the sector, and the regional entities within their respective administrative jurisdictions; the network support would be an emergency component designed to rapidly improve the quantity and quality of health services offered by public establishments in the areas of greatest poverty.

1/ The networks are groups of posts, centers and hospitals in which clients may be referred from one treatment facility to a more advanced one in the chain, which offer services in a determined geographical area. The operational interrelationships between the establishments of each network would be strengthened as a result of program execution and would be improved on the basis of the findings of the institutional and preinvestment studies.

1. Institutional and preinvestment studies (US$12.3 million)

2.4 The purpose of this component would be to conduct studies which would serve as the basis for: (i) reorganizing the sector and making adjustments in sector policy in order to define a new structure and organization of the sector; (ii) laying the groundwork for structural reform of the sector; and (iii) preparation of a priority short- and medium-term investment program.

2.5 In order to ensure the validity and usefulness of the studies within the changing context of national reforms now being introduced in the country, it has been decided that this component would be implemented in coordination with MINSA and the Ministry of Economy and Finance, by the interinstitutional committee to be set up for the purpose (see resolution), which in turn would consult with other appropriate entities in the sector. For the same reason the approval of the Bank would be obtained at each stage of the studies so that any necessary adjustments could be made in the terms of reference to ensure the usefulness of the studies for the purposes defined in the program (Recommendations).

a. Basic studies for sector reform

(i) Institutional and general studies of the sector

2.6 Within this subcomponent, an analysis of the health sector would be conducted to permit the government:

a. To define a new structure and organization of the sector and strengthen the areas of planning and intrasectoral coordination with a view to creating a harmonious and efficient health care system, experimenting with new approaches to coordination between the public and private sectors in order to optimize the resources of society as a whole.

b. To analyze spending on public and private health care services with a view to identifying, testing and evaluating the viability of new forms of financing services and agreements between public health care and social security institutions on the one hand and private sector institutions on the other.

c. To understand the problems associated with the training, distribution and use of health human resources nationwide and of personnel policies of public health institutions. The findings of these studies would make it possible to improve the efficiency of human resource policies and to design new incentive schemes, and thus to reduce the size of MINSA and other public service personnel while improving the incentives for retaining essential personnel through reasonable salaries.

d. To prepare infrastructure development policies and programs, to formulate and implement methodologies and diagnostic systems

permitting resources, programs and investments to be targeted towards specific population groups (such as the most needy) and towards geographic areas selected according to socioeconomic, demographic and epidemiological criteria.

2.7 Among the main results of these studies, the following are particularly noteworthy: (i) elements for a matrix of sector policy reforms; (ii) definition of financing alternatives for the sector; (iii) inventory of physical resources and a map of health services; (iv) demographic and epidemiological maps; (v) studies of service needs, supply and demand; (vi) identification of geographic areas to be given investment priority; (vii) consolidation of the new organizational structure of MINSA; and (viii) identification of programs for greater participation by women in the fields of health, illness and nutrition.

(ii) Experimental studies on integration with the private sector

2.8 Within the context of support for future sector reforms, the objective of these studies would be to generate empirical data on the possibilities for coordination between the public health and social security sector and private entities for the integrated operation of health services in the most disadvantaged areas, by means of functional coordination mechanisms, agreements on resource use and others; in order to improve the efficiency of health service networks. To this end, the following would be conducted:

a. An evaluation of existing cases of participation by public and private institutions in the management of establishments and the delivery of health services, with a view to verifying the viability of implementing the solutions at regional or national levels.

b. The design and implementation of new approaches to participation by the private sector in the management of public establishments and the evaluation of financing alternatives for these services, involving the community in the planning, execution and evaluation of these services.

2.9 The objective of the experiments would be to test the following hypotheses: (i) it is feasible to contract or transfer to the private sector, fully or partially, specialized end activities, such as tomography and echography; general technical support, such as laboratory, radiology, pharmaceutical and pathological anatomy services; general support, such as food service, laundry, sterilization, cleaning and security; and administrative services, such as accounting, statistics and personnel; and (ii) it is advantageous to turn over some establishments to private sector operation, within defined frameworks for the provision of selected preventive services (free of charge) and curative services (for a fee).

b. Technical and preinvestment studies for the preparation of investment programs

(i) Prefeasibility studies

2.10 Based on the information obtained from the general studies mentioned above, and the empirical data resulting from the experiments on integration with the private sector, the prefeasibility studies would permit analysis of the alternatives for combining public and private resources in order to successfully treat a greater proportion of the health problems in priority geographic areas.

2.11 In the geographic areas selected for investment priority, functional networks would be developed according to demographic and epidemiological criteria and the availability of transport facilities, with the aim of improving local treatment capabilities. Efforts would be made to expand the basic concept of networks of increasing complexity, which were regulated in the form of UTES.

(ii) Feasibility studies

2.12 The aim of this phase would be to demonstrate that each of the alternative solutions for public and private investment, selected on the basis of prefeasibility studies, is viable from the institutional, financial, technical and socioeconomic standpoint. The feasibility studies would include, at the minimum, the following aspects: (i) demonstration that the solution chosen is the least-cost option, in terms of investment, operation and maintenance; (ii) demonstration that the solution chosen is legally viable and that the institutions involved (regional, subregional, municipal, private sector, social security) would agree to participate with defined roles; (iii) confirmation that the human and financial resources exist to carry it out; (iv) an assessment of its impact on low-income segments of the population; (v) assessment of its impact on women; and (vi) assessment of its environmental impact.

(iii) Preparation of designs

2.13 The program would include the preparation of designs necessary to determine the general plan of operation of the establishment and its internal relations and links with the community, the functional structure of the working units, technologies, the human resources necessary, the placement of large equipment and the cost of engineering and construction. It would include: (i) medical and functional programming according to the specific roles and the estimated demand for each establishment to be included in an investment program; (ii) medical and architectural planning of space and surface area according to the medical and functional programming, equipment, personnel and number and type of patients expected in each location; (iii) schematic designs for each functional center; (iv) preliminary architectural designs incorporating all physical works, earthquake provisions in earthquake-prone

areas; and (v) calculation of the preliminary costs of the investments.

(iv) Water and food disinfection experiment

2.14 The purpose of this study, which would be conducted in several communities, would be to confirm the feasibility of simple solutions for the supply and domestic storage of drinking water in low income areas, through the generation of oxidants in marginal urban and rural communities, using simple technology whose effectiveness and efficiency has been confirmed in experiments on a smaller scale in laboratories, small communities and military bases. If use of the technology by community organizations proves reliable, it would contribute greatly to the reduction of intestinal diseases, by interrupting the chain of infection by water- and foodborne vectors.

2.15 The experimental studies would attempt to confirm that: (i) it is feasible to produce at the point of use and at low cost, a mixture of disinfectants through electrolysis of sodium chloride, which improves the taste, odor and color of water, making it more palatable than that obtained through chlorination; (ii) the use of specially designed water containers could prevent the contamination of disinfected water and thus significantly reduce outbreaks of cholera and other diseases that are transmitted through excreta and water; (iii) the disinfection and storage of water in household containers is an economic, acceptable, practical and sustainable solution which yields immediate epidemiological results; and (iv) the organization of community cooperatives for the production and distribution of the mixture of oxidants for domestic use is feasible.

2. Institutional strengthening (US$11.1 million)

2.16 To improve the sector's functioning, aside from the policy changes, it is necessary to strengthen MINSA's regulatory functions and redesign the critical administrative subsystems and transfer them to the decentralized bodies and to the health establishments.

2.17 For the purpose indicated above, the institutional strengthening component would include the design and introduction of seven technical-administrative systems that would strengthen areas identified as critical because, as a result of the abrupt regionalization, these systems, which were centralized, were not properly transferred, and indeed were impaired by the disorderly decentralization. The systems concerned are supervision and monitoring, the procurement of critical inputs, maintenance, communications, hospital waste management, information and human resource training.

2.18 In order to perform its role as policy-setting and regulatory agency, MINSA needs to develop rules and policies, especially in the seven areas indicated. These would be developed and

implemented initially within the ministry and, as they are developed, would be implemented in the regional health subdirectorates. Similarly, some of the systems, or parts of them, would be adapted and introduced into the hospitals where they are needed. The component would permit the establishment of systems as well as the corresponding regulatory guidelines.

a. Supervision and monitoring system

2.19 The purpose of this system would be to ensure that all health care services delivered by institutions in the sector are conducted effectively and efficiently at all treatment levels. The system would include activities in the following fields: trends in health indicators; the management of epidemic outbreaks; priority health programs; public and private institutions and establishments; professional practice in the area of health; production, marketing and use of food, drugs and other medicinal products; research and training, and health insurance. With program resources the following activities would be conducted: (i) diagnosis of supervision, monitoring and epidemiological and health control activities; (ii) formulation of policies, rules and procedures for supervision and monitoring; and (iii) strengthening of the central and the regional epidemiological and health monitoring bodies.

b. System of procurement of critical inputs

2.20 The objective of this system would be to offer timely information to health institutions and establishments with respect to the acquisition, distribution, use and control of medicinal products and other basic inputs. The following activities would be conducted: (i) design of a computerized information system for technical and administrative decision-making in areas falling under the jurisdiction of MINSA, and the gradual transfer of technical expertise to the regions so that they can support their own procurement processes; (ii) adaptation of the rules and procedures concerning the supply of inputs according to the programming of goods and services, acquisitions, storage, distribution, final disposal and property management; (iii) restructuring of the organization, functions and responsibilities of procurement offices within MINSA and the basic outline of a model for the regions and municipalities; (iv) formulation of a human resource development and training plan according to occupational levels and its execution at the central level; and (v) design, testing, startup and implementation of organized logistical systems at the national level.

c. Maintenance system

2.21 It is proposed to offer information and technical advice to health institutions and establishments in connection with policies, standards, procedures, and health equipment and building maintenance resources and firms. To this end, the following will be prepared:

(i) a diagnosis of maintenance at the national level, including the functional condition of the maintenance equipment within the network in order to permit its transfer to areas requiring the service; (ii) an operating plan and regulations concerning the organization, functions and responsibilities of the maintenance system, at its various levels, in coordination with the regional governments; (iii) a manual containing rules and technical instructions for operating the maintenance system at its various levels, in coordination with the regional governments; and (iv) a maintenance training plan for use by the regions and health establishments, and initial implementation. In addition, a maintenance technical reference and information center would be established with data on companies offering maintenance services, as well as an inventory of existing equipment; and the organization of the regional maintenance technical centers would be defined.

d. Communications system

2.22 The objective would be to integrate the communications media of public health institutions and establishments by means of a radio and telecommunications network that would permit the rapid, timely and confidential flow of health data and information. The activities to be conducted for this purpose would be: (i) an analysis of the situation and recommendations with respect to the necessary strengthening measures; (ii) preparation of regional plans for horizontal and vertical integration; and (iii) supervision and technical assistance for the regions during the implementation stage.

e. Hospital waste management system

2.23 The purpose of this system would be to reduce or control occupational, community and environmental health risks associated with the handling of potentially hazardous substances and solid and liquid waste from hospital establishments. The following activities would be conducted to accomplish this purpose: (i) a diagnosis of current waste management and methodologies for internal management and treatment of waste; (ii) modern methods for the transport, external processing and final disposal of the waste; (iii) regulations taking into account the levels of risk for persons and the environment; (iv) training of professionals and technical personnel at the national, regional and local levels; (v) preparation of studies on alternatives, design and implementation of measures and systems for final disposal of waste from hospitals and health posts and centers and training of existing personnel; and (vi) extension seminars.

f. Health information system

2.24 The objective here would be to integrate the information concerning health programs, institutions and establishments with a view to ensuring the availability of the specific data and information

required by decision-makers. To that end, the following activities would be conducted: (i) a diagnosis of the situation and study of alternatives; (ii) development and implementation of a mixed system (manual and automated) of data for monitoring and decision-making in the policy, administrative and technical areas; (iii) training of technical personnel and users; (iv) determination of infrastructure and data processing needs; and (v) development of a standardized information system.

g. Health manpower system

2.25 The objective of this system would be to establish policies and standards for increasing the efficiency of training and the use of health care personnel. The activities for strengthening the Public Health School of MINSA and the regional agencies would be financed, including: (i) the design and implementation of a system of information on the training and use of health professionals, middle-level technicians and auxiliaries; (ii) the training of professionals in methodologies for occupational analysis and instruction; and (iii) the preparation of a human resource policy and career plan for civil servants.

3. Network support (US$57.5 million)

2.26 Network support would consist of the financing of projects through a Health Investment Fund for the strengthening of health posts and centers and general hospitals of MINSA and the regions, grouped in networks of establishments and located in priority areas. This would be accomplished by providing basic equipment, medicinal products and other inputs, strengthening management, and training. In the eligible networks technical assistance would be provided in connection with the preparation of applications. The expected result of this component would be an immediate improvement in the quantity and quality of basic preventative and curative care in these priority areas. Investments in physical rehabilitation are not included since the optimum configuration of the networks still has not been determined.

a. Basic equipment, medicinal products and other inputs

2.27 The type of equipment that the program would provide would vary according to the complexity of the different establishments, as indicated in the following paragraphs, and would essentially be used for replacement. A common condition is that the equipment must not require special installation or construction for its use and must be easily transportable from one establishment to another.

a. The health centers and posts without beds would be provided with the equipment necessary to attain operational capacity required to meet demand for the services it is to provide. Examples of such equipment include: stethoscopes,

sphygmomanometers, anthropometric scales, medical instruments, refrigerators, furniture and file cabinets.

b. The more complex health centers (with beds and emergency, technical support, diagnostic or therapeutic services), would be provided with equipment and resources for image diagnosis, sterilization and laboratory service, so that in addition to improving their operating capacity, they can serve as referral centers. Equipment would be provided for first aid services, outpatient consultations, basic laboratory service, hospitalization for the four basic specialties (internal medicine, general surgery, pediatrics and gynecology/obstetrics), delivery rooms and beds for patient observation and stabilization.

c. The general hospitals would be provided with the following basic equipment for the centers indicated: (i) surgical center: operating tables and auxiliary equipment, lamps, equipment for anesthesiology, surgical instruments and nursing and administration materials; (ii) intensive care: vital signs monitors, resuscitators and nursing equipment; (iii) obstetrics and neonatology centers: delivery beds, surgical and obstetrics instruments, incubators and cribs, anesthesiology machines; (iv) emergency services: resuscitator, electrocardiograph, surgical equipment; (v) outpatient consultation service: furniture, anthropometric scales, examination tables, stethoscopes, sphygmomanometers and others; (vi) inpatient units: beds, stretchers, wheelchairs; (vii) radiology centers: x-ray equipment, film processors or darkroom equipment, echographs, negatoscopes, fluoroscopes and basic radiological instruments; (viii) laboratory: parasitological, hematological and biochemical testing apparatus and other basic instruments and (ix) sterilization centers: autoclaves, dry heat sterilizers, work tables, sterilization cartridges and others. Also to be furnished are equipment for inpatient care and administration, radio and telecommunications equipment, equipment for nursing posts and, on a selective basis, ambulances and other means of transport and systems of communication in order to interconnect establishments in the network.

2.28 With regard to medicinal products and other inputs, the program would include additional starting resources necessary to begin use of the replacement equipment in the networks of establishments covered by the program.

b. Support for administration of the establishments

2.29 Management support would consist of designing and implementing simple management systems in order to strengthen the basic administrative capacity and institute functional coordination with the other establishments in the network, guarantee the availability of critical resources and identify forms in which the community can participate in management. In this subcomponent, use would be made

of the systems developed within the institutional strengthening component.

c. Training

2.30 This subcomponent would be designed to improve the level of qualifications and expertise of professionals and technical personnel at the local level for the purpose of achieving efficient operation of the network of establishments in each spatial unit and strengthening each establishment within the network. It would include training activities in the technical, administrative and support service areas.

C. Scaling

2.31 The scaling of the institutional strengthening component was based on the activities identified in each of the seven systems to be developed and the resources needed to do so. The scaling of the institutional studies component was based on the studies and experiments identified in this component and the resources required to carry it out.

2.32 The scaling of the network support component was based on analysis of the country's existing networks, identifying 76 networks of establishments whose characteristics were obtained from an analysis of a survey conducted in four representative areas of the country: Tumbes, Cajamarca, Loreto and North Lima. The concept of network used defines the existence of a lead hospital to which the health centers and posts would refer clients.

2.33 Nationwide, the current situation of the equipment in the networks is one of virtual collapse, so the initially efforts would be made to provide basic equipment to all of the networks at an estimated cost of US$175 million. Taking into consideration the financial implications, the component size was adopted on the basis of two criteria: (i) degree of deterioration of the health indicators; and (ii) very underdeveloped and low-income areas. Using these criteria, 46 potential networks were identified with an estimated cost of US$110 million. However, because of the inadequate human resources within MINSA as well as the regions, a more conservative alternative was proposed based on the time required for preparation, approval and establishment of the networks, so it was concluded that it would be feasible to implement only half of the priority networks. Consequently, the size proposed for the network support component is 23 networks with an estimated cost of US$57.5 million, which would permit coverage of approximately 1,034 health posts (33% of existing posts), 218 health centers (21%) and 38 hospitals (10%).

D. Cost and financing of the program

1. Costs by investment category

2.34 The cost of the program would amount to US$98 million, distributed among the investment categories shown in the following table (see Annex I-2, Breakdown of Direct Costs):

STRENGTHENING OF HEALTH SERVICES IN PERU
TOTAL COSTS IN THOUSANDS OF US$

Categories	IDB	COFIN.	Local	Total	% Total
1. Administration	700	0	1,000	1,700	1.7
2. Direct costs	55,177	20,000	5,700	80,877	82.5
2.1 Projects	37,500	20,000	0	57,500	58.7
2.2 Institutional strengthening	6,100	0	5,000	11,100	11.3
2.2.1 Consulting services	4,600	0	5,000	9,600	9.8
2.2.2 Equipment	1,500	0	0	1,500	1.5
2.3 Preinvestment	11,577	0	700	12,277	12.5
3. Associated costs	1,629	0	680	2,309	2.4
3.1 International agencies	1,629	0	0	1,629	1.7
3.2 Incremental personnel	0	0	186	186	0.2
3.3 Supplies	0	0	396	396	0.4
3.4 Maintenance	0	0	98	98	0.1
4. Unallocated	305	0	199	504	0.5
4.1 Contingencies	305	0	199	504	0.5
5. Financial costs	10,189	0	2,421	12,610	12.9
5.1 Interest	9,509	0	1,426	10,935	11.2
5.2 Credit fee	0	0	995	995	1.0
5.3 Inspection and supervision	680	0	0	680	0.7
TOTAL	68,000	20,000	10,000	98,000	100.0
% Fund/Project	70%	20%	10%	100%	

2. Description of the investment categories

a. Administration (1.7%)

2.35 This category includes the costs of administering the program through the coordinating unit, for the purposes of program management at national level as well as support for the participating institutions. The costs, including salaries and fees, were estimated on the basis of prevailing levels in the country for local technical personnel.

b. Direct costs (82.5%)

2.36 The item Projects (58.7%) corresponds to resources allocated to the Health Investment Fund, and the amount was estimated on the basis of needs identified in the institutions participating in the four networks surveyed. The costs were estimated on the basis of the scale established for the network support component. Recurrent costs were not estimated for this component, since, as a "global program", these would be established in each of the requests presented to the Fund.

2.37 The item Preinvestment (12.5%) includes consulting services for the preinvestment studies. The costs, largely for consulting firms, have been estimated on the basis of prevailing local and international rates.

2.38 The item Institutional strengthening (11.3%) includes outlays for consulting services (9.8%) as well as equipment (1.5%) to develop and implement the seven systems under consideration. The related costs were estimated on the basis of activities planned for each system and in accordance with the prevailing consulting rates, local as well as international.

c. Associated costs (2.4%)

2.39 These costs correspond to: (i) the estimated cost of participation by international agencies, consisting of the cost of advisory services provided by PAHO/WHO, calculated on the basis of international consulting rates plus a 13% overhead for the agency; and the cost of procurement management by UNDP, estimated at 2% of the value of the equipment purchased; and (ii) the incremental operating costs that the institutional strengthening component would generate. The item "incremental personnel" refers basically to the technical personnel in the areas of institutional strengthening that would have to be hired as the units of each participating entity are provided with the systems being developed, as well as the additional technical personnel that would be required by MINSA's data processing system once it has been fully installed. Also included are the cost of supplies (diskettes, paper, printer ribbons, etc.) that the new systems and procedures, especially the automated ones, would require, and the estimated cost of maintaining the equipment to be acquired with program resources in good condition.

d. Unallocated (0.5%)

2.40 This category corresponds to contingencies in the institutional strengthening component only, since contingencies as well as cost escalation have already been included in the total for projects, which is all-inclusive.

e. Financial costs (12.9%)

2.41 The financial costs consist of interest, the credit fee and the inspection and supervision fee. They were estimated for the four-year period of execution in accordance with the conditions that would be established for the Bank's loan.

E. Financing

1. IDB financing

2.42 The Bank's financing would amount to US$68 million in foreign exchange from the ordinary capital. This amount would represent 70% of the total program cost, which is consistent with the limits provided for in document AB-1378 for project financing in Group B countries (60%) and up to 10% additional (also permitted by the aforementioned document) because more than 50% of the beneficiaries of the program would be from low income groups.

2.43 The financing conditions would be as follows:

Amortization period:	25 years
Disbursement period:	4 years
Interest rate:	variable
Inspection and supervision:	1%
Credit fee:	0.75%

2. Local counterpart

2.44 The program counterpart would amount to a total of US$30 million. In view of the country's economic and financial situation – and in particular its fiscal situation which, although it has improved considerably in recent years, continues to be precarious – the government would obtain cofinancing resources in the amount of US$20 million and is holding conversations with the Japanese government to obtain a soft loan from the Overseas Economic Cooperation Fund for this purpose. In addition, the Andean Development Corporation and Spanish government have expressed interest in cofinancing the program. The country would provide US$10 million from its own budget, which it is considered able to do on a timely basis and without difficulty.

III. PROGRAM EXECUTION

A. General aspects of program execution

1. General framework

3.1 The borrower would be the Republic of Peru. The executing agency would be the Ministry of Health (MINSA), which would implement all program activities through its existing technical units and through a program coordinating unit (PCU) set up for this purpose and situated within the ministry.

3.2 The borrower would place the proceeds of the financing in a special account that would be established for the purposes of the program (see Resolution).

2. Program coordination

3.3 The responsibility for executing the subcomponents of the program within MINSA would be assumed by the following units:

COMPONENT/SUBCOMPONENT	RESPONSIBLE UNIT WITHIN MINSA
1. Institutional and preinvestment studies	General Planning Office
2. Institutional strengthening	
Supervision and monitoring	General Directorate of Human Health (DGSP)
Procurement of inputs	Office of Logistics
Maintenance	Directorate of Equipment Rehabilitation and Maintenance
Communications	Subdirectorate of Communications
Hospital waste management	General Directorate of Environmental Health
Information	Directorate of Data Processing
Human Resources	School of Public Health
3. Support for the network of establishments	DGSP

3.4 The PCU would be entrusted with coordinating program execution with the participating institutions. The PCU would also be responsible for the operational side of the Health Investment Fund (the "Fund") of the network support component.

3.5 The PCU would be managed by a director, who would assume responsibility for execution and monitoring of the program and would come under the authority of MINSA. The director would be aided by two assistant directors, one responsible for administrative aspects and

the other for technical aspects. The assistant director for administrative affairs would oversee six persons: one specialist in public bidding and procurement and another in charge of program accounting; an assistant in charge of reports and general record-keeping for the program, and three administrative support staff members. The assistant director for technical aspects would oversee four specialists whose responsibilities would be to evaluate the financing request presented to the Fund, as well as to provide technical assistance to the requestors. Their respective fields of specialization would be: medical equipment, data processing, administrative management and training. (See Annex II-3, Organizational structure and Operating Budget of the PCV.)

3.6 The function of the PCU would be: (i) to coordinate program activities in order to ensure their implementation on an integrated basis; (ii) to advise MINSA technical units, regions, municipalities and establishments on the formulation of requests to be submitted to the Fund, for which it would be provided with resources to engage the necessary consulting services; (iii) to coordinate the acquisition of equipment; (iv) to maintain the financial records and accounts of the program, prepare reimbursement requests and draw up reports to be agreed upon with the Bank; and (v) to prepare evaluations of requests submitted to the Fund by the networks.

3.7 External coordination would be the responsibility of an Inter-institutional Coordination Committee, composed of representatives of MINSA and the Ministry of Economy and Finance, whose function would be to ensure that the institutional and preinvestment studies: (a) will provide an effective basis for decision-making with regard to institutional reforms and sector policies; and (b) are compatible with the institutional and policy adjustments and reforms being implemented at national level (see Resolution).

3.8 Internal coordination would be assured by a committee composed of the manager of the PCU, the administrative specialist, the technical specialists and, depending on the case under analysis, the officer responsible for a specific component, subcomponent or activity. This committee would serve as a functional link responsible for gathering and coordinating program resources.

3.9 Establishment of the PCU, including the hiring of its director, assistant directors and other personnel needed to begin operations, and the composition and final terms of reference of the Inter-institutional Coordination Committee would be completed prior to the first disbursement of the Bank loan (see Resolution).

B. Execution of the program components

3.10 In order to ensure timely program startup, once the Bank loan has been declared eligible for disbursement, and within a period of no more than three months, the Bank, with the participation of the

project team and in cooperation with the officers responsible for executing the program within MINSA, would conduct a technical mission to carry out all technical, methodological and financial activities required for program start-up (see Appendix III of the contract).

1. Institutional and preinvestment studies

3.11 This component would be executed on behalf of MINSA's General Planning Office by three consulting firms hired to carry out respectively the basic studies, an inventory of physical resources of the sector, and the prefeasibility and feasibility studies and designs. Its execution would be strictly coordinated with the Ministry of Economy and Finance through the Inter-institutional Committee mentioned above. The consulting services for the preparation of the general sector studies, the inventory of physical resources, the experiment on integration with the private sector and the water and food disinfection experiment, would be engaged within nine months after the date of the loan contract and in accordance with the terms of reference agreed upon with the Bank.

3.12 The experimental study on sector integration and private sector participation would be carried out by the PCU through agreements established between MINSA, the IPSS and private community organizations and health worker associations.

3.13 The water and food disinfection experimental study would be executed by PAHO/WHO through its country office and the Pan American Center for Sanitary Engineering (CEPIS), which is headquartered in Lima, with the active participation of the appropriate technical offices of the Ministry of Health. PAHO/WHO will be responsible for identifying community organizations to which technology for the production, delivery and use of disinfection methods could be viably transferred and encouraging their involvement.

3.14 In order to maintain effective monitoring and ensure the usefulness of the studies, the Bank would approve their content at each stage (general, prefeasibility, feasibility or design) in each of the areas covered. Thus, once each institutional or general study or integration experiment has been completed, independent consultants would be hired to prepare a summary, which the government and the Bank would examine in deciding on the elements to be included in the prefeasibility studies, if necessary, and the corresponding terms of reference would be adjusted accordingly. Once the prefeasibility studies have been completed, the terms of reference for the feasibility study and design contracts would be adjusted to reflect the results of the previous stages and of the integration experiments with the private sector, as well as the studies conducted with financing from other agencies. These revisions would be made in coordination with the PCU and the Inter-institutional Committee (see Recommendations).

2. Institutional strengthening

3.15 This component would be executed by consulting firms working in coordination with the MINSA offices. One of the firms would develop the hospital waste system, since it calls for specific expertise. Its introduction into the hospitals would be financed through the network support component. The other six systems would be developed by a consulting firm, in accordance with the following timetable: during the first 12 months the diagnosis of each system would be evaluated; during the subsequent 15 months the system, rules and manuals would be designed; finally, training would be provided and would be implemented within MINSA and the regional directorates. The approach to regional interpretation of these systems would be determined during the design phase.

3.16 The systems for supervision and monitoring communications, procurement of critical inputs and maintenance would be established in the regions as the networks receive financing through the network support component. The information system will operate in conjunction with the other systems, and will be designed accordingly and fully implemented only when the other systems are already in place. The Health manpower system is intended to form part of a permanent personnel development policy to meet the health sector's future need.

3.17 The consulting services needed to implement the systems included within the institutional strengthening component would be engaged within nine months after the date of the contract and in accordance with the terms of reference agreed upon with the Bank (see Recommendations).

3. Network support

3.18 For the execution of this component, the regional directorate of the area where the network is located, with technical support from MINSA, would prepare the request justifying the equipment, management support and training required, and present it to MINSA.

3.19 Within MINSA, the Health Projects Investment Fund (the "Fund"), would be established as a temporary mechanism to effectively channel the resources of the network support component. The objective of the Fund would be to provide nonreimbursable financing for projects meeting the criteria defined in the Operating Regulations of the Fund (Annex III-3), which would be formalized prior to the first disbursement (see Recommendations).

3.20 The resources of the Fund would consist of proceeds from the Bank's loan as well as the local counterpart contribution and its sphere of responsibility would be limited to the administration of these resources.

3.21 The operations of the Fund would come under the responsibility of three bodies: (i) a board of directors, composed of the Minister

of Health or his representative, as chairman, the Technical Director of the Office of Financing, Investment and External Cooperation, the Technical Director of the Office of the Legal Counsel, and the Technical Director of the General Administration Office; (ii) financial administration would be the responsibility of the Financial Control Unit of MINSA; and (iii) operational administration would be the responsibility of the PCU.

3.22 Although for purposes of description and scaling the network support component has been presented with three subcomponents (equipment, management and training), its implementation would be consolidated since the needs of each subcomponent would have to be presented in the reports as a requirement of eligibility.

3.23 The operations of the Fund would begin with general parameters since the definitive quantitative parameters would be based on an examination of the first five networks submitting requests. This first group is currently in preparation with PAHO/WHO financing. Based on the first group of five requests, the Bank's project team, jointly with the PCU, would establish the final parameters for eligibility to be incorporated in the Operating Regulations of the Fund (see Resolution).

3.24 Each group of request will be processed in four stages: (i) preparation of the request, which would be carried out by the health establishments with advisory assistance provided by the PCU and would take an estimated six months; (ii) evaluation and approval of the request, which would be carried out within MINSA's PCU and would take approximately three months; (iii) calls for bids for the acquisition of the equipment, inputs and medicinal products, which would be carried out by UNDP under an agreement especially established with the government and would take an estimated nine months; and (iv) purchase, delivery and installation of the equipment and services in the respective network, which would be coordinated by the Office of Logistics of MINSA and UNDP, the technical supervision of PAHO/WHO, and by the goods receiving committee, set up for the purposes of the program and entrusted with verifying, certifying and receiving the goods acquired as well as ensuring that the goods reach their correct destination (see Recommendations). It is estimated that this last stage would take six months.

4. Timetable for execution of the three program components

INSTITUTIONAL AND PREINVESTMENT STUDIES

STUDY	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
Sector financing																
Human resources																
Structure and organization																
Physical resource inventory																
Maps																
Summary of the diagnosis																
Integration experiment																
Disinfection experiment																
Prefeasibility																
Feasibility																
Designs																

INSTITUTIONAL STRENGTHENING

ACTIVITY	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
Review of diagnosis																
Systems design and development																
Development of rules and manuals																
Training																
Implementation at national level																

NETWORK SUPPORT

STAGES	YEAR 1				YEAR 2				YEAR 3				YEAR 4			
Hiring of consultants																
Preparation of requests		1			2			3								
Evaluation of requests				1			2			3						
Tendering					1			2			3					
Purchase and delivery								1			2			3		

Note: The numbers represent groups of networks; it is expected that the first group will have five networks and the two remaining groups will have nine networks each.

C. Participation by PAHO/WHO and UNDP in program execution

3.25 PAHO/WHO would provide program support in three areas: (i) advising MINSA on the engagement and supervision of consulting services necessary for the institutional and preinvestment studies component, the institutional strengthening component, and the management and training activities within the network support component; (ii) advising MINSA with regard to technical monitoring of the specifications for equipment, medicinal products and other inputs of the network support component and supervision of its proper installation; and (iii) carrying out the water and food disinfection experiment through the Pan American Center for Sanitary Engineering (CEPIS), which operates under the authority of PAHO/WHO. For the advisory work PAHO/WHO and MINSA would sign an agreement that would be submitted to the Bank prior to the first disbursement (see Resolution). The terms of reference for the water and food disinfection experiment would be agreed upon with the Bank within nine months after the date of the loan contract (see Recommendations).

3.26 The engagement of PAHO/WHO is justified by its experience in and knowledge of Peruvian health conditions since it has worked closely with MINSA for a number of years on various health programs. PAHO/WHO, with its staff professionals and consultants, has covered the entire country without restrictions, even areas at highest risk from terrorism, in implementing immunization programs, emergency action to control cholera and other activities.

3.27 In the case of the water and food disinfection experiment, CEPIS is the only Latin American entity that is promoting innovative studies in the area of sanitation, and has a professional team with expertise in planning, execution and evaluation of experiments of the type proposed.

3.28 The United Nations Development Programme (UNDP) would advise MINSA on the public bidding process for the acquisition of equipment, medicinal products and other inputs of the network support component. The project team has concluded that direct engagement of this agency from the outset of program execution would be fully justified by the inadequate procurement capacity of MINSA's logistics unit at the current time for the magnitude of the program and given the Bank's requirements. It is not considered advisable to establish such capacity fully on a permanent basis given the temporary nature of this function within the period of program execution. In addition, the relatively high degree of personnel mobility now prevalent in the country, even at the highest levels - and understandably so given the current transformations, low salaries, etc. - would lead to discontinuity and instability in the tendering process that could jeopardize execution of the entire network support component.

3.29 The government's request that UNDP participate in this program is not isolated but rather forms part of a decision by the Peruvian authorities to streamline the entire process of State procurement and increase its transparency, irrespective of the source of funds. This is due not only to the institutional weakness of the public institutions, but also to the country's law on procurement, which is highly complex, and the process of decision-making, which is slow and bureaucratic. This complexity is compounded by the Bank's policies and procedures with respect to the procurement of goods and services.

3.30 In Bolivia, UNDP was highly successful in streamlining the State procurement process, which was virtually paralyzed. In four years, UNDP has organized more than 800 international invitations to tender with a value in excess of US$2 billion, of which approximately US$600 million came from IDB loans. The 800 invitations to tender were completed virtually without protest or complaint and within reasonable timeframes. Based on this experience, the government has decided to request UNDP to provide such support in Peru.

3.31 In view of the experience indicated, and the agreement between the Bank and UNDP for joint execution of programs and projects, it was decided to involve UNDP in the procurement process. An agreement to that effect would be signed between UNDP and the government prior to the first disbursement and submitted to the Bank for approval (see Resolution).

D. Other aspects of execution

1. Period of execution and disbursement timetable

3.32 The program would be executed within a period of four years and disbursements would be made according to the following timetable:

DISBURSEMENT TIMETABLE
(excluding financial costs)
(in thousands of US$ equivalent)

SOURCE	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTAL	%/SOURCE
IDB	8,345	20,738	20,525	8,203	57,811	67.7%
COFINANCING	3,000	7,500	7,000	2,500	20,000	23.4%
LOCAL	1,162	2,312	2,722	1,383	7,579	8.9%
TOTAL	12,507	30,550	30,247	12,086	85,390	100.0%
% per year	14.6%	35.8%	35.4%	14.2%	100.0%	

2. Recognition of expenses and retroactive financing

3.33 The borrower would request that the Bank recognize expenses to be incurred prior to consideration of the proposed loan by the Bank's Board of Executive Directors. The project team has estimated that up to US$500,000 in expenses incurred by the PCU in preparing requests to the Fund and in administrative expenses incurred by the executing agency in connection with the program could be recognized as chargeable to the loan. Part of these expenses would be covered with proceeds from a "bridge" loan from PAHO/WHO for preparation of network support requests (see Resolution).

3. Procedures for the engagement of individual consultants and consulting firms and the procurement of goods

3.34 All hiring of individual consultant and consulting firms and all procurement of goods with program resources would be conducted in accordance with standard Bank procedures (Annexes A, B and C of the Loan Contract).

4. Equipment maintenance

3.35 The borrower, through MINSA, would undertake to maintain the equipment procured for the program in a condition compatible with the service to be provided in accordance with generally accepted technical standards. The executing agency would present to the Bank, within the first quarter of each calendar year for a period of five years from completion of the first acquisition of equipment, an annual maintenance plan for the equipment and a report on the state of maintenance of the equipment. The plan would include: (i) details on the organization and structure of personnel responsible for maintenance; (ii) information concerning the resources to be invested in maintenance during the current year and those to be appropriated in the budget for the following year; and (iii) a report on maintenance conditions (see Recommendations).

5. Advances

3.36 Given the country's financial situation, and particularly that of MINSA, it is recommended that funds be advanced in accordance with Bank procedures.

6. External audit

3.37 The program would be audited by an independent firm of public accountants acceptable to the Bank and hired for this purpose, in accordance with the rules and procedures set forth in the country's legislation.

7. Agreements

3.38 The executing agency would sign agreements with PAHO/WHO and with UNDP in which it would establish the conditions under which these two agencies would carry out the work indicated in the previous paragraphs. These agencies would submit a detailed technical offer to MINSA, which would become an integral part of the agreement between them and the borrower. The agreements with each of these agencies would be submitted to the Bank for approval.

8. Interim and ex post evaluation

3.39 An interim as well as a general ex post evaluation of program execution would be performed. The objective of the interim evaluation would be to measure progress, detect problems and permit the introduction of corrective measures during execution if necessary. The objective of the ex post evaluation is to verify the extent to which the objectives, goals and expected outcome of the program have been fulfilled, particularly with respect to the following objectives: (i) institutional strengthening; and (ii) improvement in the efficiency and equity of services (see Recommendations).

3.40 The executing agency would be responsible for the interim and ex post evaluations, for which purpose it would assemble the information by component. This information should be attached to the appropriate evaluation report as an appendix. To that end, the borrower is to present to the Bank, six months after the effective date of the loan contract, an initial report including: (i) the baseline data by component; and (ii) a description of the methodology to be used to collect and process information in order to compare the baseline data with the results (see Recommendations).

3.41 In order to measure the impact of the program and the extent to which its goals have been accomplished, information would be collected on:

a. Institutional and preinvestment studies: goals programmed and reached.

b. Institutional strengthening: (i) type of activities planned and executed; (ii) goals accomplished in the process of decentralization.

c. Network support: (i) number of consultations, immunizations, house calls, etc. per establishment; (ii) effective coverage per health program: maternal and child care, communicable diseases and others; (iii) occupancy rate of hospital establishments by department or service; (iv) discharge rate in hospitals (cures, transfers, no change, deaths); (v) volume of referrals and counterreferrals between hospitals and health centers and posts; (vi) establishments with financial administration systems in operation; (vii) costs of hospitalization,

outpatient consultations and emergencies by department or service; (viii) cost of care in health centers and posts: personnel, medicinal product and other variable costs; (ix) equipment and infrastructure maintenance costs by establishment; (x) ratio of trained personnel by type of establishment; and (xi) survey of low-income groups by network establishment.

3.42 With the elements indicated above, and in accordance with the methodology mentioned in subparagraph (a) of the following paragraph, an ex post evaluation would be presented two years after the date of the final disbursement, which would include, *inter alia*, the following aspects: (i) analysis of the strengthening of MINSA; (ii) goals attained in the process of decentralization; (iii) improvements made in the efficiency and equity of service; and (iv) conclusions and recommendations.

3.43 For the purposes of both evaluations, the normative documents include the following contractual stipulations:

a. Within 18 months from the effective date of the loan contract, the borrower, through the intermediary of the executing agency, shall present, to the satisfaction of the Bank, the baseline data indicated in the preceding paragraph; and a detailed description of the methodology that would be used to compile, process and analyze the data to be compared with the baseline data in order to prepare the ex post evaluation upon conclusion of the program.

b. Within 24 months from the effective date of the loan contract, and annually up to the second year following the final disbursement of the financing: (i) the annual data shall be compiled following the same guidelines as for the baseline data referred to in the previous subparagraph; and (ii) an interim evaluation report shall be presented to the Bank.

9. <u>Reports and supervision</u>

3.44 As from the first year of the loan contract, during execution of the program and no later than 60 days prior to the close of each calendar year, the borrower, through MINSA, must present to the Bank an annual operating plan that will be executed in the following calendar year. The report on execution of the operating plan corresponding to the previous year must be presented 60 days after the close of the year. This report must include, at the minimum, a description of plan activities, a budget, a timetable for disbursements, and procedures for implementation of and resources allocated to each of the components of the program (see Recommendations).

E. Environmental impact

3.45 The Environmental Management Committee has classified the program under Category II. The program does not in itself have an incremental environmental impact, since it involves the acquisition of basic medical equipment for previously existing installations and the conduct of studies, with no new construction or renovation.

3.46 The program would help to protect the environment because within the institutional strengthening component, a waste management system would be executed in the hospitals at national, regional and local level, which would make it possible to improve sanitation in health establishments and minimize the risks to human health and the environment posed by solid hospital waste.

F. The possibility of natural disasters

3.47 Since the program does not entail investments in infra-structure, no provision is made for the possible effect of natural disasters, such as earthquakes and floods in the existing establishments, but such provisions have been made in the designs for new structures within the institutional and preinvestment studies component. Under the supervision and monitoring system subcomponent, the program provides for strengthening of MINSA that will enable it to respond immediately to epidemics.

G. Status of program preparation

3.48 The preliminary terms of reference for the institutional and preinvestment studies component are prepared and would be revised in stages in accordance with the plan of execution designed for the program, and would be used in the first international invitation to tender to enable prequalified firms to prepare their detailed technical offers.

3.49 With regard to the institutional strengthening component, the plans of action and terms of reference have been prepared, so that technical offers can be presented by consulting firms for the seven subcomponents. Outstanding problems, general and specific objectives, goals, activities, estimated consulting needs, timetables and cost estimates have all been defined and the related materials have been examined by the project team.

3.50 Within the network support component, the networks identified as priority have already begun to prepare their requests and a group of at least five requests will be ready during the first half of 1993.

IV. THE BORROWER AND THE EXECUTING UNIT

A. Institutional analysis

1. Introduction

4.1 The borrower would be the Government of Peru and the executing agency would be the Ministry of Health (MINSA) which would execute the program through its own technical units and the program coordinating unit (PCU), established for the purposes of the program. The office of the Minister would supervise implementation.

2. Organizational structure and functions of the Ministry of Health

4.2 Article 52 of Title IV of the Basic Regionalization Law provides that it is the responsibility of the ministerial organs and central agencies to define policy, as well as to issue the related sector regulations. Within this new context, on April 16, 1990, Legislative Decree 584 was issued promulgating the current law of organization and functions of the Ministry of Health. This law also establishes MINSA as the governing body for the national health system.

4.3 Decree 584 establishes as objectives for MINSA improvement of the health situation and standard of living of the country's population with the participation of the components of the national health system and the active involvement of the community. Among the functions assigned to it by the law, the following are particularly noteworthy: (i) proposal of the national health policy and the national health sector plan to the Executive Branch; (ii) formulation, in coordination with the regional governments, of the national health policy and health sector plan; (iii) issuance of national regulations to govern the activities of the health care system and monitoring of compliance with them; (iv) organization, consolidation and updating of national health records; (v) regulation, coordination and consolidation of social information in the field of health; and (vi) provision of advice and support to the components of the in the areas of their responsibility.

4.4 According to the aforementioned decree, MINSA has the following organizational structure: (i) senior management: Minister and Deputy Minister; (ii) consultative body: MINSA Consultative Committee; (iii) coordination bodies: National Board of Health, National Technical Coordination Committee and National Functional Integration Committee; (iv) monitoring bodies: General Inspector's Office; (v) advisory bodies: General Planning Office, Office of Legal Counsel, Office of Finance, Investment and External Cooperation and General Office of Epidemiology; (vi) support agencies: General Administration Office, Office of Statistics and Information

and Office of Communications; and (vii) line agencies: General Directorate of Human Health, General Directorate of Environmental Health, General Directorate of Medicinal Products and Inputs.

4.5 The National Board of Health is the coordinating body of MINSA and the national health system. It is responsible for the formulation of national health policy set forth in the country's economic and social development plan. It is chaired by the Minister of Health and composed of representatives from all of the components of the system: IPSS, Defense Health Service, health and health worker associations and regional governments.

4.6 The National Technical Coordination Committee is chaired by MINSA and composed of the regional departments of social affairs and the regional health authorities. It coordinates sector plans and programs between the central and regional levels, the formulation of budgets and the analysis of reports evaluating the regional health systems.

4.7 The National Functional Integration Committee is responsible for regulating the process of integration between the health services of the IPSS and those of the regional governments. It is chaired by the Ministry of Health and composed of representatives from the aforementioned entities.

4.8 It should be noted that MINSA has already been restructured so as to effectively fulfill its monitoring role. Supreme Decree 02-SA-92 of August 1992 approved the organizational and functional regulations under which MINSA is currently operating. It is important to note that consideration was given, in formulating these regulations, to MINSA's new operating needs within the regionalization framework and the operational problems experienced in the past.

4.9 From a structural point of view, one of MINSA's fundamental problems has been its high degree of vertical disaggregation, in some cases extending to the sixth organizational level; the current structure reduces it to three. Similarly, the large number of organizational units (more than 300), which complicated the supervision and coordination of activities; at the current time 43 units are operating. This distorted organizational structure resulted in an imprecise delineation of functions and thus in overlap and confusion as to spheres of responsibility. With the disproportionate growth in MINSA's organization came a fragmentation of responsibilities, affecting the continuity and coherence of its activities. The new delineation of functions is designed to remedy this situation.

4.10 National policies and MINSA's role in the establishment of health standards and enforcement vis-à-vis public and private entities must still be defined with regard to: (i) the practice of health care professions; (ii) health services; (iii) commercial and

industrial establishments; (iv) producers and marketers of food, medicinal products and medical equipment and instruments; (v) occupational health; (vi) environmental health; (vii) health insurance; and (viii) health research.

4.11 The problems currently confronting MINSA are related to the definitions indicated above and the institutional weaknesses affecting its ability to carry out its functions within the new structure.

4.12 With regard to personnel, the situation within MINSA is critical since nearly 30% of its personnel, mostly professionals, took advantage of the incentives offered under the volunteer retirement program established by Supreme Decree 004-91-PCM of January 1991, seriously weakening the administration of this sector. The vacant posts have been filled with insufficiently experienced personnel, necessitating an intensive training effort.

4.13 With the transfer of human resources to the regions, MINSA personnel was reduced from 70,552 posts to 28,671 posts, including personnel serving in the Lima/Callao region. The headquarters is now staffed by approximately 730 persons; their distribution is poor, since more than 50% are assigned to the administrative offices, giving greater importance to internal problems than to the ministry's supervisory and monitoring functions in the sector. The shortage of qualified personnel in technical and professional areas, as well as the use of largely obsolete equipment and technology, is reflected in the low quality and productivity of MINSA's services. Many of the workers perform functions that do not correspond to their capacities.

4.14 The process of regionalization has created two fundamental problems for the institutional viability of MINSA and the regions. First, regionalization was decided "by decree" with no transition, making institutional adaptation difficult, especially in the hospitals and health centers and posts which were accustomed to central support services (supply of inputs, maintenance, personnel, etc.). Second, with the fiscal crisis and its inefficient organizational structure, MINSA did not respond effectively to its new role as regulatory and supervisory entity for the sector.

B. Financial analysis

1. The budget of the Ministry of Health

4.15 At the current time, MINSA's budget does not include appropriations from the Public Treasury for hospitals and health centers and posts in the regions (which enjoy autonomy in the administration of resources for the various sectors, including health), with the exception of Lima and Callao. Thus, MINSA's financial purview has been reduced to its own offices and to the hospitals, with 7,722 beds, and the 184 health centers and 309 health posts of Lima and Callao. Nor does MINSA participate in other phases of the

hospital's budgetary administration, such as approval, evaluation and control.

4.16 The presentation of MINSA's budget shows the various amounts of income and expenditure by item. The budget is administered by the Finance Department of the Technical Directorate of Administration. This department is responsible for managing all of the institution's resources and is subject to audit by the Comptroller of the Republic. An internal preaudit is also conducted by one section.

4.17 Once the budget is approved, the amounts available at the beginning of the budgetary period are referred to as "the initial appropriation", but their use must be authorized by the Ministry of Economy and Finance (MEF). These initial amounts, however, provide no indication as to the volume of resources MINSA will utilize during the year; the budget is subject to a series of amendments throughout the budgetary period involving amounts which often exceed the initial appropriation several times over. In short, the entire budgetary process is plagued by serious limitations, especially with regard to forecasting. In 1987, the initial appropriation was increased by 71%, in 1988 by 72%, in 1989 by 436% and in 1990 by 1,452%.

4.18 This permanent situation of deficits at the beginning of each budgetary period prevents the adoption of clearly defined plans for service delivery and investment; budgetary execution is thus characterized by irregular or uncertain resources that are adjusted throughout the year according to the ability to appropriate additional funds from the Treasury.

4.19 Until 1989, the proceeds of transfers for the operation of hospitals in the regions were channeled through MINSA's budget; a major budgetary change occurred in 1990, when the volume of resources was reduced, especially those intended to defray payroll costs. Total execution during the 1987-1989 period shows a downward trend from US$382.6 million in 1987 to US$355 million in 1989.

4.20 In view of the economic crisis affecting Peru during the period 1986-1990, the central government reduced its expenditure by 41.7%, and the social sector by 38.6% Since that time, most of the items in MINSA's budget have been restored. MINSA's total budgetary execution in 1991 increased by 49% over the year 1990 (from US$122 million to US$182 million).

4.21 During the same two-year period, the remuneration heading increased by 22%, reflecting incentive payments under the voluntary resignation policy, which resulted in a staff reduction of nearly 40%. Those officials who took advantage of the incentives, however, tended to be the best trained and most highly skilled – i.e. those best able to compete in the labor market.

4.22 During the period 1987-1990, operating expenses accounted for an ever increasing share of MINSA's total expenditure, with a corresponding decline in investment, excepting the year 1991. The reduction in investment is reflected by the obsolescence and shortage of equipment, especially computers, and in the physical installations. The relative shares of expenditure devoted to operations and investment are shown below:

YEAR	OPERATIONS (%)	INVESTMENT (%)
1987	91.8	8.2
1988	93.8	6.2
1989	96.3	3.7
1990	99.0	1.0
1991	95.2	4.8

4.23 Ordinarily, MINSA authorities expect the budget appropriated to cover projected expenditure for the year in question; but the reality is quite different, and budgets frequently open with deficits. The initial appropriation is usually very low compared with the volume of resources actually spent during the year; the initial amounts are therefore not accurate representations, and therein lies the weakness of the budget formulation and income and expenditures calculation processes. The scarcity of resources resulting from the chronic opening deficits (insufficient initial allocations) particularly affect the procurement of goods and services, seriously complicating the institution's administration. Payroll, pensions and current transfers (payments to staff for all items) have been permanently assured by the Public Treasury so layoffs have not been necessary. The budgetary items assigned to MINSA are lump-sum amounts covering six programs and 52 subprograms.

2. Financing scheme for the decentralized services

4.24 The health institutions in the regions – with the exception of Lima and Callao, which are still not within the regional scheme – come under the authority of the respective regional government for administrative matters but remain under the authority of MINSA for technical matters.

4.25 In the hospitals, as in other public sector entities, the effects of the country's economic crisis can be clearly seen. Financially speaking, the effects are reflected in their budgets, which are highly dependent on national resources (budgeted as "Public Treasury"). The other source, "earned income", accounts for a very small share of the financing, perhaps reflecting the community's inability to pay for services.

4.26 The hospitals do not have socioeconomic studies on the populations within their areas of coverage that might validate the previous assessment nor do they have methodologies for adjusting fee schedules to local economic conditions. Within this context, the risk of, or effective, deterioration in the quality of services provided by the hospitals as a result of declining income is significant.

4.27 The hospitals, 130 in number, receive no contributions from the regional governments; their own income accounts for a very small share of financing (less than 10%) which is why they remain dependent on the MEF for financing not only because of its role in allocating funds from the Public Treasury but also because the State's liquidity problems during this time of monetary contraction and public spending restrictions have serious implications for such time-sensitive areas as medicinal products, food, etc.

4.28 New alternatives must be studied for improving current income sources and creating new ones, in which the regional governments would play a more prominent role in the field of health within the new context of decentralization.

3. Financial scheme of the hospitals

4.29 The country has 130 hospitals under the authority of MINSA and the regions, 20 of which are specialized, providing services to segments of the population not covered by other subsectors - that is, the lowest income segments - and obtain most of their income from the central government.

4.30 With the movement towards regionalization, MINSA no longer maintains financial information on the country's hospitals, nor does MEF. The volume of resources invested in them by the country could be estimated on the basis of survey data. If the average annual expenditure per bed by a hospital with 350 beds or more is considered equivalent to that of a specialized institution, the annual expenditure of the 20 specialized hospitals would amount to US$87.7 million. Irrespective of the methodological assumptions, it can be estimated that the health care expenditure by the government is on the order of US$227.3 million (based on 17,257 beds and 53,200 employees).

4.31 According to the limited financial data available from the survey conducted in preparing the program, the hospitals have limited potential for generating income through the sale of services, which is even more true in the rural areas where the level of income of the population is well below that of the cities. Earned income as a percentage of total income appears to amount to between 3% and 11%.

V. FEASIBILITY, DISTRIBUTIONAL IMPACT AND RISKS

A. Feasibility of the program

1. General considerations

5.1 An analysis of the program and the measures planned to reduce the risks resulting from insufficient data and the weakness of MINSA and the transformation and adjustment processes now affecting the country, indicate that its execution is viable.

5.2 With regard to the institutional strengthening component, the administrative systems to be strengthened would be essential within any decentralization framework. Moreover, the systems are sufficiently well defined, in terms of objectives, and sufficiently flexible to adapt to regional responsibilities.

5.3 Input from the consultants and the training programs would help to retain basic personnel necessary during the execution period. In turn, the institutional and preinvestment studies component would provide the foundation for a human resource policy offering sufficient incentives to retain and attract suitably qualified personnel.

5.4 With regard to the network support component, the surveys conducted in the four representative networks in the areas of Cajamarca, Loreto, Tumbes and North Lima showed that:

a. It is possible to work with the health establishments grouped in functionally organized service networks.

b. It is feasible, with the help of consultants, to ensure that the operational personnel within the establishments participate in an active and coordinated fashion in the definition of needs and priorities in preparing the requests for equipment, management support and training.

c. There is sufficient physical space for additional or replacement equipment.

d. The technical and administrative problems in the establishments are sufficiently homogeneous to permit the design of advisory and training modules that can be used, with slight adjustments, in the various regions of the country.

e. The equipment to be obtained with program resources does not require technological change, and the existing personnel can easily be trained to operate and maintain it.

f. The users of the MINSA and regional establishments are predominantly from low-income groups.

2. Technical aspects

5.5 The program is justified from a technical standpoint since:

a. Health problems, which are more prevalent among low-income groups, have accumulated under the effect of pent-up demand within this population group, which depends on the services offered by MINSA and the regional establishments.

b. There are still human resources in the public establishments whose efficiency would be maximized if trained in technical and administrative management and provided with the minimum equipment required to provide basic care.

c. The program would not change the levels of care offered by the various establishments; equipment would be replaced, and the level of complexity and technology would be such that it should be manageable on a day-to-day basis by the personnel of these establishments. Consequently, it would not be necessary to change the qualifications required of the personnel operating the equipment.

3. Institutional aspects

5.6 Two years after the initiation of decentralization, MINSA recognizes the need to adapt to change and introduce a new organizational structure in accordance with its new function and designed to resolve the existing problems. According to the analysis performed, this new structure represents a good foundation for its new functions. From an institutional point of view, the program is fundamental to the success of this very important and necessary change. The areas to be strengthened would not only increase the internal efficiency of the Ministry, but would also help it in its new role of supporting the regions, since it would be in a position to provide technical assistance to and set operating standards for the regional institutions. The program is designed in such a way that not only is its implementation feasible with the existing capacity, but also, the executing units involved would benefit from technology transfer.

5.7 The viability of the operation, from the standpoint of the number and type of participating institutions, is considered assured given the evident need for the activities proposed as well as the national political consensus in support of them. The government has held meetings at various levels (regional and municipal) and the reaction to the program has been very positive.

5.8 Given the fragile institutional situation, the program has been designed in such a way that while the proposed strengthening is

being achieved, the necessary stability and continuity for execution would be temporarily assured by the use of international agencies recognized by the authorities as competent to assist them. So assisted, the MINSA technical units responsible for executing the program are deemed capable of successfully carrying out the tasks assigned to them. It must be noted that the type of activities planned respond to basic needs by providing participating institutions with the technical and administrative tools fundamental to successful operation independent of the organizational hierarchical structure.

4. Financial aspects

5.9 Given that classification as a Group B country imposes a maximum financing matrix of 70%, a counterpart equivalent to US$30 million would be required. In view of the financial difficulties currently besetting Peru, consideration has been given to obtaining cofinancing, especially with "soft" funds, for which approaches have been made to OECF of Japan for an amount of about US$20 million, which would reduce the amount the Government of Peru would have to contribute to US$10 million over four years. This figure is regarded as well within the government's capacity since the program would represent its only major investment in the health sector over the next four years.

5.10 The impact of the recurrent costs connected with the program, beyond those related to projects explained further on, could be easily absorbed by MINSA since they would not exceed US$267,000 annually as from the fourth year. This represents less than one-tenth of 1% of MINSA's total expenditure in 1991.

5.11 With regard to the network support component in order to minimize increases in the recurrent costs, investments that would represent a significant additional budgetary burden for the requesting institutions would not be financed. Eligibility criteria would be established for the program requiring that a proper operating budget exist for the investments requested, and amounts acceptable in cases where an increase in recurrent costs is justified would be stipulated. Temporary parameters have been set for the first five requests, following whose analysis the final parameters would be established.

5. Socioeconomic aspects

5.12 The program, as already indicated, was designed to avoid further short-term deterioration in basic health services in the most depressed areas of the country, while the processes of sector reform are initiated and the groundwork is laid for long-term planning. Reinforcing the leadership role played in the sector by MINSA and the regional health directorates would help to improve the efficiency of services offered by public establishments, channeling

resources towards the poorest groups most exposed to the risk of illness.

5.13 The information available shows that the public health care system administered by MINSA and the regional governments has undergone severe deterioration in recent years. The number of total consultations, which was 9.6 million in 1987, declined to 8.2 million in 1990 and the number of hospital discharges, which in 1987 amounted to 462,300, declined to 327,000. These results can be explained in terms of supply as well as demand.

5.14 With regard to supply, the system entered into a state of virtual collapse for lack of the budgetary resources needed to maintain the minimum levels of care required, especially with cuts in spending for equipment, medicinal products and salaries. In the latter case, the result was strikes by health care workers in 1990 and 1991 lasting four and five continuous months with no health care services. This led to a sharp deterioration in supply capacity. The surveys conducted in four networks (Loreto, Cajamarca, Tumbes and North Lima), among users of the health posts and centers, revealed that approximately 80% of all patient rejections resulted from shortages in three areas: equipment and instruments, medicinal products and drugs, and personnel.

5.15 On the demand side, declining incomes among the poor segments of the population, coupled with pent-up demand, have led many to improvise health remedies of their own and thus in some cases to worsen their condition before going to the emergency ward.

5.16 The basic equipment and the provision of essential medication is designed to reverse the situation through: (i) the replacement of equipment used to provide essential services; (ii) the use of non-fixed equipment, that is, which can be moved to another establishment if the one where it is installed is subsequently closed.

5.17 The program is justified economically because it is necessary to recover acceptable levels of coverage for health service contributing to the development of human capital in order to bring about more stable socioeconomic development and give political viability to the process of democratization in Peru. The aim is to regain levels of coverage attained in the past – a conservative goal in view of the levels considered desirable. However, in the context of severe fiscal restraint and other reforms of the public sector, these goals are realistic and feasible. If the program manages to simply check the current downward trend it will have achieved an important objective. Similarly, the availability of equipment and basic instruments and drugs and essential medicinal products would permit more efficient use of the available human resources and infrastructure, thus increasing their productivity.

5.18 The program is justified in social terms because of the benefits it will provide for the poorest population groups with the greatest

health problems, as shown by the analysis of its distributional impact.

B. Distributional impact

5.19 The health sector provides services to four categories of users: (i) the highest income group, which resorts to the private sector, accounting for 19.5% of hospital beds currently in service; (ii) salaried workers, served mainly by the Social Security Administration, which accounts for 15.6%; (iii) members of the Armed Forces and the police, which account for 10.6%; and (iv) the lowest income groups, composed of casual laborers and informal sector workers, small rural producers and the unemployed, which are covered by MINSA and regional government establishments and account for 53%. The program focuses on this last group, since all of the activities would be designed to improve the capacity of MINSA and the regional establishments.

5.20 Poverty in Peru has worsened in recent years. In 1970, 50% of the population was considered poor. The efforts made during the second half of the 1970s brought improvement, and by 1980 the portion of the population considered poor had fallen to 46%. But by the end of 1986 deterioration had resumed, with 52% considered poor. By 1991 the figure had risen to 54% according to Bank studies. (Poverty Issues and Social Sector Policies and Programs, May 1992.)

5.21 Surveys conducted among the four above-mentioned groups yielded the following figures for population falling below the low-income line, as defined by the Bank (1,239 new soles per capita per year for December 1991): Loreto 64%, Cajamarca 77%, Tumbes 78% and North Lima 68%. The weighted average for the four areas was 69%; the population sample was 2,329,000. The overall impact of the program would be approximately 68.85%.

C. Impact on women

5.22 Women of low income constitute the largest population group receiving care in the hospitals and health posts and centers to be covered by the program, and therefore would be the primary beneficiaries.

5.23 Another important benefit would be the training that the women working in the posts, centers and hospitals would receive from the network support and institutional strengthening components.

5.24 Within a framework of greater participation by the private sector, the program could also create career opportunities for women in private companies providing services to health establishments. This would be defined in the general studies in which the role of women with respect to health, illness and nutrition is included as an active part of the process.

D. Benefits and risks of the program

1. Benefits

5.25 Successful execution of the program would yield benefits in the following areas:

a. It would generate the necessary elements for implementation of sector policies and strategies within the context of regionalization. This would help to channel public spending and investment more efficiently and gain access to additional resources from international financing sources.

b. It would help to consolidate the decentralization process by strengthening the administrative capacity of the decentralized bodies and health establishments. At the central level it would strengthen MINSA's regulatory role, implementing the existing structure of reforms within the regionalized context; the capacity for self-management of the establishments themselves would be strengthened.

c. It would help to increase the number and quality of qualified health care personnel by providing training in connection with the institutional strengthening of MINSA and the regions and by conducting human resource development and training activities in connection with the network support component.

d. It would improve the efficiency of establishments providing services by promoting their coordination in functional networks, which would in turn increase local capacity to solve health problems.

e. It would produce operating instruments for better targeting of investments and programs towards specific population groups according to their demographic, socioeconomic and epidemiological characteristics.

f. It would have a direct impact on low-income groups since the public health establishments to be benefited by the program are virtually the only ones serving this population. In addition, the selection criteria restrict financing to networks established within the most depressed areas in terms of their socioeconomic conditions. It would especially benefit low-income women and children, who are the main users of the public service. Based on the study of the role of women with regard to health, illness and nutrition, it is hoped that other activities benefiting this group will result.

2. Risks

5.26 The risks of this program are those inherent to the specific problems and adjustment process now taking place in the country. Every

effort has been made in designing the program to incorporate the elements essential to its success.

5.27 However, the project team considers that a number of risks have still not been covered:

a. The exodus of trained personnel and the almost constant strikes that have been occurring in the public health sector as a result of low salaries. If this situation does not improve, the ability to develop a stable professional work force able to carry out the activities of MINSA and the regions will be threatened. An incentive plan would need to be established to attract qualified personnel to the new functions, which is to be analyzed as part of the institutional and preinvestment studies component.

b. The poorly defined areas of authority at regional and municipal level over health services. This could create obstacles to decision-making for the design of requests and their presentation to the Fund.

c. Although the risk that the cofinancing might not materialize is considered relatively minor, given the interest expressed by OECF, CAF and Spanish government representatives in conversations with the Bank, it remains a possibility, in which case the component affected would be network support, which would be significantly reduced in scale.

ANNEXES

PERU
PROGRAM TO STRENGTHEN HEALTH SERVICES

PRELIMINARY BREAKDOWN OF DIRECT COSTS

INSTITUTIONAL AND PREINVESTMENT STUDIES COMPONENT
(Thousands of US$)

STUDY	TOTAL	%
Health situation	800	6.5%
Institutional Policy Analysis	125	1.0%
Sector Financial Analysis	100	0.8%
Diagnostic Summary	100	0.8%
Physical Inventory	1,500	12.2%
Prefeasibility Studies	500	4.1%
Feasibility Studies	3,000	24.4%
Designs	1,700	13.8%
Disinfection Pilot Project	3,600	29.3%
Experiments	852	6.9%
Total	$12,277	100.0%

INSTITUTIONAL STRENGTHENING COMPONENT
(Thousands of US$)

SUBCOMPONENT	TOTAL	%
Maintenance	1,635	14.7%
Information System	2,393	21.6%
Supply of Inputs	1,813	16.3%
Supervision and Monitoring	1,284	11.6%
Communications	966	8.7%
Training	1,976	17.8%
Hospital Waste	1,033	9.3%
TOTAL	$11,100	100.0%

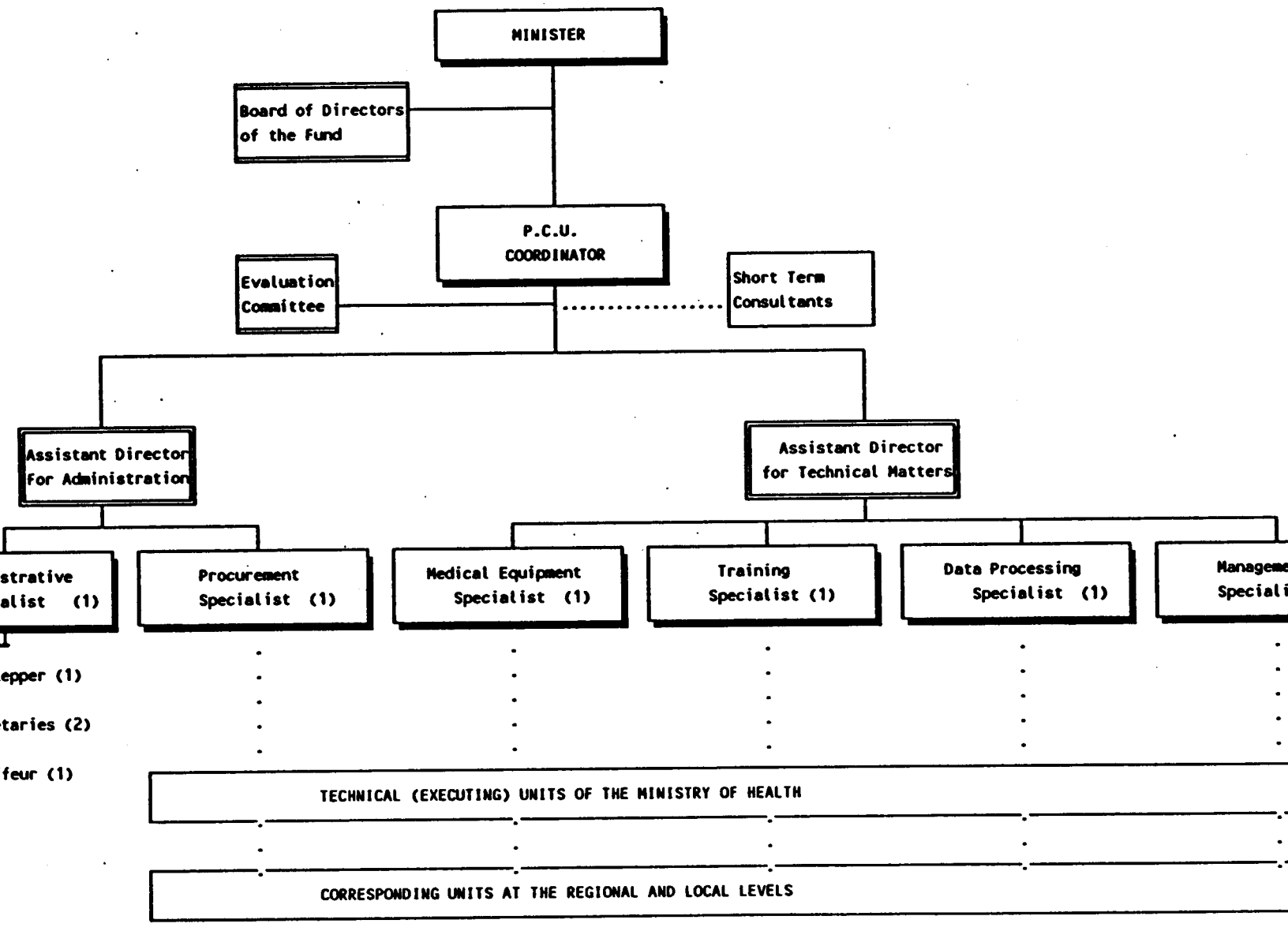
NETWORK SUPPORT COMPONENT
(Thousands of US$)

ITEM	TOTAL	%
Management Support	5,000	8.7%
Training	7,500	13.0%
Equipment	40,000	69.6%
Inputs and Spare Parts	5,000	8.7%
TOTAL	$57,500	100.0%

PE-0030

Program to Strengthen Health Services

ORGANIZATIONAL STRUCTURE OF THE PROGRAM COORDINATING UNIT



PE-0030

OPERATING BUDGET
PROGRAM COORDINATING UNIT
(US$)

	Monthly Salary	Months	Total	Year 1	Year 2	Year 3	Year 4	
Salaries and Benefits								
Personnel								
Coordinator	3000	48	144,000	36,000	36,000	36,000	36,000	
Administrative Specialist	2000	48	96,000	24,000	24,000	24,000	24,000	
Public Health Officer	2000	48	96,000	24,000	24,000	24,000	24,000	
Data Processing Specialist	2000	36	72,000	12,000	24,000	24,000	12,000	
Procurement Specialist	2000	36	72,000	12,000	24,000	24,000	12,000	
Equipment Specialist	2000	36	72,000	12,000	24,000	24,000	12,000	
Management Specialist	2000	36	72,000	12,000	24,000	24,000	12,000	
Training Specialist	2000	36	72,000	12,000	24,000	24,000	12,000	
Bookkeeper	800	48	38,400	9,600	9,600	9,600	9,600	
Secretaries (2)	500	96	48,000	12,000	12,000	12,000	12,000	
Chauffeur	300	48	14,400	3,600	3,600	3,600	3,600	
			796,800	169,200	229,200	229,200	169,200	
Benefits								
30% of the salaries			239,040	50,760	68,760	68,760	50,760	
Total Benefits and Salaries			1,035,840	219,960	297,960	297,960	219,960	60.9%
Travel Expenses								
International Tickets	1500	4	6,000	1,500	1,500	1,500	1,500	
Domestic Tickets	200	15	3,000	400	1,000	1,000	600	
International per diems	180	20	3,600	900	900	900	900	
Domestic per diems	50	75	3,750	625	1,250	1,250	625	
			16,350	3,425	4,650	4,650	3,625	1.0%
Furniture and Equipment								
Desks	400	12	4,800	4,800	0	0	0	
Chairs	200	17	3,400	3,400	0	0	0	
Computers	3500	8	28,000	28,000	0	0	0	
Printers	1000	2	2,000	2,000	0	0	0	
Photocopy machines	1800	1	1,800	1,800	0	0	0	
Telephones	200	12	2,400	2,400	0	0	0	
Fax machines	800	1	800	800	0	0	0	
Vehicles	25000	2	50,000	50,000	0	0	0	
Other			10,000	10,000	0	0	0	
			93,200	93,200	0	0	0	5.5%
Operating Expenses	3000	48	144,000	36,000	36,000	36,000	36,000	8.5%
Fund for short term consultants	1500	192	288,000	144,000	144,000	0	0	16.9%
Contingencies			122,610	39,233	39,233	39,233	4,911	7.2%
TOTAL BUDGET OF THE PCU			1,700,000	535,818	521,843	377,843	264,496	100.0%

OPERATING REGULATIONS OF THE HEALTH PROJECTS INVESTMENT FUND

I. NATURE OF THE FUND

1.1 The Health Projects Investment Fund (Fund) is a temporary financial instrument established as a mechanism for appropriate channeling of the resources assigned to the establishments Network Support component of the "Program to Strengthen Health Services" (PE-0030).

II. PURPOSES

2.1 The purposes of the Fund are:

a. To provide nonreimbursable financing for investment projects whose characteristics conform to those defined in loan contract CO/ -PE between the Republic of Peru and the Inter-American Development Bank (IDB).

b. To provide technical assistance, either directly or by means of contractual services, for the formulation and/or preparation of projects for financing.

III. ASSETS OF THE FUND

3.1 The assets of the Fund consist of income from the following sources:

a. Proceeds from the IDB loan.

b. National counterpart contributions.

IV. SCOPE OF FUND OPERATIONS

4.1 The operations of the Fund shall be limited to administration of those program resources earmarked for the financing of projects identified in the units responsible for providing services at the national level. No assets of the Fund may be used to finance projects which are not within the scope of the program.

V. ORGANIZATION AND MANAGEMENT

5.1 Responsibility for the Fund's operations shall be exercised at three levels with the following scope and authority:

1. Board of Directors

5.2 The Fund shall be governed by a Board of Directors with four members, the Minister of Health or his/her representative, as Chairman, and the following three directors:

- The Technical Director of the Office for Financing, Investments and External Cooperation.
- The Technical Director of the Office of the General Counsel.
- The Technical Director of the General Administrative Office.

5.3 The Director of the Project Coordination Unit shall also participate, with the right to speak but not to vote, in meetings of the Board of Directors.

5.4 An alternate shall be appointed for each principal director.

5.5 The powers of the Fund's Board of Directors are:

a. To approve the annual financing program.

b. To approve health projects.

c. To monitor investments financed by the Fund for compatibility with the national investment plan.

5.6 The Rules of Procedure of the Board of Directors are presented in Appendix 1.

2. Administration

5.7 The highest authority of the Fund is the Minister of Health or his/her representative, who shall chair the Board of Directors. Management of the fund shall be vested in two units:

a. Financial management

5.8 Day-to-day management of the Fund's assets shall be vested in the General Directorate of the Ministry of the Economy – Ministry Financial Control Unit – which shall maintain a special account into which the proceeds of disbursements from the IDB loan and from counterpart contributions shall be deposited. The unit shall be responsible for issuing checks pursuant to instructions received from the Director of the Program Coordination Unit with the prior approval of the Minister of Health.

b. Operations management

5.9 Operations in support of the Fund are conducted through the Program Coordination Unit, the purposes of which are: (i) to plan, coordinate, execute and evaluate the program; (ii) to coordinate activities of Ministry of Health units and other public or private agencies related to the objectives and execution of the program; (iii) to evaluate financing requests submitted by the Ministry of Health and the Regional Units; and (iv) to provide technical assistance in preparing the documentation required to obtain financing.

APPENDIX 1 OF THE REGULATIONS

RULES OF PROCEDURE OF THE Board of Directors OF THE FUND

1. Scope

The Board of Directors is responsible for the review and approval of all financing requests received by the Fund from the Ministry of Health or a Regional Unit.

2. Amendments

These Rules may be amended by the Board of Directors with the Bank's concurrence.

3. Precedence

In the absence of the Chairman of the Board, a duly convened meeting or ongoing session shall be chaired by Directors chosen in accordance with a predetermined order of precedence. The order of precedence shall be established at the first meeting held by the Board at the start of each year and may rotate over the course of the year.

4. Meetings of the Board

The Chairman or, in the absence thereof, the Director whose turn it is to occupy the chair in accordance with the order established under chapter I, section 3, of these rules, shall call and preside over meetings of the Board. A meeting may be called at any time upon written request of any Director.

5. Meeting agenda

An agenda shall be drawn up for each meeting of the Board and distributed to the Directors at least five working days in advance together with the the pertinent documents, i. e. an executive summary of each application listed on the agenda.

Consideration of an application submitted to the Board, or a decision thereon, shall be deferred, only once and for a period of 10 calendar days, at the request of the Chairman or a Director.

Any application which is listed on the agenda of a meeting and the consideration of which has not been completed during the meeting in question shall be automatically included on the agenda of the following meeting in the absence of a contrary decision by the Board.

6. Voting

When a Director requests a formal vote on an application, each Director shall be entitled to cast one vote and the Chairman shall be authorized to cast a second vote for the purpose of breaking a tie. In the absence of such a request, the Chairman shall declare the application to be approved and the consent of the Board shall be assumed. The Directors, however, shall always be entitled to have a statement of their views included in the record.

7. Notices to Directors

Notices and documents shall be transmitted to the Directors in writing and delivered during working hours at their respective offices.

8. Secretary

The Board of Directors shall have a Secretary and the necessary staff for the performance of its functions.

The Secretary shall be responsible for preparing the minutes of meetings of the Board and for making certain that they reflect the sense of the discussions and decisions. The Directors shall be entitled to have a statement of their views included in the minutes of any meeting.

The draft of the minutes of any meeting shall be distributed to the Directors no more than 48 hours after the meeting except in special circumstances, and in any event before the next meeting.

The Secretary shall forward a certified copy of the resolution adopted with respect to each application considered at a meeting of the Board to the Director of the Program Coordination Unit.

The Secretary shall be responsible for maintaining the book of minutes and other documents pertaining to the work of the Board. He shall maintain a registry assigning a consecutive number to each resolution and containing evidence of its delivery to the Program Coordination Unit.

9. Publications

The Board of Directors may determine which information considered in the course of sessions may be disclosed and may authorize its Chairman to release it.

10. Expenses of the Board

The necessary expenses for the Board's operations shall be covered by the budget of the Program Coordination Unit.

APPENDIX 2 OF THE REGULATIONS
ELIGIBILITY OF THE NETWORKS

The subregions must present basic information on the networks selected in the first instance, lead hospital, number and type of establishments that would be included in the project, diagram of geographic distribution of the establishments (map) and an outline of the operations of the subregion and the network to be submitted.

Acceptance at this preliminary level will be based on three criteria:

1. Inclusion in the program area

The proposed network must be included in the priority program area defined with the Bank for the purposes of the project, based on family income and the population in the area where the network is located.

2. Subregional level

Subregions submitting network proposals should be implemented and operational and thus be in a position to effectively administer resources provided to them if accepted.

3. Network level

Requests submitted with regard to networks must demonstrate that the network actually exists, that is, that it has the characteristics required for the purposes of the project. It must have a lead hospital, be composed of establishments of varying complexity and serve a steady flow of users.

The existence of operating reference and cross-reference systems within the network should not be considered a prerequisite, since to a large extent, this is the aim of the project itself.

4. Level of establishments within the network

a. Criteria with regard to physical infrastructure

The construction of the establishments included in the network must meet minimum security standards to ensure that the equipment to be installed is protected against theft, exposure to sun, air, rain or flooding. The work environments must provide sufficient space and conditions conducive to effective operation and maintenance of the equipment.

b. Criteria with regard to personnel

The personnel must meet minimum requirements for the operation and maintenance of the equipment or ensure its incorporation in the preparatory phase of the network project in question.

c. Financial criteria

The budget for operation, care and maintenance of the equipment, with funds from the Ministry of Health and the regions must be approved.

d. Economic criteria

The principle is sufficient demand in each establishment in the network. Eligibility from an economic point of view will be determined based primarily on the analysis of demand for the network's services. This will be conducted by the Evaluation Committee of the Financial Fund, which will review all of the terms of the initial steps taken by the network project applicants to gain eligibility.

APPENDIX 3 OF THE REGULATIONS
SELECTION AND EVALUATION OF APPLICATIONS (PROJECTS)

A. Selection

The selection criteria would vary in accordance with the level of complexity of the various establishments as stated in the following paragraphs. A condition which is common to all facilities, is that the equipment must be such that it does not require any special installation or construction for its use and it can be readily transferred from one establishment to another.

1. Equipment, medicinal products and other inputs

a. Medicinal products and other inputs

The establishments in the networks selected would receive an initial basic incremental supply, as needed for initial operation of equipment item replacements in health establishment networks benefiting under the program.

b. Equipment

The following guidelines would apply:

(1) Health posts and health centers without beds could be provided with the equipment needed for attaining an operating capacity commensurate with the demand for the activities under their responsibility. Examples of such equipment are stethoscopes, sphigmanometers, anthropometric scales, curative instruments, refrigerators, furniture and filing cabinets.

(2) More sophisticated health centers (those with beds, emergency services and diagnostic or therapeutic technical support services) could be provided with diagnostic imaging, sterilization and laboratory equipment and resources to improve their operating capacity and, in addition, enable them to operate effectively as referral centers. Such establishments would be supplied with equipment for their first-aid, outpatient, and basic laboratory services, their inpatient departments in the four basic specialties (internal medicine, general surgery, pediatrics, and gynecology and obstetrics), and their delivery rooms, as well as beds for patient observation and stabilization.

(3) General hospitals could be provided with basic equipment such as the following: (i) for the surgical center: operating tables and auxiliary equipment, lamps, anesthesiology equipment, surgical tools and nursing and administrative supplies; (ii) intensive care unit: vital-signs monitors, resuscitators and nursing equipment;

(iii) obstetrics and neonatology centers: delivery table, surgical and obstetrical tools, incubators and cribs, anesthesiology equipment; (iv) emergency room: resuscitator, electrocardiograph and surgical supplies; (v) outpatient service: furniture, anthropometric scales, examination cots, stethoscopes, sphigmanometers and the like; (vi) inpatient units: beds, cots, wheelchairs; (vii) radiology centers: X-ray machines, film processors or darkroom equipment, ultrasound equipment, negatoscopes, fluoroscopes and basic radiology equipment; (viii) laboratory: instruments for parasitology, hematology, biochemical and other basic examinations; and (ix) sterilization centers: autoclaves, dry sterilization ovens, work tables, sterilization cylinders, etc. Also to be provided would be inpatient care equipment, administrative equipment, radio- or telecomunications equipment, nursing post supplies and, on a selective basis, at strategic points, ambulances or other transportation equipment and communication systems to interconnect the various components of the network of establishments and for use in the movement of patients.

In the case of hospitals, the equipment to be procured must meet the following criteria: (i) Less than US$1,000 per functional center: no special conditions; (ii) US$1,000-US$5,000 per functional center: must be agreed upon with the Bank; (iii) More than US$5,000 per functional center: must meet the following criteria:

(a) it must respond to the needs of the functions assigned to the establishment and the functional center 1/ where the equipment is to be used;

(b) it must be intended to replace or supplement existing equipment; 2/

(c) the costs for installing the equipment on a ready-to-use basis should not exceed 10% of the cost of the equipment;

(d) the technological level of the center should remain unchanged;

1/ A functional center is a set of units, personnel and equipment needed for the performance of activities in the areas of consultation, inpatient or emergency services (e.g. surgery center, obstetrical center, sterilization center, outpatient consultations, emergency services), technical support services (e.g. laboratories, radiology); or administrative and general services.

2/ Supplementary equipment items are those which have not been previously available but which are considered essential or indispensable for the performance of the functions assigned to the facility. For example, supplementary equipment would be needed if the surgery center were equipped.

(e) the basic trained personnel should be available to operate the equipment at the time of its installation; 3/

(f) the government level involved must have assumed a commitment to maintain the equipment in accordance with the conditions laid down in the contract; and

(g) the equipment must be movable or transferrable from one establishment to another without sustaining any damage.

2. Managerial support for facilities

Simple managerial control systems aimed at strengthening basic administrative capabilities of individual units and instituting functional linkage with other establishments making up the network will be designed and implemented in the establishments of the networks selected ensuring the supply of critical resources, and identifying ways in which the community can participate in management.

3. Training

Training would be provided in the establishments of the networks selected to improve the skills and knowledge of professionals and technicians at the local level and thus ensure efficient operation of the network of establishments at each area unit while strengthening each of its component establishments. Training in technical, administrative and support-service areas would be included.

B. Evaluation of applications

The project evaluation criteria specified in these Regulations need to be supplemented by setting forth specific parameters for eligibility for Fund assistance. To this end, at such time as applications from at least five networks are in hand, a technical mission would be carried out for the purpose of defininining such parameters.

1. Basic criteria for evaluating equipment

Equipment requested will be approved and included provided that the following evaluation criteria are met:

(1) There is demand for it.

(2) The necessary staff is available.

3/ The government level involved could hire the necessary personnel prior to approval of the application.

(3) The activity for which the equipment has been requested is actually being performed (activity programming document to be submitted only for hospitals and health centers).

(4) The equipment requested is the key factor affecting the efficiency of the service in question.

Equipment will be considered for inclusion in a project if it involves:

(1) Replacement by reason of obsolescence (physical and technological).

(2) Replacement by reason of irreparability.

(3) Inadequacy in relation to demonstrated demand, provided the necessary space and installations are available.

a. Technical evaluation

In equipping elegible establishments forming part of a network:

(1) All aspects of the infrastructure for the establishments selected will be analyzed with a view to making certain of their ability to provide adequate support to the reequipped services envisaged in the project. Special consideration will be given to establishments equipped with sanitation and potable water services or, in the case of the latter, appropriate equipment will be included.

(2) The equipping of each faciliity will be based on its level and role in the network, with the following criteria taken into account:

(a) Each network's main hospital must be equipped at the minimum level consistent with its level of complexity (I to V).

(b) Network support hospitals must have access to the minimumequipment needed to provide proper support to the network; in some cases, this will involve simply the removal of bottlenecks so as to avert possible duplication of hospital equipment leading to inefficiencies in the program.

(c) Health stations and centers should be endowed with a minimum set of basic equipment, the makeup of which will depend on the actual coverage assigned to each.

(d) The technical evaluation will determine whether the requested equipment is consistent with the pre-defined levels of health care and roles and will contain the necessary recommendations in this regard.

b. Institutional evaluation

The purpose is to evaluate the institutional capacity to implement the project submitted. This involves:

(1) Using the information submitted with the project to assess the level of progress in the organization and determine the present and future supply of human resources required to enable the Ministry of Health, the Region and the Subregion to extend adequate support to the proposed project. This implies that progress must have been made in instituting a human resource policy suited to the needs of the project and that this policy must have been implemented in the specific regions and subregions involved.

(2) Examining the existing and proposed procedures for budget preparation, approval, execution and control, for the movement of funds between the central and regional levels and individual network facilities, and for purchases and procurement. Making certain that these procedures do not discriminate against or adversely affect the system's weakest units (health stations and centers).

(3) Evaluating the operational schemes designed for the operation of the networks to be strengthened, with emphasis on their impact on networks not included in the project. Seeing to it that the operational capacity required of the network or networks to be strengthened and of other networks does not exceed the management capabilities of the region or subregion.

(4) Examining the existing internal audit procedures and the frequency of audits and comparing them with pre-established standards.

c. Financial evaluation

The purpose here is to ensure that the project will have access to the funds required for its operation once the equipment and training have been provided and the network's operational capability has been strengthened, and determine whether the unit costs are appropriate in relation to costs considered acceptable in terms of levels prevailing in the country for each type of service and level of care. This involves:

(1) Examining the impact of the incremental costs on the operating budgets for the region and on the Ministry's central allocations, checking to make certain that those costs are correctly estimated within the projected outlays for individual establishments and for the network as a whole.

(2) Examining the funding structure for the network and its facilities, including the contribution from establishment revenues (self-financing through charges for services), and the regional and central contributions. Check for compatibility with other

budgetary commitments and with possible constraints on expenditures at the various levels of the Ministry and the regions.

d. Socioeconomic evaluation

The purpose is to confirm the existence of sufficient demand for the services to be provided and evaluate their units costs in order to be certain that they are not out of line with levels considered acceptable in the country.

(1) Demand for services. Make certain that there is an adequate level of demand (one exceeding a predetermined minimum level to be defined) for the various services to be offered by each establishment included in the network project.

(2) The demand for each establishment will be checked in terms of the potential user population in its service area.

(3) The evaluation must determine that the scale of the project is appropriate in terms of the number of establishments it includes and that the demand projections are appropriate. The projection criteria must be verified, supplemented and adjusted.

(4) The evaluation must determine with special clarity whether the rate policy for services in the establishments is regarded as an impediment to adequate access by lower-income clients and should propose adjustments on the basis of surveys to be commissioned as a supplementary measure to cast additional light on this point.

(5) The socioeconomic specialist will work in this area in close cooperation with the financial specialist.

(6) A scheme will be established for evaluating the structure and level of total and unit costs arising from the various project proposals, focusing primarily on the identification of costs which are unwarranted or unduly high in terms of preset criteria, will be developed jointly with the financial specialist.

(7) Unit costs by type of establishment and by type of health care (cost per discharge; cost per consultation; cost of first-care-level procedures under the principal existing programs; may be overall costs per person covered in the case of health stations without a physician).

(8) After taking into consideration the costs of the alternative or alternatives chosen, the economic specialist will determine which is the least-cost alternative or, if the project involves an improvement in efficiency, that the costs of the alternative selected do not favor the selection of a lower-cost alternative as being equally effective. The cost-effectiveness methodology will be principally applied.

(9) A special effort will be made to ensure that all network projects are targeted toward beneficiaries in the lower per capita income strata based on the current levels established in accordance with the IDB methodology.

2. Evaluation report

When the entire project has been evaluated, an evaluation report will be prepared and submitted with the project to the Evaluation Committee, which will forward it with appropriate recommendations to the Director of the Program Coordination Unit for subsequent submittal to the Board of Directors of the Fund.

APPENDIX 4 OF THE REGULATIONS

PROCEDURE, MECHANISMS AND TIME FRAME FOR PROVISION OF THE TECHNICAL ASSISTANCE AND SUPPORT IN THE PREPARATION OF APPLICATIONS

1. The Network Administration Unit (Subregion) may receive technical assistance during the preparation of the application.

2. The technical assistance will be provided through national consultants who are specialists in the areas of equipping, training and management, and who will travel to the networks to work directly with the local technical team responsible for preparing the application.

3. The Network Administration Unit (Subregion) will make available the physical space required for the work of the consultants and provide their transportation to each of the facililites making up the network.

4. The consultants who are to provide technical assistance will be supplied with the following materials for use in their work:

   - Guidelines for the preparation and evaluation of applications for the provision of support services to the health care network
   - List of equipment, with unit costs and use codes
   - List of possible training courses and their costs
   - List of possible problem areas in the management field, with alternative solutions and their costs

5. The material indicated above will be provided for the consultant's sole use and is to be used after the local level has identified its needs and potential solutions.

APPENDIX 5 OF THE REGULATIONS

INFORMATION TO BE CONTAINED IN THE TERMS OF REFERENCE FOR THE ENGAGEMENT OF CONSULTANTS FOR THE MANAGEMENT AND TRAINING SUBCOMPONENTS

1. Area of specialization

a. Requirements:

Specify the training (academic and graduate degrees) and minimum experience (in years of service by area of specialization or type of work) needed for proper performance of the work or tasks described.

b. Objectives:

Describe the overall objective of the mission or of the group of consultants being hired.

Describe the specific objective of the individual consulting assignment within the work of the team.

c. Tasks:

Describe in detail each of the activities and tasks the consultant is expected to carry out. Be specific enough that subsequent briefings can be dispensed with. Add a clause to the effect that the consultant may be asked to perform other tasks related to those described.

d. Expected outputs:

Describe the intermediate and final products the consultant is expected to produce (e. g. reports, manuals, etc.); specify the content and characteristics of each product.

e. Duration:

Estimate the amount of time in days (up to five), in weeks (up to three), or in months.

f. Other conditions:

Specify whether the consultant is to perform his work in the area where he is recruited or elsewhere. Specify how much time in each place. Estimate the number and duration of trips.

APPENDIX 6 OF THE REGULATIONS

GUIDELINES FOR THE TRAINING SUBCOMPONENT

1. Definition of the problem:

Provide a summary description of the problem to be solved through the proposed activity.

2. Objectives:

List the objectives of the training activity.

3. Expected results:

Provide a clear description of the expected products and results of the proposed training activity. Be sure to specify clearly what is expected of participants by the end of each stage of the proposed activity, couching it in terms of knowledge, attitudes or observable behaviors, psychomotor skills, etc. In defining the results, use specific action verbs, e.g. identify (alternative solutions), arrive at (decisions), carry out (activities), analyze (data, information), propose (a solution), etc. Avoid verbs denoting actions or behaviors which are not observable (i. e. sensitize, familiarize, etc.).

4. Evaluation criteria:

The criteria for determining the acceptability of the teaching content in terms of the expected results as defined should be specified from the outset.

5. Definition of training strategy and techniques:

Specify the strategy to be followed, i. e. in-service training, seminars, programmed education, simulation, problem solving, etc., depending on which is considered the most conducive to the expected results.

6. Identification of contents:

Specify the subject contents for arriving at the expected results.

7. Sequential arrangement of learning contents:

The contents should not necessarily be arranged by disciplines but should be presented in a logical sequence to facilitate learning, beginning with the basic items of knowledge, the simplest skills, etc.

8. Selection of instructors:

Identify instructors, if possible, on the basis of pre-established criteria. Indicate if they are members of government services or if they are consultants.

9. Teaching materials:

Describe the materials and equipment needed for conducting the activity, distinguishing between items that would be purchased o prepared with funds from the operation and items that would be borrowed or would not need to be prepared.

10. Selection of the training venue:

Specify the training venue(s) clearly, including address(es), room number(s), etc. if possible.

11. Determination of number of hours:

This determination should be based on a consideration of all the foregoing factors. It should not be made at the outset, but only after the definitions and decisions pertaining to all of those factors have been arrived at.

12. Preparation of the schedule of activities:

Prepare a schedule setting tentative dates for the major events.

13. Estimation of the budget:

Estimate by expenditure categories. Use a classification comparable to those utilized by the Bank.

PROPOSED RESOLUTION 1/

PERU. LOAN /OC- TO THE REPUBLIC OF PERU
PROGRAM TO STRENGTHEN HEALTH SERVICES

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Republic of Peru, as Borrower, for the purpose of granting it a financing to cooperate in the execution of a program to strengthen health services, hereinafter referred to as the "Program". This Financing shall be subject substantially to the following conditions:

1. Amount and currencies: Up to US$68,000,000 or its equivalent in other currencies, except that of Peru, which are part of the ordinary capital resources of the Bank, to pay for goods and services acquired through international competition in the member countries of the Bank and for such other purposes as may be specified in the loan contract. Payments of amortization and interest shall be made in the currency or currencies specified by the Bank, in a quantity equivalent to the corresponding amount owed, calculated in units of account in terms of dollars of the United States of America, in accordance with provisions to be included in the loan contract.

2. Source of Funds: The ordinary capital resources of the Bank.

3. Guarantee: The general responsibility of the Borrower.

4. Credit fee: 0.75% per annum on the undisbursed portion of the Financing, which fee shall commence to accrue 60 days after the date of the loan contract and payable in dollars of the United States of America on the same dates as the interest.

5. Amortization: The Borrower shall amortize the loan in a period of 25 years from the date of the loan contract, by means of semi-annual, consecutive and, insofar as possible, equal installments.

1/ The provisions contained in this Appendix I and in Appendices II and III will be final only when the Board of Executive Directors has approved the loan proposal.

The first installment shall be paid on the first interest payment date, six months after the date scheduled for the last disbursement of the Financing.

6. Interest: The Borrower shall pay interest semiannually on the daily outstanding balances of the loan. The first payment shall be made six months after the date of the loan contract. The Bank shall determine the rates of interest to be applied during the life of the loan, in accordance with the lending rate policy of the Bank. At the request of the Borrower, resources of the Financing may be used to pay interest during the period of disbursement thereof.

7. Commitment and disbursement: The term for commitment of the financing for the support for the Health Care Networks component referred to in paragraph 2.5 of Appendix III shall expire three years after the effective date of the loan contract, and the term for disbursement of the Financing shall expire four years after the same date.

8. Special conditions:

(a) The execution of the Program and the utilization of the resources of the loan shall be performed in their entirety by the Borrower through the Ministry of Health, hereinafter referred to as the "Executing Agency" or "MINSA", which shall carry out the Program through the Program Coordinating Unit ("PCU") in coordination with the technical units of MINSA, and, with regard to what is referred to in paragraph 2.3 of Appendix III, with the Inter-institutional Committee.

(b) The resources of the loan shall be used to participate in the execution of a Program the total cost of which is estimated at the equivalent of US$98,000,000. Consequently, the loan contract shall contain the appropriate provisions to ensure that such additional resources as may be necessary for the complete execution of the Program shall be duly provided in an amount estimated at the equivalent of US$30,000,000, which may include up to the equivalent of US$20,000,000 in parallel financing, in accordance with a schedule of investments satisfactory to the Bank.

(c) Prior to the first disbursement of the Financing, the Borrower, through the Executing Agency, shall present to the satisfaction of the Bank, evidence that:

(i) the PCU has been legally established and the director, the deputy directors and additional personnel necessary to initiate the Program have

been hired in accordance with terms of reference previously agreed upon with the Bank;

(ii) the Inter-institutional Coordinating Committee of the Program has been established in accordance with terms of reference previously agreed upon with the Bank;

(iii) a special account has been established in which the proceeds from the Financing shall be deposited;

(iv) the Operating Regulations of the Health Investment Fund (the "Fund") referred to in paragraph 2.5 of Appendix III have been formalized;

(v) an agreement has been signed between the Pan-American Health Organization (PAHO/WHO) and MINSA, in accordance with terms previously agreed upon with the Bank and consistent with the applicable national laws, under which PAHO shall undertake to provide advisory services to MINSA in the hiring and supervision of consulting services necessary for: (1) the institutional and preinvestment studies and institutional strengthening components referred to in Chapter II, sections (a) and (b) respectively, of Appendix III; (2) the management and training subcomponents referred to in subparagraphs 2.5 (ii) and 2.5 (iii) of Appendix III; and (3) the preparation of technical specifications as well as the supervision of the installation and provision of equipment, medicines and other supplies to be acquired under the Health Care Networks support component referred to in paragraph 2.5 of Appendix III;

(vi) an agreement has been signed between the United Nations Development Programme (UNDP) and MINSA, in accordance with terms agreed upon with the Bank and consistent with applicable national laws, under which the UNDP undertakes to provide advisory services to MINSA with regard to the procurement of equipment, medicines and other supplies referred to in paragraph 2.5 of Appendix III; and

(vii) it has drawn up the annual Operating Plan for the first calendar year based on the guidelines set forth in paragraph 7.1 of Appendix III.

(d) Prior to any disbursement to finance the support for the Networks described in Appendix III, the Executing Agency

must have received and reviewed the first five Network project financing applications, and based upon such review, must have prepared a report, satisfactory to the Bank, containing its recommendations regarding possible adjustments to the eligibility criteria set forth in the Operating Regulations.

(e) Upon acceptance by the Bank, up to the equivalent of US$500,000 of the resources of the Financing may be utilized to cover expenses of consulting services to prepare the Program, incurred during the 12 month period immediately prior to the date of this resolution, provided that requirements substantially similar to those of this resolution and the loan contract have been fulfilled.

(f) In the acquisition of equipment and other goods for the Program the system of public bidding shall be followed in each case in which the value of such acquisitions exceeds the equivalent of US$250,000. The bidding shall be subject to the procedures to be appended as an Annex to the loan contract. This provision shall not apply to acquisitions made with resources from suppliers' credits or from other sources of credit.

(g) The Bank shall establish such inspection procedures as it deems necessary to assure the satisfactory execution of the Program and the Borrower shall extend all cooperation which is required for the most effective accomplishment of this purpose. From the amount of the Financing the sum of US$680,000 shall be allocated for credit to the income accounts of the Bank to meet expenses of general inspection and supervision.

RECOMMENDATIONS

A. It is recommended that the following conditions, to be met to the Bank's satisfaction, be included in the loan contract, in addition to those set forth in the proposed resolution:

1. During the execution of the Program and in accordance with the guidelines set forth in paragraph 7.1 of Appendix III, the Borrower, through the Executing Agency, shall submit to the Bank at least 60 days prior to the end of each calendar year, the annual Operating Plan to be carried out during the following calendar year, and within 60 days of the beginning of each calendar year, the report of the execution of the prior year's Operating Plan.

2. Unless the parties agree otherwise, prior to issuing each call for public bids, or if there is no need for public bids, prior to the acquisition of the goods, the Borrower, through the Executing Agency, shall submit to the Bank, for its consideration, the specifications, budgets and other documents needed for the acquisition of goods and for the call for bids.

3. Prior to the first call for bids on equipment, medicines and other supplies to be obtained for the Program, the Executing Agency shall establish a receiving committee whose purpose shall be to verify, certify and take delivery of the goods procured, as well as to verify that the goods have arrived at the correct destination.

4. For each of the studies included in the institutional and preinvestment studies component referred to in section (a) of Chapter II of Appendix III, the Executing Agency shall not issue the call for proposals for: (a) prefeasibility studies, until such time as the Bank has approved the corresponding general studies; (b) feasibility studies, until such time as the Bank has approved either the corresponding prefeasibility studies or, if necessary, the results of the experimental study on integration between the public and private sectors; and (c) designs, until such time as the Bank has approved the corresponding feasibility studies, when applicable.

5. Within nine months of the date of the loan contract, the Borrower, through the Executing Agency, shall engage, in accordance with terms of reference agreed upon with the Bank: (a) the consultant services needed to carry out the institutional strengthening component referred to in

paragraph 2.4 of Appendix III; and (b) the consultant services referred to in paragraph 2.2 of Appendix III.

6. Within nine months of the date of the loan contract, the Executing Agency shall present to the Bank the agreement between PAHO/WHO and MINSA, in accordance with the terms agreed upon with the Bank and the applicable national laws under which PAHO/WHO shall undertake to carry out the experimental study on water and food disinfection, within the preinvestment studies component referred to in paragraph 2.2 of Appendix III.

7. The Borrower shall: (a) assure that the equipment covered under the Program will be adequately maintained in accordance with generally accepted technical standards; and (b) submit to the Bank, during the five years following completion of the first acquisition of equipment, and within the first quarter of each calendar year, a report of the condition of such equipment and the annual maintenance plan for that year, in accordance with paragraph 6.3 of Appendix III. If the inspections conducted by the Bank, or reports it receives reveal that actual maintenance is below the agreed-upon levels, the Borrower shall take appropriate action to have the deficiencies fully corrected.

8. The Borrower, through the Executing Agency, shall submit to the Bank:

   (a) within six months from the effective date of the loan contract: (i) the baseline data the categories of which are indicated in paragraph 8.3 of Appendix III; and (ii) the description of the procedure to be used to compile and process the annual data which is to be compared to the baseline data to evaluate the results of the Program;

   (b) within 18 months from the effective date of the loan contract, the baseline data indicated in the previous section revised by the parties.

   (c) within 24 months from the effective date of the loan contract, an interim evaluation, and beginning 36 months from such effective date, and annually through the second year following the date of the last disbursement of the Financing, evaluation reports which shall follow the methodology for the baseline data referred to in the previous sections.

   (d) At the end of the second year from the date of the final disbursement of the Financing, an ex post

evaluation report following the methodology indicated in section (a) above.

9. The financial statements of the Program, during its execution, shall be presented annually to the Bank audited by an independent public accounting firm acceptable to the Bank.

B. The loan contract shall contain an annex substantially similar to Appendix III.

THE PROGRAM

Annex A to the Loan Contract

I. Objectives

1.1 The Program has three fundamental purposes:

(a) To conduct studies and take concrete measures permitting the preparation of broader sector reform Programs, taking into account the role of social security and of the other entities providing public and private health services.

(b) To strengthen the Ministry of Health ("MINSA") in its role as regulatory body for the sector as well as the decentralized entities in their coordinating and regulatory functions in their respective areas.

(c) To create the basic conditions necessary to satisfy the most urgent public health care needs in the country's poorest areas by strengthening the management capacity of health care units and providing them with basic equipment in order to restore their ability to deliver priority health care.

II. Description

2.1 The Program includes the following three components:

(a) Institutional and preinvestment studies

2.2 The purpose of these studies is: (i) to organize the sector and introduce policy adjustments to devise a new structure and to re-order the sector; (ii) to create the basis for a sector structural reform operation; and (iii) to prepare a Program for short and medium-term priority investments. These studies will include: general studies, an integration experiment with the private sector, prefeasibility and feasibility studies and designs, and a water and food disinfection experiment.

2.3 In order to decide on the content and desired results of the studies under this component, an Inter-institutional Committee will be set up and composed, at a minimum, of representatives of the Ministries of Economy and Finance, and Health. The mandate for this Committee will be to ensure that the studies: (i) provide an effective basis for decisions with regard to institutional reform and sector policies; and (ii) are compatible with the institutional adjustments and reforms and national policies.

(b) Institutional strengthening

2.4 This component will include the design and implementation of seven technical administrative systems to strengthen areas identified as critical. These systems include supervision and monitoring, provision of critical supplies, maintenance, communications, hospital waste management, information and training.

(c) Support for the Health Care Networks

2.5 The purpose of this component is to produce an immediate improvement in the quantity and quality of basic preventive and curative medical care. It will consist of projects approved by the Health Investment Fund (the "Fund"), for the strengthening of health posts and centers as well as general hospitals, grouped in Health Care Networks. Said improvement will be accomplished by providing basic equipment, medicines and other supplies, and by strengthening management and training. In addition, in the areas from which eligible applications are likely to be submitted, technical assistance in application preparation will be provided. This component will be governed by the Fund's Operating Regulations, which will contain operating procedures and criteria for the eligibility and evaluation of project applications. As set forth in paragraph 8.2 of this Annex, the Fund's Operating Regulations shall be reviewed by the Executing Agency and the Bank upon the receipt of the first five Health Care Network project applications. This component includes: (i) furnishing of basic equipment, medicines and other supplies; (ii) support for the management of health care units; and (iii) training.

III. Total Cost of the Program and Financing Plan

3.1 The estimated cost of the Program is the equivalent of US$98 million, in accordance with the following investment categories and sources of financing:

TOTAL COST IN THOUSANDS OF US$ STRENGTHENING OF HEALTH SERVICES IN PERU					
Investment Categories	IDB	COFIN.	Local	Total	% of Total
1. Administration	700	0	1,000	1,700	1.7%
2. Direct costs	55,177	20,000	5,700	80,877	82.5%
2.1 Projects	37,500	20,000	0	57,500	58.7%
2.2 Institutional strengthening	6,100	0	5,000	11,100	11.3%
2.2.1 Consultant services	4,600	0	5,000	9,600	9.8%
2.2.2 Equipment	1,500	0	0	1,500	1.5%
2.3 Preinvestment	11,577	0	700	12,277	12.5%
3. Associated costs	1,629	0	680	2,309	2.4%
3.1 International agencies	1629	0	0	1,629	1.7%
3.2 Additional personnel	0	0	186	186	0.2%
3.3 Supplies	0	0	396	396	0.4%
3.4 Maintenance	0	0	98	98	0.1%
4. Unallocated	305	0	199	504	0.5%
4.1 Contingencies	305	0	199	504	0.5%
5. Financial costs	10,189	0	2,421	12,610	12.9%
5.1 Interest	9,509	0	1,426	10,935	11.2%
5.2 Credit fee	0	0	995	995	1.0%
5.3 Inspection and supervision	680	0	0	680	0.7%
TOTAL	68,000	20,000	10,000	98,000	100%
% Fund/Program	70%	20%	10%	100%	

IV. Procurement

4.1 When goods to be procured or services to be contracted for the Program, including those related to any form of transportation or insurance, are to be financed in whole or in part with foreign exchange from the Financing, the procedures and specific requirements for the bidding or other forms of contracting, shall

permit the unrestricted participation of goods and services from member countries of the Bank. Consequently, no conditions that would prevent or restrict the offer of goods or the participation of contractors from such countries shall be established in such procedures or specific requirements.

4.2 When sources of credit other than the resources of the Financing or the local counterpart are to be used, the Borrower may agree with the creditor upon the procurement procedure to be followed. However, upon the Bank's request, the Borrower shall demonstrate the reasonableness of both the price agreed upon or paid for the purchase of the goods and services and the financial conditions of the credits. The Borrower shall also demonstrate that the quality of the goods is in conformity with the technical requirements of the Program.

V. Consulting services

5.1 In the selection and contracting of consulting services financed in whole or in part with resources from the Financing: (a) the procedures agreed upon with the Bank shall apply, and (b) no conditions or stipulations may be established that would restrict or prevent the participation of consultants from the Bank's member countries.

5.2 With respect to consulting services financed with the resources of the local counterpart, the Bank reserves the right to review and approve, prior to the Borrower proceeding with the corresponding hire, the names and background of the firms or individual consultants selected, their terms of reference and the agreed fees.

VI. Maintenance

6.1 The purpose of the maintenance shall be to preserve the equipment covered under the Program in the operating condition in which they were when supplied, at a level compatible with the services they are intended to provide.

6.2 The first annual maintenance plan shall correspond to the fiscal year subsequent to that in which the first batch of equipment was acquired with resources from the Program.

6.3 The annual maintenance plan shall include: (a) details of the organization responsible for maintenance, the personnel involved and the number, type and condition of the maintenance equipment; (b) information pertaining to the resources to be allocated for maintenance during the current year and the amount to be allocated in the budget during the following year; and (c) a report on the status of maintenance.

VII. Operating Plan

7.1 The annual Operating Plan referred to in Recommendation A.1 of Appendix II shall include at least a description of the activities being considered, a budget, a disbursement timetable and procedures for implementation, as well as resources allocated to each of the components of the Program.

VIII. Monitoring and evaluation

1. Initiation of execution

8.1 Within a period of three months from the effective date of the loan contract, the Bank will conduct, together with MINSA, a technical mission to Peru to carry out activities related to the start-up of the Program, in all of its technical, methodological and financial aspects.

2. Evaluation of the first group of applications for support of the Networks

8.2 The Borrower, through the Executing Agency, shall submit to the Bank, for its approval, a first group of project applications from five Networks. Based on this first group of applications a determination will be made, together with the PCU, as to the quantitative parameters and eligibility criteria to be finally included in the Operating Regulations of the Fund.

3. Initial report

8.3 The initial report that will contain the baseline data referred to in section (a) of Recommendation A.8 in Appendix II shall include, for each component, the following information:

(a) Preinvestment: (i) the terms of reference for the programmed consulting services; (ii) timetable of activities; and (iii) budget.

(b) Strengthening of MINSA: (i) terms of reference for the hiring of consulting services; (ii) timetable of work; (iii) budget; and (iv) indicators as to the condition of the seven administrative systems.

(c) Support for the Networks: (i) timetable of work; (ii) tentative annual budget based on the number of networks to be assisted; and (iii) basic data per establishment in each network, such as: (1) size of the beneficiary population; (2) number of consultations, immunizations, house calls, etc.; (3) effective coverage by health program (maternal and child care, communicable disease, etc); (4) turnover rate by department or

service; (5) discharge rate by service and type of outcome (cure, transfer, improvement without change, voluntary and death) in hospital facilities; (6) volume of referrals and cross-referrals between hospitals and health centers and posts; (7) facilities with financial administration systems in operation; (8) cost of hospitalization, outpatient consultation and emergencies, by department or service; (9) cost of medical care in health centers and posts (personnel, medication and other variables); (10) cost of maintaining equipment and infrastructure; (11) ratio of trained personnel; and (12) low income survey.

4. Interim evaluation and Annual Reports

8.4 The Borrower, through the Executing Agency, shall submit to the Bank an interim evaluation report and annual evaluation reports to measure progress, detect problems and introduce adjustments and corrective measures during the Program, in accordance with section (c) of Recommendation A.8 of Appendix II.

5. Ex post evaluation

8.5 In accordance with the methodology referred to in Recommendation A.8 of Appendix II, the Borrower, through the Executing Agency, shall submit to the Bank an ex post evaluation of the Program in order to verify the degree of accomplishment of the goals and results expected of the Program, particularly with respect to the process of strengthening MINSA and improvement in the coverage and quality of health services in the Networks benefited by the operation. The information by component indicated above shall be attached to the ex post evaluation.