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PROJECT PERFORMANCE ASSESSMENT REPORT

PERU

BASIC HEALTH AND NUTRITION PROJECT (LOAN 3701)

MOTHER AND CHILD INSURANCE AND DECENTRALIZATION OF HEALTH SERVICES, FIRST PHASE OF HEALTH REFORM PROGRAM (LOAN 4527)

June 26, 2009

Sector Evaluation Division
Independent Evaluation Group (World Bank)

Currency Equivalents (annual averages)

Currency Unit = Nuevo Sol

1994	US$1.00	$2.20
1995	US$1.00	$2.25
1996	US$1.00	$2.45
1997	US$1.00	$2.66
1998	US$1.00	$2.93
1999	US$1.00	$3.38
2000	US$1.00	$3.49
2001	US$1.00	$3.51
2002	US$1.00	$3.52
2003	US$1.00	$3.48
2004	US$1.00	$3.41
2005	US$1.00	$3.30
2006	US$1.00	$3.27
2007	US$1.00	$3.21

Abbreviations and Acronyms

AAA	Analytic and Advisory Services
APL	Adaptable Program Loan
ARI	Acute respiratory infections
BHNP	Basic Health and Nutrition Project (*Programa de Salud y Nutrición Basica*)
BONF	Basic Obstetric and Neonatal Functions
CAS	Country Assistance Strategy
CDD	Control of diarrheal diseases
CIAS	Inter-Ministerial Social Policy Commission *(Comisión Interministerial de Asuntos Sociales)*
CHW	Community Health Workers
CLAS	Community Managed Health Facilities *(Comunidades Locales de Administración deSalud)*
CPS	Country Partnership Strategy
CUHSM	Coordination Unit for Health Sector Modernization (Unidad de Coordinación para la Modernización del Sector Salud)
DFID	Department for International Development (UK)
DGAES	General Directorate for Economics Social Affairs *(Dirección General de Asuntos Económicos y Sociales)*
DHS	Demographic and Health Survey *(Encuesta Demográfica y de salud familiar - ENDES)*
DIRESA	Regional Health Department *(Dirección Regional de Salud)*
DISA	Health Directorate *(Dirección de Salud)*
DPL	Development Policy Loan
EDA	Acute Diarrhea Diseases (*Enfermedades Diarreicas Agudas*)
ELITES	Local Traveling Health Teams *(Equipos locales itinerantes de trabajo extramural en salud)*
ENAHO	National Household Survey *(Encuesta Nacional de Hogares)*
EONF	Essential Obstetric Functions
ESSALUD	Health Social Security Institute (formerly known as IPSS)
ESW	Economic and Sector Work
FONCODES	National Fund for Social Compensation and Development *(Fondo Nacional de Compensación y Desarrollo Social*
GDP	Gross Domestic Product
GIS	Geographic Information System
GOP	Government of Peru
HNP	Health, Nutrition and Population
ICR	Implementation Completion Report
IDB	Inter-American Development Bank
IEC	Information, education, and communication

IEG	Independent Evaluation Group
IEGWB	Independent Evaluation Group World Bank
IFC	International Financial Corporation
IMCI	Integrated management of childhood illness
IMF	International Monetary Fund
IMR	Infant Mortality Rate
INEI	National Statistics Institute *(Instituto Nacional de Estadística e Informática)*
IPSS	Social Security System *(Instituto Peruano de Seguridad Social)*
JSDF	Japan Social Development Fund
KAP	Knowledge, attitudes and practices
MCH	Maternal and child health
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MEF	Ministry of Economy and Finance *(Ministerio de Economia y Finanzas)*
MIPRE	Ministry of the Presidency *(Ministerio de la Presidencia)*
MMR	Maternal Mortality Rate
MOH	Ministry of Health
NGO	Non-governmental organization
OPEC	Organization of Petroleum Exporting Countries
PAD	Project Appraisal Document
PAHO	Panamerican Health Organization
PARSALUD	Health Reform Program (*Programa de Apoyo a la Reforma en Salud*)
PCM	Prime Minister's Office *(Presidencia de Consejo de Ministros)*
PCU	Project Coordination Unit
PHC	Primary Health Care
PPAR	Project Performance Assessment Report
PSAL	Programmatic Structural Adjustment Loans
PSBPT	Basic Health for All Program (Programa Salud Basica Para Todos)
PSRL	Programmatic Social Reform Loan
RECURSO	Audit Accounts for the Social Reform (*Rendición de Cuentas para la Reforma Social*)
SAR	Staff Appraisal Report
SEG	Free School Insurance (*Seguro Escolar Gratuito*)
SHSP	Strengthening Health Services Program (*Programa de Fortalecimiento de Servicios de Salud*)
SIS	Comprehensive Health Insurance (*Seguro Integral de Salud – SIS)*
SISFOH	Household Targeting System *(Sistema de Focalización de Hogares)*
SMI	Mother Child Insurance (*Seguro Materno Infantil*)
SNIP	Budgetary System (*Sistema Nacional de Inversion Presupuestal*)
TBSE	Targeting of Basic Social Expenditure (Focalización de Gasto Social Basico)
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNOPS	United National Office of Project Services
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

Fiscal Year

Government: January 1 – December 31

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IEGWB Mission: Enhancing development effectiveness through excellence and independence in evaluation.

About this Report

The Independent Evaluation Group assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the Bank's self-evaluation process and to verify that the Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, IEGWB annually assesses about 25 percent of the Bank's lending operations through field work. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or Bank management have requested assessments; and those that are likely to generate important lessons.

To prepare a Project Performance Assessment Report (PPAR), IEGWB staff examine project files and other documents, interview operational staff, visit the borrowing country to discuss the operation with the government, and other in-country stakeholders, and interview Bank staff and other donor agency staff both at headquarters and in local offices as appropriate.

Each PPAR is subject to internal IEGWB peer review, Panel review, and management approval. Once cleared internally, the PPAR is commented on by the responsible Bank department. IEGWB incorporates the comments as relevant. The completed PPAR is then sent to the borrower for review; the borrowers' comments are attached to the document that is sent to the Bank's Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

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Outcome: The extent to which the operation's major relevant objectives were achieved, or are expected to be achieved, efficiently. The rating has three dimensions: relevance, efficacy, and efficiency. *Relevance* includes relevance of objectives and relevance of design. Relevance of objectives is the extent to which the project's objectives are consistent with the country's current development priorities and with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies). Relevance of design is the extent to which the project's design is consistent with the stated objectives. *Efficacy* is the extent to which the project's objectives were achieved, or are expected to be achieved, taking into account their relative importance. *Efficiency* is the extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. The efficiency dimension generally is not applied to adjustment operations. *Possible ratings for Outcome:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Risk to Development Outcome: The risk, at the time of evaluation, that development outcomes (or expected outcomes) will not be maintained (or realized). *Possible ratings for Risk to Development Outcome:* High Significant, Moderate, Negligible to Low, Not Evaluable.

Bank Performance: The extent to which services provided by the Bank ensured quality at entry of the operation and supported effective implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of supported activities after loan/credit closing, toward the achievement of development outcomes. The rating has two dimensions: quality at entry and quality of supervision. *Possible ratings for Bank Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Borrower Performance: The extent to which the borrower (including the government and implementing agency or agencies) ensured quality of preparation and implementation, and complied with covenants and agreements, toward the achievement of development outcomes. The rating has two dimensions: government performance and implementing agency(ies) performance. *Possible ratings for Borrower Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Contents

This report was prepared by Mollie Fair and Patricia Ramirez, consultants, who assessed the project in January 2008. Marie-Jeanne Ndiaye provided administrative support.

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PRINCIPAL RATINGS

	*ICR**	*ICR Review**	*PPAR*
Basic Health and Nutrition Project (Loan 3701)			
Outcome	Satisfactory	Moderately Satisfactory	Moderately Satisfactory
Institutional Development Impact**	Substantial	Substantial	———
Risk to Development Outcome	———	———	Moderate
Sustainability***	Likely	Likely	———
Bank Performance	Satisfactory	Satisfactory	Satisfactory
Borrower Performance	Satisfactory	Satisfactory	Satisfactory
Health Reform Program, Phase I (Loan 4527)			
Outcome	Satisfactory	Satisfactory	Satisfactory
Risk to Development Outcome	Negligible to Low	Negligible to Low	Moderate
Bank Performance	Satisfactory	Satisfactory	Satisfactory
Borrower Performance	Satisfactory	Satisfactory	Moderately Satisfactory

* The Implementation Completion Report (ICR) is a self-evaluation by the responsible Bank department. The ICR Review is an intermediate IEGWB product that seeks to independently verify the findings of the ICR.
**As of July 1, 2006, Institutional Development Impact is assessed as part of the Outcome rating.
***As of July 1, 2006, Sustainability has been replaced by Risk to Development Outcome. As the scales are different, the ratings are not directly comparable.

KEY STAFF RESPONSIBLE

Project	*Task Manager/Leader*	*Division Chief/ Sector Director*	*Country Director*
Basic Health and Nutrition Project (Loan 3701)			
Appraisal	Theresa P. Jones	Alain Colliou	Rainer Steckhan
Completion	Livia M. Benavides	Charles C. Griffin	Isabel M. Guerrero
Health Reform Program, Phase I (Loan 4527)			
Appraisal	Evangeline Javier	Xavier E. Coll	Isabel M. Guerrero
Completion	Livia M. Benavides	Keith Hansen	Marcelo Giugale

PREFACE

This is a Project Performance Assessment Report (PPAR) for the Peru Basic Health and Nutrition Project (BHNP, Loan No.3701) and the Peru Health Reform Program (PARSALUD, Loan No. 4527).

The BHNP (US$44.5 million) was approved in February 1994 and sought to improve maternal and child health and nutrition status in the project area. It was supported by an IBRD loan of US$34 million and planned government contribution of US$10.5 million. The loan was closed in December 2000, following a six-month extension of the closing date. It was about 99 percent disbursed.

PARSALUD was approved on December 16, 1999 and sought to support the government's medium-term goals to improve maternal and child health and to reduce morbidity and deaths of the poor from communicable diseases and inadequate environmental conditions. The US$239 million project was to be supported by an IBRD loan of US$80 million, US$95 million in financing from the Inter-American Development Bank (IDB), the U.K. Department for International Development (DFID), and the OPEC fund, and government counterpart financing of US$64.3 million. At negotiations, the government decided to finance a larger share of total project costs than originally planned, so both the World Bank and IDB contributions were scaled back, to US$27 million and US$28 million, respectively. The project closed on June 30, 2006, two and a half years later than planned. Ninety-seven percent of the project funds were expended and 99 percent of the World Bank loan was disbursed.

This PPAR was prepared by consultants Mollie Fair and Patricia Ramirez, who conducted an evaluation mission to Peru in January 2008. The PPAR findings are based on: (a) interviews with World Bank and IDB staff, several current and former representatives from directorates at the Ministry of Health, the Ministry of Economics and Finance, the Interministerial Commission for Social Affairs, former project staff, individuals from NGOs, universities, research centers and international aid organizations active in the health sector in Peru; (b) field visits to Lima and the Cuzco region; (c) A review of project design documents, lending agreements, project files, and the Implementation Completion Reports (ICR); (d) a review of literature and evaluations of health; and (e) analysis of health data for Peru. IEG gratefully acknowledges all those who made time for interviews and provided documents and information.

The findings of this in-depth PPAR have informed the IEG evaluation of the Bank's support for health, nutrition, and population (HNP). A supplemental section of the PPAR addresses some of the specific issues raised by that broader evaluation.

Following standard IEG procedures, a copy of the draft PPAR was sent to the relevant government officials and agencies for their review and comments. Their comments are presented in Annex H.

SUMMARY

There have been sustained improvements in maternal, under-5 mortality and particularly infant mortality at the national level in Peru since the early 1990s. Nevertheless, maternal mortality rates remain nearly twice as high as the Latin American average, and in recent years indicators for nutrition have stagnated. Furthermore, significant inequities persist between different socio-economic groups, and between rural and urban areas. For example, there was no reduction in the percentage of moderately stunted or moderately underweight children under 5 in the lowest wealth quintile between 1996-2006, and the number of severely or moderately stunted children in rural areas reached 39 percent in 2006. The total fertility rate (TFR) dropped from 4.0 in 1992 to 2.6 in 2006; however the TFR of those in the lowest wealth quintile (4.9 in 2006) remains almost twice that of the national average, and the TFR of rural women was also high, at 3.7. Contraceptive prevalence increased steadily from 1992- 2000 but then plateaued. Socio-economic and cultural factors remain important determinants of the demand for and use of health, nutrition and population (HNP) services.

Over the period of this analysis, 1994- 2006, Peru has also dealt with significant economic and political crises, including hyper-inflation and terrorism. At the start of this period, the health system had practically collapsed and Peruvians were forced to rely on out-of-pocket expenditures to cover their health care needs. Political and economic recovery occurred through the mid-to-late 1990s, and the Government of Peru (GoP) began to articulate a vision for the reform of the health system, particularly to address the economic barriers that prevented a large portion of the population from accessing basic health services.

Basic Health and Nutrition Project

After Peru's arrears cleared in 1993, the World Bank became active in the health sector with the approval in 1994 of a US$45 million loan in support of the Basic Health and Nutrition Project (BHNP). The project's objective was to improve maternal and child health and nutrition status in the project area, particularly among poor women and children. It sought to achieve this objective by improving access, use, and the quality of health and nutrition services, as well as by promoting healthy behaviors. During project implementation, several parallel projects were being implemented by the government and other donors, as the health sector was recovering from collapse and articulating a strategy for health reform. The BHNP was restructured on several occasions to increase its focus on health service delivery, although the objectives were not changed. Originally scheduled to close in June 2000, the project was extended by six months to December 2000 by which point it had disbursed 99 percent of funds.

There was a substantial increase in utilization of services in project areas, but improvements in the quality of services were modest and in healthy practices negligible. There were no improvements in child nutritional status between 1996-2000 in the departments in which BHNP was active. Although the project was targeted to the poorest areas, data were not collected separately on outcomes among the poor and non-poor

within those areas. While the project's efficacy was *modest*, the relevance of its objectives and design and its efficiency were *substantial*, resulting in an overall *moderately satisfactory* outcome rating. The project's risk to development outcome is *moderate* and both Bank and borrower performance are rated *satisfactory.*

Health Reform Program, Phase I

The Bank's next lending activity, the Health Reform Project (PARSALUD, First Phase-Mother and Child Insurance and Decentralization), was approved by the Board on December 16, 1999, and closed on June 30, 2006, two and a half years later than planned. The objective of the US$239 million project, funded by an Adaptable Program Loan (APL), was to support the government's medium-term goals to: (a) improve maternal and child health; and (b) reduce morbidity and deaths of the poor from communicable diseases and inadequate environmental conditions. The project aimed to accomplish these objectives by increasing the access of the poor to better quality health programs and services. At the beginning, implementation of the program was affected by political instability caused by a scandal in 2000 that led to the resignation of the president and a transition government. However, the project eventually spent 97 percent of planned expenditure.

PARSALUD had a substantial impact on the overall objective of improving maternal and child health within the project area. There was substantial increase in access to services, primarily as a result of wide adoption of Comprehensive Health Insurance (Seguro Integral de Salud – SIS), which reduced the economic barriers to utilization of health services. The quality of services also improved. Although overall coverage of the poor is still low, it seems that the gap between the poor and non-poor has narrowed, even if still great. The project's outcome is rated as *satisfactory* based on its continued *high relevance, substantial* efficacy, and *substantial* efficiency. PARSALUD's risk to development outcome is *moderate*. The Bank's overall performance is *satisfactory*, although it could have assessed the political risks better, and overall borrower performance is *moderately satisfactory.*

Thus, since 1994, over the course of these two projects the World Bank's support to Peru has been targeted to the poor. Whereas the first project focused on the poorest regions, support for PARSALUD represented a more substantial commitment to reaching the poor, with work to develop the SIS and support the implementation of targeting mechanisms and an intercultural strategy to better reach Andean communities. It is difficult to assess the impact of the World Bank's support on health outcomes among the poor, however, because the Bank's support in later years was for a national program and there are no areas of Peru without the SIS with which program areas could be compared.

In addition to project lending, the World Bank supported Peru's health sector through policy dialogue, economic and sector work (ESW) and with broader support to the social sectors through lending to National Fund for Social Compensation and Development (FONCODES) in the 1990s, and a series of four Programmatic Sectoral Reform Loans (PRSLs) implemented parallel to PARSALUD. The World Bank has been instrumental in helping to introduce an integrated model of health care in Peru that gives priority to maternal and child health issues, supporting the government on some health

innovations such as the integrated health insurance and the development of Local Committees for Health Administration (CLAS). The Bank has also played an important role in promoting better targeting on health issues and protecting social targets and social expenditure in times of crisis. Other influential international institutions in Peru that have also supported health reform include the IDB and the United States Agency for International Development (USAID).

The SIS still needs to be strengthened in technical, administrative, and financial aspects, and its targeting can be improved. The organization of the health sector remains fragmented and inefficient. Peru also has a very complex labor regime for healthcare workers. Any given health facility may have workers subject to entirely different labor regimes with different remuneration, job protection, and benefits. These complexities are institutionalized and severely limit the rate at which the health sector can be reformed. Decentralization of the health sector is still in progress and the CLAS model needs to be revisited and strengthened. Nutrition and population have not been priorities for World Bank support over the period of analysis.

Lessons

The Bank's support over the decade covered by these two projects has demonstrated some important lessons with respect to reaching the poor, health reform, and donor coordination, and points to continued value added of the Bank's engagement.

1. Reaching the poor

- **An emphasis on pro-poor health policies can be sustained through the use of multiple instruments in a constantly changing political environment**. Even as the health investment projects' activities were adapted over time, the poverty focus did not change.

- **However, the failure of monitoring and evaluation design and implementation to focus explicitly on the poor weakens the ability of programs to assess impacts and to learn from and perfect pro-poor targeting**. Although the two investment projects explicitly addressed HNP outcomes among people in poor regions and the poorest groups in the population, evidence was collected in most cases on *average* health outcomes in the poorest regions.

2. Health reform

- **Health system reforms that proceed in a piecemeal way can nevertheless result in improvements in access and efficiency**.

- **Creating new institutions can be less difficult than reforming existing ones**: the transformation of ESSALUD and the health care units of the Armed Forces and the National Police have proved to be more difficult than the creation of new organizations such as SIS.

- **Health reform projects need a realistic *ex ante* assessment of political and institutional risks – including analysis of the interests of specific key stakeholders in the health system – and mitigation strategies.**

- **The strategy of using multiple lending instruments and analytic work to maintain a focus on the poor was equally important in maintaining a focus on health reform.**

3. Donor coordination

- **Donor coordination can be enhanced by the implementation of joint management units, like the one established for PARSALUD.** Following a government request, the combined financing from the World Bank and IDB was managed through a joint PCU, helping to eliminate parallel project structures and improve inter-agency coordination in support of the government's agenda.

Value added and comparative advantage of the Bank

Given that Peru is a middle income country experiencing continued economic growth and substantial poverty reduction, the comparative advantage of the World Bank's engagement in health is evolving. Interviews with individuals from the MOH and other organizations indicated that the World Bank is viewed as an institution with strong political leverage. Its ability to convene national actors, help to maintain a medium term agenda for health reform, provide lessons of comparison from other Latin American countries, and a high level of analytic services are seen as its areas of comparative advantage in the health sector. On the other hand, the World Bank is criticized for failing to more actively incorporate the views of civil society organizations into its dialogue with the government, coordinate with other actors with technical know-how, and take a position on politically sensitive topics.

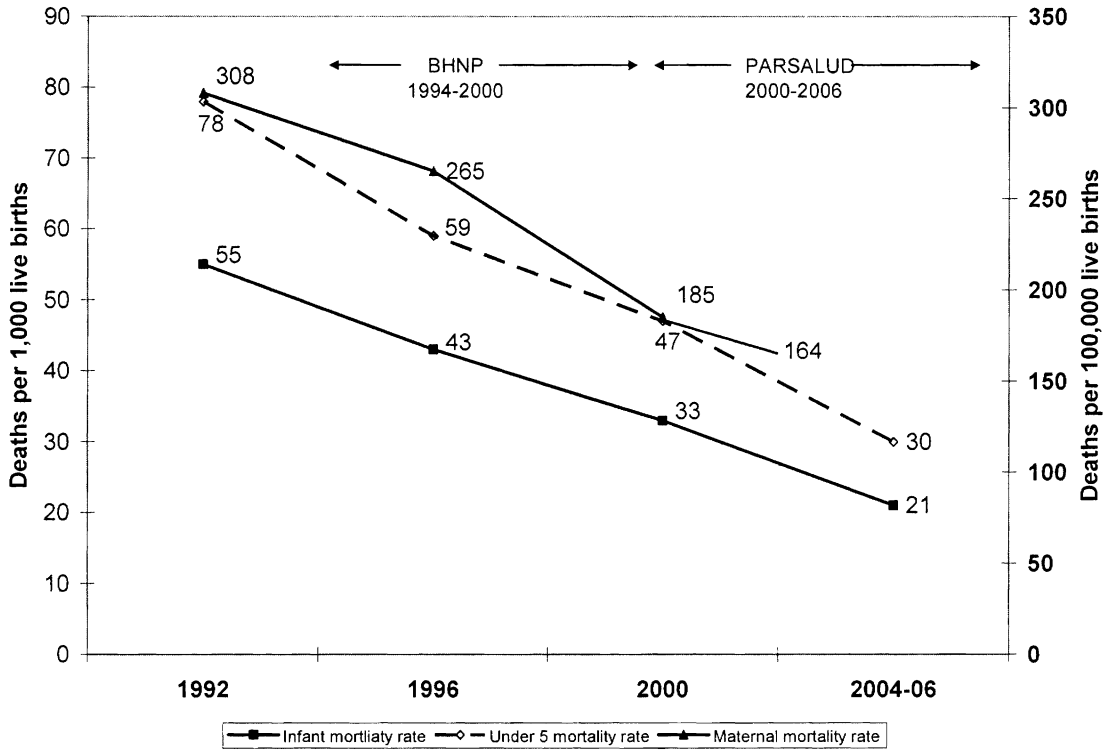
Overall, this PPAR concludes that the World Bank has continued to advocate improvements in the Peruvian health system, particularly for the poor, and this support has been influential and remains relevant. The impact of the Bank's support has been constrained by difficulty with project implementation readiness, project and political cycles, and unresolved human resource issues.

Vinod Thomas
Director-General
Evaluation

1. BACKGROUND AND CONTEXT

1.1 **Trends in HNP Status**. There have been sustained improvements in maternal, infant, and under-5 mortality at the national level in Peru from the early 1990s (as the first project under evaluation was being prepared) through the present (Figure 1-1). The reduction in infant mortality has been one of the main achievements in Peru during this period – a decline by more than half, from 55 to 21 per 1,000 live births. The maternal mortality rate (MMR) has also declined by nearly half, at the same time as the share of mothers receiving medical care at birth has increased, from 53 to 73 percent (Annex Table D-1). While Peru's infant mortality rate (IMR) is now close to the Latin American regional average, the MMR remains nearly twice as high as the regional average.

Figure 1-1: Trends in Mortality in Peru



Source: IMR and Under-5 Mortality from DHS 1992, 1996, 2000, and 2004- 06; MMR 1992- 2000 from INEI, UNFPA, 2002 from MOH

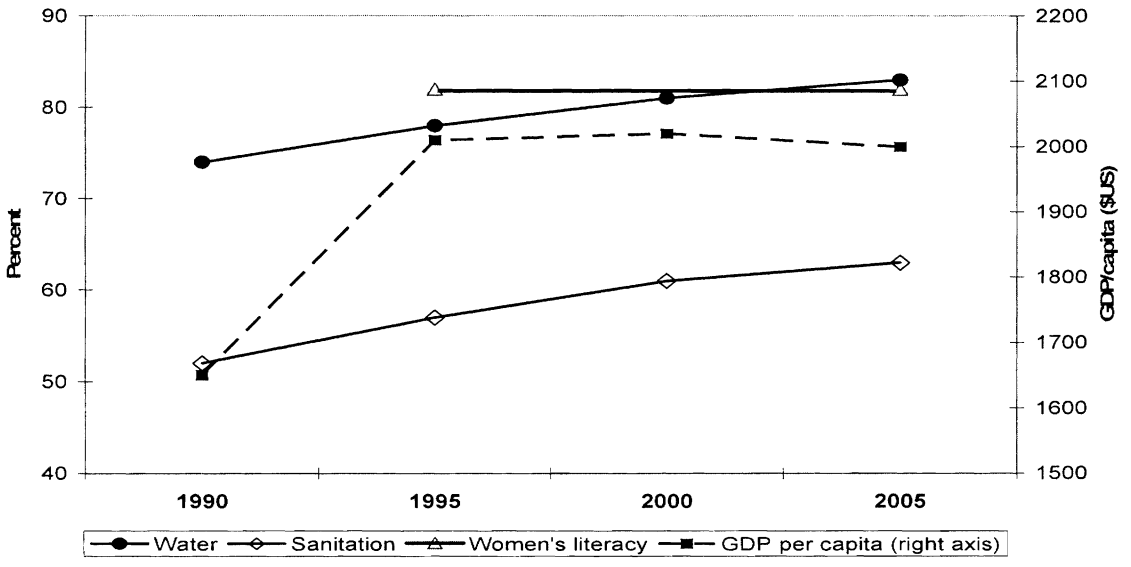
1.2 Beyond these reductions in mortality, the total fertility rate (TFR) has declined significantly, from 4.0 in 1992 to 2.6 in 2006, in parallel with an increase from 33 to 48 percent in modern contraceptive use among women of reproductive age (Annex Table D-1). However, malnutrition among children under five has remained basically unchanged over the decade 1996-2006, whether measured in terms of stunting (about 25 percent), wasting (1 percent), or underweight (7-8 percent, Annex Table D-1).

1.3 The poorest groups and rural residents shared in these improvements, and in some cases the gaps between the poor and non-poor have narrowed. The TFR dropped faster

among the lowest wealth quintile (from 6.6 to 4.9) than among the highest quintile (from 1.7 to 1.4), reducing the fertility gap between poor and non-poor in both absolute and relative terms (Annex Table D-2). The fertility of rural women dropped even more rapidly (from 6.2 to 3.7). Both the poorest and rural women substantially increased modern contraceptive use, more than their non-poor and urban counterparts. The share of deliveries attended by a trained health practitioner rose from 14 to 31 percent among women in the lowest wealth quintile, while fluctuating generally at 90 percent or higher among women in the highest quintile (Annex Table D-2). However, infant mortality declined at the same or a faster rate among the non-poor than among the poor: between 1996 and 2000 infant mortality declined 19 percent in the lowest income quintile and 29 percent in the highest income quintile, while under-5 child mortality declined by 16 percent and 20 percent in the respective quintile (Alvarado, 2007). There was no significant reduction in malnutrition among the poor or non-poor, though stunting in urban areas declined (Annex Tables D-1 and D-2).

1.4 **Determinants of Health, Nutrition and Fertility**. Health, nutrition, and fertility outcomes are determined by a range of factors including those influenced by the health sector, such as service delivery and quality, by the availability and affordability of health-related commodities, as well as by factors outside of the health sector, like education, water supply and sanitation, electricity, transportation, culture, geography, gender, and broader political and economic developments. Access to water and sanitation improved gradually from 1990-2005, while for the decade corresponding to the two projects reviewed here, women's literacy and per capita gross domestic product (GDP) showed little or no improvement (Figure 1-2).

Figure 1-2: Improvement in key non-health determinants of HNP outcomes, 1990-2005



Sources: World Development Indicators, WHO

1.5 **Disease Burden**. The epidemiological transition presents a substantial challenge to middle-income countries with large inequalities in wealth, such as Peru. The share of

deaths from communicable diseases has dropped from 19.8 to 17.1 percent from 1996 to 2001, whereas the share of deaths caused by malignant tumors and circulatory diseases increased from 13.8 to 17.2 percent and 16.2 to 18.2 percent, respectively (World Bank 2006b).[1] Whereas urban and wealthier populations are more often affected by non-communicable diseases, communicable diseases remain a persistent threat among poorer and rural populations. Between 1998 and 2002, there were outbreaks of malaria, dengue, bartonellosis, and tuberculosis, although all were eventually controlled (World Bank, 2006b).

POLITICAL AND ECONOMIC CONTEXT

1.6 In the period leading up to the two projects that are the subject of this assessment, Peru experienced and was in the course of recovering from extreme economic and political crises (see Annex G for a timeline of events). In 1986, under President Alan Garcia, a perceived "debt trap" led Peru to stop all payments on foreign debt, increase protectionism and finance a high fiscal deficit with money creation. The results were inflation, a fall in both economic output and real wages, and hyperinflation by 1989. Between 1989 and 1990 central government spending dropped to less than 15 percent of GDP.

1.7 Peru also faced the challenge of terrorism. The Shining Path (*Sendero Luminoso),* a Maoist organization, emerged on the political scene in 1980 when it launched guerrilla warfare in the highlands of the Ayacucho region on the eve of Peru's first democratic elections. During the 1980s the organization, known for its brutality and rejection of human rights, gained control of much of the countryside in the interior and south and advanced to the outskirts of Lima. The group also engaged in conflict with Peru's other large terrorist organization, *Tupac Amaru.*

1.8 After taking office in July 1990, President Alberto Fujimori introduced dramatic economic reforms to bring inflation under control and stabilize the economy. The Shining Path's leader, Abimael Guzman, was captured in 1992, marking an end to the period of heightened terrorism. To encourage continued stabilization of the economy, the tax regime was simplified, trade was liberalized, and the size of the public sector was reduced. GDP per capita rose sharply from 1990-95 (Figure 1-2), and from 1992-95, public expenditure on health rose from 0.9 percent to 1.1 percent of GDP (Annex Figure F-1).

HEALTH SECTOR ORGANIZATION AND PERFORMANCE

1.9 During the 1980's, at the height of the political and economic crisis, the health system collapsed and public health services were essentially non-existent. The Ministry of Health (MOH) was the main provider of primary health care services, but it reached only 26 percent of the population as of 1984. Urban residents, particularly in Lima, and workers from the private sector were covered by the social security system (IPSS),[2] but by 1989 its coverage had declined to 9 percent, from 18 percent in 1984 (World Bank

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[1] Data are from the Ministry of Health, Oficina de Estadistica e Informacion.
[2] *Instituto Peruano de Seguridad Social*

1994b). Non-governmental organizations (NGOs) were active in providing preventive services, particularly in rural areas.

1.10 The 1979 Constitution included provisions for decentralization of the power concentrated in Lima and later in 1985 a regionalization law was approved that eventually affected the organization of social services. The SAR notes that different administrations throughout the 1980s launched their own "hybrids" of decentralization. Although twelve regions were initially formed by Alan Garcia in 1989, they lacked resources to function independently and only later became autonomous under Fujimori through the 1993 Constitution.

1.11 The 12 regions (exclusive of Lima) were divided further into 24 departments. In addition to the four departments that composed Lima, there were 28 sub-regions or departmental health units. Sub-regional health directors prepared budget requests which were consolidated into requests for the region, submitted to the Ministry of Economy and Finance, allocated back to the region, and then disseminated by the regional authorities. The MCH program along with some others, however, were funded centrally (BHNP 1994B)

1.12 As of the early 1990s, the system managed by the MOH was extremely fragmented, with 16 national programs under the General Directorate for Human Health, including family planning, maternal-perinatal health, child growth and development, control of diarrheal diseases (CDD), control of acute respiratory infections (ARI), immunizations, control of iodine deficiency and tuberculosis control (World Bank 1994b, p. 5). These programs were implemented through sub-regional Health Directorates (DISAs).

1.13 Peru's health system was complex and included several public programs in addition to the private sector, with little coordination among them. The main public programs were the MOH (financed by tax revenues and copayments by users), the Health Social Security Institute (ESSALUD), financed by a 9 percent payroll tax and covering health care needs of its formal sector contributors, and the private sector financed mainly by out of pocket expenditure as private insurance coverage was very low. There was also fragmentation and duplication within MOH and weak information on health service production (World Bank 1994b).

WORLD BANK SUPPORT TO HNP

1.14 In 1983 the World Bank approved the Primary Health Care Project (Loan 2211-PE), to introduce a comprehensive model for primary health care (PHC) services. According to the Project Completion Report, the project initially suffered from slow implementation due to trouble securing counterpart contributions and establishing procedures (World Bank 1993b). A new government in 1985 lessened its focus on implementing the new health model to increase its focus on health service infrastructure and expanded the project area. However, by 1987 Peru had fallen behind on its payments to the World Bank causing a halt to all loans to the country. When the PHC Project closed in 1991, only US$5.8 million of the US$33.5 million that was approved (17 percent) had been disbursed and its overall outcome rating was unsatisfactory.

1.15 The World Bank saw an opportunity in mid-1992 to use an agreement between the Peruvian government and the United Nations Development Program (UNDP) and funds from the Japanese government to design a new project for the health sector. Peru's arrears with the World Bank and International Monetary Fund (IMF) were cleared in March 1993.

1.16 In May 1993 a report, *Peru: Poverty Assessment and Social Policies and Programs for the Poor* (World Bank 1993c), noted that despite an extensive network of primary health care centers, health indicators remained poor due to scarcity of equipment, the poor distribution of health personnel, and low government expenditure on health. It recommended that health programs focus on the poor by providing primary health care to women and young children. A US$100 million loan to support Peru's social investment fund, the National Fund for Social Compensation and Development (FONCODES[3]), which included social investment projects prepared by local communities in poor rural areas, to promote temporary employment and to assist in emergency situations, was approved by the World Bank in December 1993 (Box 1-1).

Box 1-1: World Bank support for health through the National Fund for Social Compensation and Development (FONCODES)

Created in 1991, FONCODES was the extension of an emergency social assistance program that provided direct food and health assistance to the poor. It was designed to channel government and donor financing to labor-intensive projects in poor communities to broaden access to social services, with an emphasis on community participation. Between 1991- 93 the only source of external financing for FONCODES was an institutional development grant from the Interamerican Development Bank (IDB). However, both the IDB and the World Bank developed projects in 1993 to institutionalize the lessons learned through early experiences. The World Bank provided support for two projects:

FONCODES I (1993- 98; US$100 million IBRD loan): Seventy percent of the sub-projects were implemented in "extremely poor" or "very poor" communities with the remaining 30 percent in "poor" communities. The Bank project financed 5,472 of the 12,630 sub-projects; about seven percent of the World Bank's financing supported health care, including medicine, health prevention campaigns, family planning, integral health campaigns, and the rehabilitation and construction of 143 health posts and centers.

FONCODES II (1996- 2000; US$124 million IBRD loan disbursed): The sub-projects included primarily social and economic infrastructure projects including health posts, schools, potable water, sanitation, irrigation and roads. Evaluations showed that FONCODES targeting was more effective than other social funds in Peru. Because decision-making was delegated to regional offices, the project also fostered decentralization.

1.17 The two main Bank lending operations to the HNP sector in Peru between 1994 and 2006 were the Basic Health and Nutrition Project (BHNP, 1994-2000), financed by a specific investment loan, and the Health Reform Program (PARSALUD, 1999-2006), an adaptable program loan (APL). The Bank also funded the second FONCODES project in 1996.

1.18 During the period under review, the Bank issued three Country Assistance Strategies (CAS, 1994, 1997, 2002) and a Country Partnership Strategy (2006). In addition to project lending, a series of four complementary Programmatic Social Reform

[3] *Fondo Nacional de Compensación y Desarrollo Social,*

Loans (PSRLs) with health policy content were approved. On the analytical side, Peru: *Improving Health Care for the Poor* was published by the Bank in 1999, and two other major Bank-financed studies were published shortly before the election cycle in 2006: *A New Social Contract Peru* (Cotlear 2006) and *An Opportunity for a Different Peru* (Giugale and others 2007).[4]

ORGANIZATION AND UNDERLYING THEMES OF THE REPORT

1.19 This report is organized in four chapters. Following this background, the next two chapters assess the development effectiveness of the BHNP (Chapter 2) and the Health Reform Project (Chapter 3). The fourth chapter presents the value added of the Bank and the lessons with respect to these projects and the entirety of Bank HNP support to Peru between 1994-2006, including policy dialogue, analytic work, and lending.

2. BASIC HEALTH AND NUTRITION PROJECT

OBJECTIVES AND DESIGN

2.1 The objective of the BHNP was to improve health and nutritional status in the project area, particularly among poor women and children. It sought to achieve this objective by: (a) increasing the use of maternal and child health (MCH) and nutrition services by extending access and improving quality of services; and (b) promoting better health and nutrition practices, with an emphasis on preventive care and education. BHNP's objectives were aligned with Peru's health-related objectives expressed in the 1994 CAS: "to enhance the quality of primary health services, especially in maternal and child health" (World Bank 1994c).

2.2 The project aimed to reach the poorest women and children by targeting interventions to the poorest areas of the country. At the time that the project was under preparation, Peru was divided into 12 regions. The BHNP targeted women of reproductive age (15-49) and children under three in 15 provinces of three of the country's poorest regions: Piura, Cuzco, and Cajamarca, and in one district of greater Lima. Within these regions, the project areas were selected primarily according to a poverty map based on a composite index of socio-economic variables. Thirteen of the provinces were classified as "most deprived", and the other two provinces as "deprived". The district in Lima (San Juan de Lurigancho) was one of the poorest and had experienced declines in per capita consumption in the years preceding the project. Among the most deprived areas, these were also deemed secure enough for World Bank supervision.[5] Additionally, the regions were identified as areas without a strong state presence and with few resources from other donors or outside sources. The Staff Appraisal Report (SAR) estimated that the project would directly cover approximately 1.7 million Peruvians (roughly 8 percent of the total population in 1993), and that some

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[4] See Annex E Tables E-1and E-2 for World Bank lending and non-lending activities 1994- 2006.
[5] At the time of project preparation, World Bank missions were not supposed to leave Lima due to security concerns.

of its activities, particularly those related to communication, would have spillover effects beyond the project areas. [6]

2.3 **Components.** Originally, the project had five components (Table 2-1). Lessons learned from the PHC Project were reflected in the relatively simple design of BHNP, its plan initially to work on a small scale and focus on a few interventions (with the idea of scaling-up once they had positive results), and its mechanism for monitoring and evaluation (M&E) designed during project preparation.

Table 2-1: BHNP Original Components and Main Activities

Component[a]	Main Activities
Maternal and Child Health Care ($20.1 million, 43 percent)	• Training professionals and community health workers (CHW) • Providing medicine, supplies, equipment and vehicles
Nutrition ($3.2 million, 7 percent)	• Community-based monitoring and follow-up • Distribution of micro-nutrient supplements and anti-parasitic medicine • Operations research • Cooperation with local NGOs to support community education in nutrition and feeding practices
Tuberculosis Treatment ($0.1 million, 0.2 percent)	• Training CHWs to detect and refer cases • Providing TB testing equipment and medicines for health centers
Information, Education, and Communication (IEC) and Training ($18.8 million, 42 percent)	• Educational MCH activities through use of mass media, community participation and inter-personal communication • Training for health professionals and CHWs to enhance knowledge of health and nutrition practices and improve the quality of care
Management and Evaluation ($2.3 million, 5 percent)	• Project coordination • Monitoring and evaluation

a. Cost at appraisal and share of total project cost. All costs are in US dollars.

2.4 **Implementation arrangements.** The project planned to use experienced NGOs for implementation, channel funds through central government, and fund the recurrent costs of close monitoring and supervision in order to address the potential risks identified: weak government capacity to implement the project; fear that the government would reverse the decentralization process during implementation; and public facilities with a poor record of outreach. The first four project components intended to rely on community health workers (CHW)—trained and supported by NGOs—for their implementation and sought to work with health workers identified by the community and already active in that role.

2.5 The Project Coordinating Unit (PCU) in the MOH's Office of External Cooperation was to be led by a project coordinator who would monitor implementation, including frequent visits to the regions. Four sub-regional directors would be responsible for implementing project activities, preparing annual sub-regional workplans, and negotiating agreements with NGOs (although larger agreements could be signed at the national level). The SAR estimated that 75 percent of the activities for training, national consultancies and studies, 20 percent of activities for provision of health and nutrition

[6] Altogether, the project covered 15 of Peru's 195 provinces and two of Lima's 43 districts, albeit the poorest.

services, and 40 percent of information, education, and communication (IEC) activities would be executed by NGOs. A 3-member IEC Management Team was to be formed to manage the IEC component, ensuring linkages with other activities in the MOH and the MOH Communications Office. A Project Steering Committee was to be formed and meet twice annually to monitor project progress and provide guidance.

2.6 **Monitoring and evaluation design.** The indicators for project implementation were related to maternal health services, deliveries, child health services, tuberculosis, IEC, training and supervision.[7] They were all counts of outputs, as opposed to measures of coverage. Targets were to be established following the baseline study by the MOH and the World Bank after the project launch. The monitoring system was to rely on service data collected by CHWs, consolidated six times per year with supervision of health facility staff, and supplemented by information from existing information systems. A mid-term evaluation by an outside consultant was also programmed to provide an assessment of the project's early implementation and feedback on how to strengthen the project. Additionally, there were five project outcome indicators[8] that were to be measured by the baseline knowledge, attitudes, and practices (KAP) study planned for 1994 and by the Impact Survey scheduled for 1998, both to be carried out by contracted agencies. The baseline study was intended to include a survey with both user and provider modules to provide additional information on the coverage and quality of care (at the institutional and community levels). A KAP survey comparable to the baseline was to be carried out at the project's close.

2.7 **Relation to other donor activities and government initiatives.** Both the IDB and the United States Agency for International Development (USAID) launched new health projects in 1993 – the Strengthening Health Services Program[9] and Project 2000,[10] respectively (Table 2-2). IDB's project was distinct from BHNP in focusing on all levels of facilities, from the primary level to hospitals, and in having more of a reform agenda from its inception. Project 2000, however, was similar in objectives and structure, yet implemented in different regions. The implementation structure of these three large projects was "parallel"—each was coordinated through MOH's Office of External Cooperation, yet with their own unique administrative and reporting requirements.

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[7] The SAR also notes that there would be an evaluation of each training activity.
[8] Percent of children exclusively breastfed 1-6 months, malnutrition prevalence (under 3), stunting prevalence (under 3), infant mortality, and child mortality
[9] *Programa de fortalecimiento de servicios de salud.*
[10] *Proyecto 2000.*

Table 2-2: Externally – Financed Health Sector Projects, circa 1993-94

Project characteristic	World Bank BHNP	IDB Strengthening Health Services	USAID Project 2000
Instrument	Loan	Loan	Grant
Dates	February 1994 – December 2000	March 1993 - 2000	September 1993-2002
Geographic coverage	15 of the poorest provinces and 2 districts in Lima	National	12 departments, not overlapping with BHNP
Donor amount (US$ millions)	34.0	68.0	30.0
Counterpart contribution (US$ millions)	10.5	10.0	30.0
Co-financing (US$ millions)	0	20.0 (JICA)	0
Total at appraisal	**44.5**	**98.0**	**60.0**

Source: IDB online Project Gateway (http://www.iadb.org/projects/Project.cfm?project=PE0030&Language=English) and Proyecto 2000 mid-term evaluation, p. 48

2.8 In addition to the three large donor-funded projects, the Peruvian government launched the Basic Health for All Program[11] in August, 1994. This program, originally called Targeting of Basic Social Expenditure[12] with an estimated cost of US$88 million for the first year, was a multi-sectoral program encompassing education, health, nutrition, and justice, later narrowed to focus only on the health sector. Thus, at the time that BHNP was launched, between the numerous vertical programs, the new Basic Health for All Program, and multiple donor projects implemented in parallel, the MOH was extremely fragmented and there were health initiatives being launched nationally and in non-project areas.

IMPLEMENTATION

2.9 The BHNP was approved on February 3, 1994 and became effective on June 2, 1994, at a time when the Peruvian economy and politics were stabilizing. The project, however, got off to a slow start. By 1997 it had disbursed only US$7.5 million of the US$15.2 million originally planned to have been disbursed by that date. The studies meant to provide a basis for the project's activities got off to a late start and had essentially become its primary activities in the first several years.

2.10 **Low disbursement at the outset can be attributed to a number of factors**:

- **Weaknesses in project design.** The project's components were not well defined or integrated, the nutrition component was not aligned with the MCH component, the organizational structure was not appropriate, and the cost categories were not well defined.
- **Lack of experience in the MOH in coordinating externally financed projects.** Because donors had not been active in Peru for several years, coordination between the Directorates and Programs in the Ministry and the project's activities initially was weak due to the inexperience of the individuals working in the PCU and turnover in

[11] *Programa Salud Básica Para Todos,* PSBPT
[12] *Focalización de Gasto Social Básico*

World Bank staff between project design and early implementation. The situation improved in 1998, when the government created the Coordination Unit for Health Sector Modernization, which gained some oversight of the project and contributed to improved management.[13]

- **A need for greater cooperation with other externally financed projects**. The three large externally-financed projects were coordinated through MOH's Office of External Cooperation, yet each had its own unique administrative and reporting requirements. Although potential duplication between the projects and opportunities for sharing were identified early on, actual coordination beyond meetings proved to be more difficult. In 1996, the World Bank established a resident mission in Lima, which improved coordination, communication, and problem-solving.
- **Difficulties with procurement arrangements through UNICEF**, which delayed the procurement of equipment and supplies, and consequently the training schedule;[14]
- **A shortage of NGOs in some of the project areas**.
- **High turnover in MOH leadership**. Between 1992 and 1997, the Minister of Health changed four times; by the end of the project in 2000, there had been six ministers and eight vice-ministers.

2.11 **Over the course of BHNP implementation, the Peruvian health sector launched major initiatives on the path to articulating a vision for health reform (Box 2-1).** While the low level of government funding for health led to the imposition of user fees, during the first half of the project's lifetime there was substantial government-financed expansion to the poor of the vertical-oriented health system, largely through investments like Basic Health for All and FONCODES. In the mid-to-late 1990s there was a push to focus on improving quality, integrating the programs, and providing a cost-effective essential package of basic services.[15] Several projects "piloted" integrated health models, including the introduction of the World Health Organization's (WHO) Integrated Management of Childhood Illness (IMCI) nation-wide in late 1996 (Box 2-2). In 1997, two laws were approved to establish the general principles for health sector reform and a unit was created within the MOH for health sector modernization. In 1999, President Fujimori announced that PHC service delivery would be transferred to municipalities. Total health spending (public and private) rose in real terms by over 50 percent between 1994-97, while public health spending as a share of GDP increased from 1.1 to 1.4 percent from 1995-99 (World Bank 1999; Annex Figure F-1). The number of public health facilities increased by 48 percent between 1992-96, and the expansion was pro-poor (Annex Table F-1).

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[13] *Undidad de Coordinación para la Modernización del Sector Salud.* The unit was responsible for approving progress reports and the program's planned activities.

[14] In 1997 the project suspended procurement arrangements with UNICEF and began to use the UN Office of Project Services (UNOPS) for procurement.

[15] The integrated model was to ensure that the most basic and prioritized health and nutrition interventions were provided to families at the primary care level. However, there was confusion in some facilities as to the appropriate norms to follow. Often the new model was implemented side-by-side with existing models instead of replacing them. Delays in implementation of the integrated model were also attributed to frequent changes in managers, and insufficient monitoring by the management team.

2.12 **As a result of these policy developments, over the course of its implementation BHNP evolved from a health care delivery and promotion project focusing on community participation and IEC, to a project that reorganized health service delivery and introduced an integrated health model into project facilities.** The government encouraged international donors, including the World Bank, to re-orient their ongoing projects towards the objectives of the reforms and to incorporate the lessons from the projects into health reform plans.

Box 2-1: Peruvian health reforms introduced in parallel with BHNP (1993-2000)

Local Committees for Health Administration (CLAS)[a], 1994: introduced to increase community participation in management of health facilities, CLAS are private, non-profit community administered institutions which by virtue of a contract with the Health Directorates (DISA) receive and administer public funds. They work with health providers to develop a local health plan, define its budget and monitor expenditures and health care delivery to the communities.

School Health Insurance (SEG)[b], 1997: Reimbursed health care and medicines provided free of charge for about 6 million children between 4-17 years old attending public schools.

General Health Law, 1997: established user's rights

Social Security Modernization Law, 1997: Approved a reorganization of social security allowing inclusion of private providers within the ESSALUD delivery system, eliminating the ESSALUD monopoly on service delivery and creating a superintendent to regulate health care providers.[c]

Mother and Child Insurance (SMI)[d],**1998**: piloted in two areas starting in 1998 before expanded nationally in the following years, SMI reimbursed public health providers for a package of basic services (including medicines and laboratory exams) rendered free of charge to eligible participants (poor mothers and children under 3).

a. *Comites Locales de Administración de Salud*
b. *Seguro Escolar Gratuito*
c. It has been slowly implemented.
d. *Seguro Materno Infantil*

Box 2-2: Integrated Management of Childhood Illness (IMCI)

IMCI is a WHO strategy to improve health and nutrition of children under 5, introduced and piloted in the late 1990s in countries with moderate to high levels of child mortality. The strategy was introduced in Peru in 1997, and the MOH quickly committed to implementing it nationwide in the same year. IMCI's main components were to improve: health worker performance through training; support for the health system, ensuring drug and vaccine availability, strengthening supervisory activities, increasing access to and quality of care in referral facilities, building support for IMCI at the national and district levels; and improving family and community practices related to child health and development. A multi-country evaluation was launched in 1998 and fieldwork in Peru took place in 2001. The evaluation of the Peru IMCI program found that:

- IMCI had not been recognized as a separate program in any of the districts and district-level coordinators had not been appointed. Instead, IMCI responsibilities were assumed by staff of the ARI program while staff of the CDD program were responsible for training health workers;
- Synergies between health facility and community interventions were not achieved;
- Few monitoring data were available to document implementation;
- The policy and program support for IMCI was weak;
- There was no significant association between training provided by the program and outpatient utilization, vaccine coverage, mortality, or malnutrition.

Sources: Huico and others 2005a, 2005b.

2.13 The BHNP was restructured three times. As early as 1995, BHNP's components were re-aligned with the MCH model for primary level care. There were few changes in project activities with the exception that the tuberculosis component was broadened into a communicable disease component, including malaria prevention and detection activities in Piura.

2.14 In 1997, the project was reformulated for a second time toward the development of decentralized health service *networks* that would ensure that basic health services were available and accessible to the entire population in a defined geographic area. Networks organized health service delivery in facilities of the appropriate level (CHW, health post, health center, referral health center), according to their complexity, and created a referral system between facilities within the network. Additionally, the system helped to decentralize management of health facilities with oversight from the central and regional levels. The network was responsible for administrative systems and management of facilities; micro-networks were responsible for developing local health plans and ensuring provision of basic services. However, during this second reorganization the activities grouped together into the health promotion component lost priority, in favor of interventions that had more to do with supply-side factors.

2.15 The project's third and final reorganization occurred in late 1998. Its activities and objectives were maintained but reorganized to contribute toward health sector reform.[16] The project's final revised components are in Table 2-3. That year, the project also was expanded to a second district in Lima.

2.16 **Project activities were intensified in August 1999 and implemented in large part by NGOs, as originally planned.** The project contracted NGOs to carry out its activities for CHWs and these experiences were later consolidated into a final document on the role, training and supervision of CHWs. In fact, an estimated US$11.3 million (approximately 25 percent) of project costs went toward contracts with NGOs.[17] However, the work with community-based health promotion was far less than anticipated in project design due to lack of MOH experience in this area and nonperformance of the first contractor, which led to the cancellation of the initial contract in 1999. Moreover, over the project's final stage of intense implementation, considerable attention was given to how to systematize the BHNP experience in order to contribute to on-going health sector reform.

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[16] However, the loan agreement was amended that year to allow for a new disbursement category for civil works, since some of the project facilities in the health networks were in need of renovation in order to be operational.

[17] See Annex C (Table C-5) for list of products and activities developed/implemented by NGOs.

Table 2-3: Revised Components and Main Activities, 1998

Component	Main Activities
Health Service Delivery (US$22.1 million, 50 percent)	Develop and introduce guidelines for organization and management of **health service networks** and micro-networks; rehabilitate health facility **infrastructure**; provide **equipment** and drug supply for health facilities; **organize services** within health facilities as well as "extramural" activities; **Quechua language and Andean culture** classes for health providers (Cuzco)
Health Promotion (US$14.9 million, 34 percent)	**Promote healthy behaviors:** Research and design sustainable integrated communications interventions in MCH and nutrition; develop IEC Commissions in five regional health departments; TB prevention sub-component **Community Activities:** Improve child feeding practices with a home and community demonstration model that involved active participation of CHWs; work with NGOs to develop outreach and training to improve the utilization and impact of CHWs **Social marketing of health services,** including a social marketing diploma for clinical management staff to empower them to design and implement health facility marketing plans; NGOs to develop local health plans and identify CHWs for training to create linkages between marketing plans and local health plans.
Management and Financing (US$5.6 million, 13 percent)	Management diploma training program for clinical and management staff ; capacity building for quality improvement projects; develop an internal control system and model for categorizing complexity of health facilities; information systems for costs and incomes (SICI); cost-based programming and budgeting (SPP)
Project Management (US$1.7 million, 4 percent)	Project coordination and monitoring and evaluation

Note: The bolded activities are activities highlighted in the BHNP Final Report as the project's eight primary intervention areas and groups the non-bolded activities under those primary interventions as opposed to reporting them by project component.

2.17 **The new health service model introduced by BHNP and the implementation of health service networks required that decision-making be decentralized to the sub-regional level, which was consistent with the project's initial emphasis on building capacity at the local level**, although these two strategies were developed later in the project. Capacity building of health managers at the local level and management training were key project activities. However, over the course of the project, the central level maintained most of its control over the organization and production of services. The transfer of management and decision-making from the central level is an ongoing process due to less management experience at the local level, high turnover in health personnel in peripheral areas, and resistance at the central level to giving up some level of authority. However, this continued resistance was reported to contribute to inefficiencies such as central level managers who are too involved in day-to-day decisions to deal with broad oversight and planning, and health providers who depend on higher levels of management and do not take the initiative or develop the capacity to deal with problems at the local level that may require immediate attention.

2.18 **Originally planned to close on June 30, 2000, the project was extended six months to close on December 31, 2000**, having disbursed over 99 percent of the loan. The extension period was the most productive time for the project, which illustrates that flexibility was crucial to allowing results to be achieved.

2.19 **Implementation of monitoring and evaluation.** Several project studies were carried out between 1994-96, most notably a KAP study and baseline household survey on infant health and nutrition.[18] Also, in 1997, the mid-term evaluation was carried out. **However, as of February 1998, three and a half years after project effectiveness, a M&E system had yet to be established.**

2.20 **A new M&E plan was developed and approved in 1998, but this was not launched until June 1999, only a year and a half before the project closed.** Project data were collected by an "integrated monitoring report"[19] and a matrix of 92 physical implementation indicators collected at the facility level. However it is not entirely clear when these tools were introduced. The report was designed to track implementation of the integrated care model in health centers and posts and focused on aspects that were directly observable and deemed to be critical to infer the quality of care provided in the facilities. It is reported that they were used at the facility, regional and central levels.

2.21 **The project's reorientation reduced the relevance of the original indicators**. For example, there was greater attention to quality of services after restructuring and less on coverage, yet the project implementation indicators were all measures of how many activities had been realized. Ultimately, project monitoring was based exclusively on inputs and outputs. Consultants were contracted to carry out studies between 2000-01, analyzing coverage indicators,[20] quality indicators for the new model,[21] and a study on perception of the quality of services and user satisfaction.[22]

2.22 Because the 1996 KAP carried out by the Peruvian NGO, AB PRISMA, was very broad in scope and did not include all indicators that were relevant to BHNP after reorganization, another KAP was carried out in the project areas in March 1999. Twenty months later, after the project's most intense phase of implementation, Universidad Peruana Cayetano Heredia carried out a follow-up KAP survey collecting data on areas that were intervened in heavily by the project, areas intervened in somewhat by the project, and areas with no project intervention.[23] This allowed for the study to compare outcomes of the target groups to the baseline in 1999, as well as to control for the impact of the level of project implementation on outcomes in order to understand attribution to the project.[24]. There were two additional impact studies, one analyzing differences in the services offered in BHNP facilities versus "control facilities",[25] and another analyzing TB

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[18] Prisma and Apoyo 1995.
[19] *Ficha de monitoreo integral*
[20] BHNP 2001b.
[21] AB PRISMA 2001.
[22] APROPO 2001.
[23] Universidad PCH 2001. The project classified these areas based on the number of interventions.
[24] The 'control' facilities in this study were comprised of those in the project area that nevertheless did not implement the project activities/reforms. Great caution is required in interpreting differences in outcomes between areas served by facilities that implemented the reforms to different degrees, as this was not a randomly assigned distribution of the intervention. It is highly likely that the facilities that did not implement the project activities (and the people who use them) are systematically different from those that did.
[25] Suarez 2001.

and malaria indicators in project and control areas.[26] The ICR and final report produced by the government rely on data from these studies.

2.23 The baseline health outcome indicators were supposed to come from over-sampling in Demographic and Health Surveys (DHS) in the project areas, which apparently took place.[27] Financing for the endline survey for these indicators was to come from a follow-on project, which was not effective in time. There was also some debate over whether the outcome indicators chosen were appropriate for the project, especially after reorganization when it was focused more on service delivery and quality than health outcomes.

2.24 **Use of M&E data.** The studies conducted in the project's earliest years provided information on local health status and behaviors in project areas which aided project planning. Unfortunately, given delays in their actualization and the restructuring of the project, there appears to have been a perception that they were less relevant. MOH Program Directors reported that the delay in establishing a monitoring system hindered understanding of the results of the innovations introduced by the project. Nevertheless, the project was able to produce adequate information at the end for project assessment through the studies that it commissioned. Also it appears that there was a desire to consolidate experiences and evidence from the multiple models for integrated care established over the period.

ACHIEVEMENT OF THE OBJECTIVE: BETTER HEALTH AND NUTRITION FOR POOR *WOMEN AND CHILDREN*

2.25 The project's development objective was to improve health and nutritional status in the project area, particularly among poor women and children. The strategy to achieve this objective was to extend access and improve the quality of services to increase use of maternal and child health and nutrition services and to use preventive care and education as means to promote better health and nutrition practices. This section assesses the project's outputs, its intermediate outcomes, and their impact on improving health and nutrition, particularly among poor women and children in the project area.

Outputs

2.26 **Table 2-4 provides a summary of the major project outputs by component**; Annex C (Table C-4) provides a table of planned versus actual outputs. Some activities were only partially implemented. Although IEC commissions were formed at the regional level to design and manage IEC activities at the local level, the objectives and policy framework to implement a coherent IEC strategy were lacking and mass media campaigns were never implemented. Social marketing focused more on improving

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[26] Perez and others 2001. However, there were no significant differences in the diagnosis and treatment of communicable disease between project and non-project areas.
[27] World Bank 2001c, footnote 19.

provider behavior toward the clients than improving healthy behaviors. One planned study of health services was eventually cancelled.[28]

2.27 **The organization of the networks provided essential experience and tools for Peru before it began to scale-up health networks at the national level.** BHNP project activities reached 14 networks, 61 micro-networks, 509 health facilities targeted by the project in addition to 17 health facilities outside of the project area that were supported through the participation of their DIRESA. BHNP provided capacity building to strengthen the organization and management of the networks, developing and introducing systems for: internal management control, cost information and income for health service networks, local health information, and referral and counter-referrals, as well as organizing a network of laboratories at the primary care level.

Table 2-4: Major Outputs

Health delivery	Health promotion	Health management and financing
• 237 primary care facilities implemented a new model of integrated patient care and management • systemized set of 42 reference manuals produced to facilitate replication of the model • clinical training provided to over 2,500 health providers in women's or child health and nutrition • renovation of 184 health facilities, as well as supply of basic medical equipment, computers, vehicles and supplies, as needed	• educational materials and IEC methodologies developed • innovative community-level activities implemented • training in Strategic Planning for Educational Communication • 15 Regional Health Departments (DISAs) formed IEC commissions • 125 DISA and primary health staff trained in social marketing diploma program • 500 CHWs trained in promotion of health services • Quechua Language and Andean Culture course developed; 94 health personnel in Cuzco trained. • 77 staff trained in empathetic communications and interpersonal relations.	• 289 health personnel trained in health service management diploma program • 88 Regional Health Department personnel trained health management • health service facilities organized into service networks • network management model with management committees and guidelines implemented • quality assurance methodology introduced • 254 quality improvement projects designed and implemented in 107 facilities

2.28 **The training programs under BHNP were not evaluated with respect to their efficacy in conveying information or changing provider behavior.** Anecdotal evidence suggests that many of the current upper-level health managers benefited from BHNP training and believe that it was fundamental for their professional development. Overall, the health personnel at facilities that participated in BHNP expressed strong beliefs that the introduction of the model changed provider attitudes to focus more on the

[28] Health Services Study, 1994 (Universidad Peruana Cayetano Heredia).

patient and service quality,[29] that it introduced important norms that improved organization, and that they benefited from the training provided.

2.29 Two important outputs for health financing were the "Information System for Costs" and "Incomes and Cost-based Program Budgeting", which was designed by Proyecto 2000 and later became a cooperative effort between USAID and the World Bank.

2.30 **There were also important outputs on nutrition and TB.** Qualitative research on nutrition was carried out to identify specific practices in child feeding to impact child anemia.[30] The project strengthened regional work and MOH coordination on nutrition, as well as food assistance programs through other ministries. The TB sub-component developed a set of methodologies applicable for CHWs in any program and trained health personnel in TB surveillance, promotion and referral, who in turn trained CHWs in these areas to disseminate the information.

Intermediate Outcomes

2.31 **The impact of BHNP on utilization of health care by women and children is unclear.** There are two sources of information: (a) analysis of patient records at health facilities in project areas and in facilities in non-project "comparison" areas within the 3 regions and 2 districts of Lima targeted by the project; [31] and (b) analysis of data from household surveys undertaken in 1999 (baseline) and 2000 (endline), comparing utilization of services by women and children in 2000 according to whether their area had full, partial or no implementation of the BHNP interventions since the baseline.[32] The methodology of both of these studies is not ideal: in the former case, the 'control' group was identified ex-post and the matching may have overlooked important factors that reduce comparability, while in the latter case there is the risk that facilities in the project area that did not fully implement the BHNP program are systematically different from those that did, in ways that are difficult to detect.[33] Furthermore, the baseline and endline household data points are only a year apart.

2.32 **Health service data suggest that utilization of health services improved in *both* project and matched, non-project ("control") areas between 1996 and 2000** (Annex Table D-3). In Cuzco, Piura, and South Lima, health care utilization in BHNP

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[29] A practical yet important innovation was the introduction of expanded clinical histories and family rather than individual files. The project also worked to develop and introduce a model to provide out-of-clinic services to populations living in remote areas that fell under a network's territory.

[30] Study of Micronutrient Deficiency in Women of Reproductive Age and Children, 1995 (Universidad Peruana Cayetano Heredia).

[31] The BHNP took place in 15 provinces in 3 regions and in 2 districts in Lima; there were other provinces in these same regions that were not selected for BHNP and households and facilities in these "non-project" areas serve as comparison groups/facilities. They benefitted from government health services and any national programs (as did the BHNP households and facilities), but were not targeted by other donors.

[32] The facilities with no implementation of BHNP are in the non-project comparison areas (BHNP 2001).

[33] The study that produced these data (BHNP 2000a) does not explain the matching process. As can be seen in Annex Table D-3, it appears that the comparison facilities had lower utilization rates for many services at the 1996 baseline than did the eventual BHNP facilities.

and comparison facilities were similar in 1996. In Piura, utilization of services by women of reproductive age increased by more in BHNP facilities, but the percent of pregnant women who made four pre-natal visits rose more rapidly in comparison facilities. In South Lima, antenatal visits rose more rapidly in BHNP facilities, but consultations by women of reproductive age did not. In Cuzco, the percent of births in facilities between 1998/99 and 2000 rose faster in project than comparison facilities, but there were no differences in utilization of other services. In North Lima, the project facilities had higher utilization than the comparison facilities at the 1996 baseline, suggesting that the project and comparison facilities were not well matched, This may explain why the BHNP facilities maintained higher utilization in two of the three indicators in 2000.

2.33 **Analysis of household data in project areas suggests that full implementation of project interventions improved the use of health services relative to the baseline only a year earlier (1999), but cases in which implementation was only partial rendered mixed results** (Figure 2-1)**.** For example, there was improvement in the percent of mothers who had post-partum check-ups within the first month after giving birth, and in the percent of children 12-35 months receiving the complete well-child services in areas with full BHNP implementation,[34] but there were also improvements in these indicators in areas with no or partial implementation.[35] These data come solely from project areas; there are no trends in non-project areas for comparison. The impact evaluation on coverage commissioned by the project also found no consistent relationship between the intensity at which the project was implemented and improvements in the coverage indicators evaluated (BHNP, 2000a).

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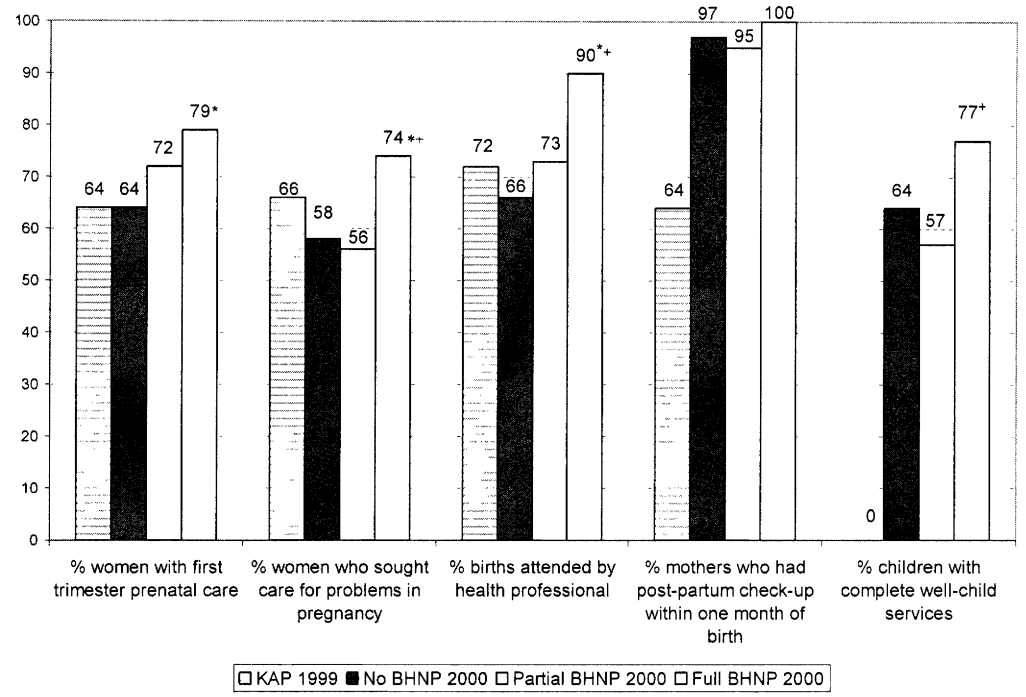
[34] Full vaccinations and more than four growth monitoring controls.

[35] Between the no intervention and partial intervention areas, there are no statistically significant differences for any of the indicators. There were statistically significant differences favoring fully intervened facilities compared to no intervention facilities for three of the five indicators, and between interventions of different intensity for three of five indicators.

Figure 2-1: Use of Maternal and Child Health Services



Source: KAP 2001
* statistically significant from No BHNP 2000
+ statistically significant from Partial BHNP 2000

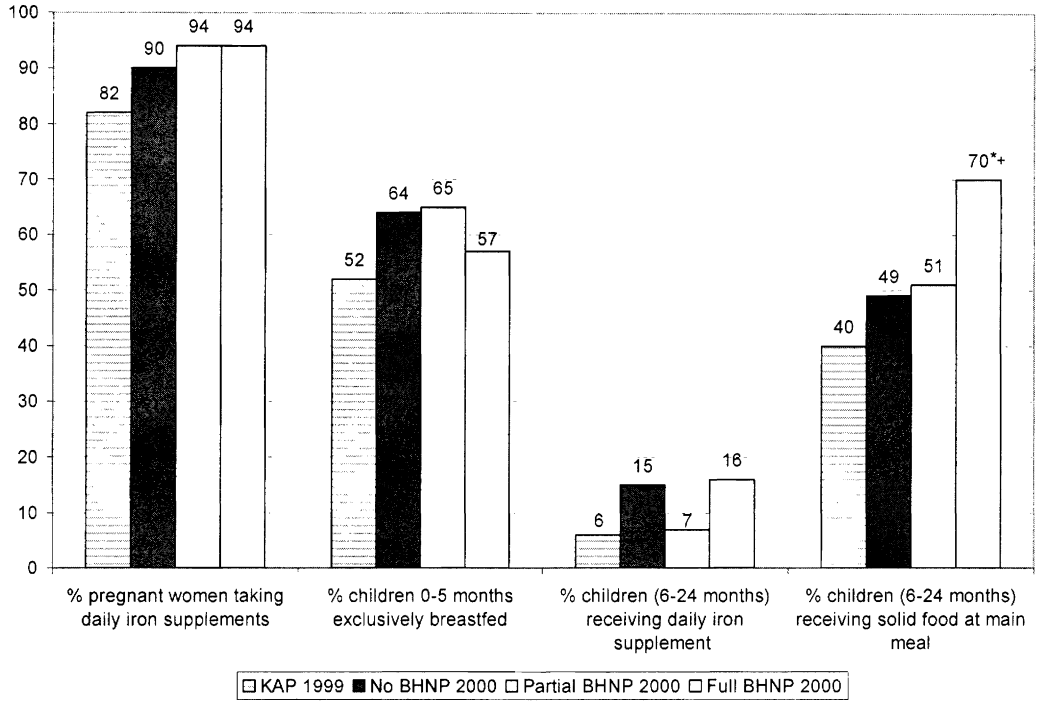
2.34 **There is some evidence that the quality of services – as measured by the number of or types of services received – were higher in BHNP facilities at the end of the project than in comparison facilities** (BHNP 2000a). This is particularly true for services for pregnant women across all four areas; in Cuzco and North Lima, some indicators for quality of children's services were also higher in project areas.[36] However, there are no baseline measures for these variables so it is difficult to know whether these differences are due to improvements or to better services at baseline. A study of the social marketing of health services interviewed 200 women in eight health networks targeted by the project; 65 percent perceived an improvement in care since 1999, 35 percent perceived that service delivery had improved; 34 percent that the organization of health care had improved; and 13 percent that infrastructure had improved.[37]

2.35 **In terms of better health and nutrition practices, the evidence is also mixed** (Figure 2-2). Taken in comparison to the 1999 KAP, there were improvements in all areas, regardless of level of project implementation, for the four indicators below (with the exception of the children receiving daily iron supplements in partial implementation areas). The only indicator for which there is a statistically significant difference between the areas of no intervention and full intervention is for the number of children receiving solid food at the main meal. It is possible that because the health promotion activities

[36] Note, however, that the average number of activities in the basic services package for a pregnant woman was higher in matched non-project areas in Piura, and that the percent of children under five that received nutritional counseling was twice as high in non-project areas in South Lima.
[37] As reported in the BHNP Final Report.

were implemented late in the project cycle (most intensively in the project's last 20 months), that their full impact was not captured when the end-line data were collected.

Figure 2-2: Better Health and Nutrition Practices



Source KAP 2001
* statistically significant from No BHNP 2000
+ statistically significant from Partial BHNP 2000

Impacts on the health and nutrition status of women and children, especially the poor

2.36 **The planned end-line data on health and nutrition outcomes in project areas – either on average or among the poor – were never collected.** Table 2-5 presents several MCH and nutrition indicators from DHS surveys for the four departments in which the project was implemented. Although the project ended in 2000, data from the 2004-06 DHS survey are included, since the most intense phase of implementation was in late 1999 and 2000, the effects of which may not have been captured by the 2000 data. Also, it is likely that there would be lag times to show results for behavior change interventions. The data must be interpreted with caution for several reasons: 1) none of the departments were fully covered by the intervention and in fact, intensity of the intervention varied significantly across regions; and 2) in a few cases the measurement of indicators changed between surveys.[38]

Table 2-5: Health utilization and nutrition indicators, by Department [39]

Indicator of mothers' and children's health and nutrition	Cajamarca			Cuzco			Metro Lima			Piura			National		
	96	00	04-06	96	00	04-06	96	00	04-06	96	00	04-06	96	00	04-06
Nutrition															
Average duration of exclusive breastfeeding (children <3) in months [a]	4	5	na	4	5	na	2	3	3.7	3	3	na	4	4.2	3.6
Stunting (<5, percent) [b]	39	43	na	41	43	na	10	7	na	28	24	na	26	25	24
Wasting (<5, percent)	2	1	na	2	2	na	0	0	na	0	2	na	1	1	1
Children's health															
Full vaccination (percent)															
Age 12- 23 months	58	58		54	45		64	59		77	76		63	56	
Age 18- 29 months			65			65			73			76		66	65.7
Women's health															
Deliveries by medical professional (percent)	19	17	42	41	35	59	93	82	98	51	46	76	56	60	73
Received tetanus vaccination at delivery (percent)	57	45	63	72	56	82	78	70	74	75	60	73	70	56	74
Modern contraception rate (%)	28	63	44	**32**	**44**	59	51	59	56	47	57	53	41	50	48

Source DHS 1996, 2000, 2004-05 and 2004-06

Shaded cells denote statistical significance at p<.05 or better; italic, bold denote statistical significance at p<.10. Standard errors were not reported for breastfeeding behavior by region and thus it is not possible to calculate statistical significance.

a. The project aimed to promote exclusive breastfeeding for children under 6 months, therefore an ideal duration of breastfeeding would be 6.0

b. Standard errors for nutrition measures for Metropolitan Lima were not reported in 1996, therefore it is not possible to calculate statistical significance.

2.37 **There were no significant improvements in nutrition or children's health indicators (proxied by vaccination rates) in any of the regions.**[40] There were no significant changes in nutrition at the national level either, however there were significant improvements in child health indicators. The most significant improvements were in women's health, however, the trends varied across department. The percent of births delivered by a medical professional and women receiving tetanus vaccinations actually *decreased* in most of the project departments between 1996 and 2000 but then recovered or surpassed the 1996 rates by 2006 in most cases. Between 1996 and 2000 the actual use of modern contraception increased in each department and at the national level, however the increase was only sustained through 2006 in Cuzco.

[39] Prior to 1996, DHS data were reported by region instead of department. Therefore, it is not possible to compare the data from 1992 to the departmental data from 1996 and 2000. Furthermore, although the DHS surveys do report infant and under-5 mortality rates, prior to the 2004-06 survey, they are ten-year rates and may not capture the changes that could be attributed to the project.

[40] There were significant reductions in infant and under-5 mortality in Piura between 1996- 2000. However, these rates at the department level are calculated as 10-year averages (so the 1996 rate is an average from 1987-96 and the 2000 rate is from 1991-2000), which are unlikely to be sensitive to interventions implemented only in 1999-2000. Thus, they are not shown.

RATINGS

2.38 Based on assessments of the BHNP's relevance, efficacy and efficiency, the overall outcome rating is moderately satisfactory as summarized in Table 2-6.

Table 2-6: BHNP – Summary of IEG Ratings

Objective	Relevance	Efficacy	Efficiency	Outcome
Improve the health and nutrition status of women and children, especially in poor areas	Substantial	Modest	Substantial	Moderately Satisfactory

2.39 **The overall relevance of the project was *substantial*. The relevance of the objectives is *high*.** The project's objective was relevant to the World Bank's 1994 CAS objective to enhance the quality of primary health care services, particularly for mothers and children, and to the objective of the 1997 CAS to promote social integration by improving infrastructure and access for the rural poor to health services. Moreover, it is relevant to the 2006 CAS which emphasizes efforts to reform the health system and improve service quality. In fact, this project helped to introduce models that were integrated into reforms in the Peruvian health system. For example, the focus on the quality of services emphasized by BHNP is highly related to the 2006 CAS to improve service quality. The Bank's geographic targeting of the deprived and most deprived regions is in line with the Bank's current emphasis on improving health outcomes among the poor.

2.40 **The relevance of the design is *modest*.** Designed at a time when health services in Peru had essentially collapsed and faced with security restrictions, the project targeted women and children in the poorest regions in which the World Bank could work. The project was intentionally designed to be relatively simple given lessons learned from the Bank's previous PHC project (para 2.3); however, the design did not sufficiently specify how the components should be implemented (para 2.10). Although a lack of coordination with the government and the projects of other donors was a weakness, the components were frequently revised in order to enhance the project's relevance with the government's health agenda as it evolved (paras 2.13-2.15). Recognizing the need to improve the coverage and quality of services as well as to stimulate demand for them and promote healthy behaviors, the project originally focused on both supply and demand. The government's capacity to efficiently implement the large IEC component may have been over-estimated. The emphasis on IEC was eventually reduced in scope and significance, yet not dropped altogether.

2.41 **Efficacy in improving the health and nutrition status of poor women and children in the project area was *modest*.** There were substantial improvements in utilization of services in project areas, particularly areas with full BHNP implementation, though not always greater than in comparison areas of the same regions (paras 2.31-2.33). Utilization was higher in project areas with full implementation of project interventions, but partial implementation yielded mixed results (para 2.33). There was evidence of only modest improvements in improved service quality (para 2.34) and negligible improvement in healthy practices (para 2.35). DHS data for the departments in which BHNP was active showed no improvements in child nutritional status between 1996-2000 (para 2.37). There was no evidence to indicate what changes, if any, occurred to

women's health or nutritional status. The project was targeted to the poorest areas; no information was collected on health outcomes among the poor vs. non-poor women or children (para 2.36).

2.42 **The project's efficiency was *substantial*.** Improved coordination with the government and other similar donor-funded programs could have improved efficiency (para 2.10); however, at the time the project was designed the system had collapsed. As it became evident that there was some overlap between the projects and as the capacity of the MOH to coordinate the projects strengthened, there was some effort to coordinate between them. There were several areas in which efficiency could have been improved, however to a large extent these were closely related to systemic and contextual factors which were not faced exclusively by BHNP nor could they be changed by one project alone. For example, there was no real transition from the few existing norms and protocols followed within health facilities to the new systems; instead the new model introduced was implemented along side the established one. Not only did this contribute to duplication, competing pressures from already established vertical programs, and additional work for health personnel, but it also created confusion over which standards and norms to follow. No incentive structure existed to ensure that the new procedures were adopted, and thus, there was an inclination to continue with what already existed. Furthermore, given high turnover in personnel, the same training activities often had to be repeated.

2.43 Initially, implementation was slow due to inefficiency in disbursing the funds. On the other hand, a major accomplishment was that that the project introduced substantial changes over the course of implementation without exceeding total project costs established from the start. This is a particularly notable achievement considering that with the same budget, the project was transformed from a health care delivery and promotion project to a project which reorganized health service delivery and introduced a new health model into project facilities. The BHNP final report also notes that pressures to close the project and financial restrictions hurried the implementation of the new model of organization and its systems, perhaps compromising the likelihood that all of the systems would be institutionalized. These, however, are more reflective of the fact that the project was implemented over a period of considerable recovery and innovation of Peru's health system. The project team was highly efficient in ensuring that BHNP maintained its original project objectives while being flexible to ensure that the project remained relevant and contributed to the direction in which the health system was moving. In summary, the project was efficient in adapting to the changing context of health services in Peru over the course of the 1990s and able to introduce an influential health model within a fixed budget.

2.44 **The project's risk to development outcome is *moderate*.** Since the project closed in 2000, the government has continued to prioritize the health of women and children, particularly in poor areas which is evident by the creation of the *Seguro Integral de Salud* (SIS, discussed in the next chapter). However, the sustainability of the health model introduced cannot be assured without further consolidation, and there are additional risks due to political factors.

2.45 **The World Bank's overall performance is rated as *satisfactory*. Quality at entry was *moderately satisfactory*.** Although the project design was relevant to the context and based upon the Bank's experience with the PHC project, it did not provide enough detail on how project components were to be implemented. Second, although the project's objectives were relevant to addressing the need for basic services and promoting healthy behaviors, it was a vertical project that may have contributed to building tension and rivalry within the MOH, and did little in terms of envisioning means to provide technical support or capacity building to strengthen the MOH's capacity to revive and reform the health sector.

2.46 **The Bank's supervision is rated as *satisfactory*.** Initially, there were problems with the turnover of World Bank consultants and task leaders, yet once the resident mission was established in Peru, multiple informants noted that BHNP project implementation improved dramatically. They believed that this allowed for problems to be addressed quickly and more efficiently and that it allowed the World Bank team leader to have a better understanding of on-the-ground challenges facing the project. Again, the flexibility demonstrated through the project was critical to complementing the changes happening in the health sector.

2.47 **Borrower performance is rated as *satisfactory*. *Government performance* is rated as *moderately satisfactory*.** The government accepted several donor projects and did little to ensure coordination between them. Initially, there was little assurance that these project would contribute to the government's health agenda. **The PCU's performance is rated as *satisfactory*.** Although there was instability within the MOH when the project was introduced and inexperience on the part of the PCU, as the situation stabilized, coordination was improved, particularly in the BHNP's final two years. The members of the PCU team were permanent from 1996, and it was cited by the World Bank as exemplary in financial management and procurement procedures. Although the loan agreement and PAD foresaw guidance from a Project Steering Committee and inter-project coordination commissions, these structures provided little support to the project.

2.48 **Monitoring and evaluation** was *modest*. Design was substantial, with planned KAP and health surveys at baseline and end-of-project, collecting data from users and providers of health care, service coverage, and quality of care (para 2.6)., However, implementation was negligible. While a number of surveys and studies were carried out in the early years, the M&E system was not established until a year and a half before the project closed and end line health data were never collected (paras 2.19-2.20). Use of the data was modest; the studies conducted late in the project did produce findings that could be used for project assessment, though with methodological issues (para 2.24).

3. HEALTH REFORM PROGRAM – PARSALUD

BACKGROUND

3.1 Reducing poverty and improving Peru's human capital was at the core of the 1997 Country Assistance Strategy. By 1999, Peru's health sector had already launched important new programs and laws and regulations, many contributing to improving health care for the poor (refer back to Box 2-1). A health sector study, *Peru: Improving Health*

Care for the Poor (World Bank 1999b), made the following recommendations: (i) allocate public funds with a sharper focus on the health needs of the poor; (ii) reinforce that focus on the poor among MOH health providers (through targeting, increased access for the poor to hospital services, enhanced community participation); (iii) create new insurance mechanisms to finance health care for the poor; (iv) improve MOH's information and management systems; and (v) refine human resource skill requirements and incentives to better serve poverty oriented programs.

3.2 Based on this dialogue, the government, the World Bank, the IDB, and other donors developed a vision of the Peru health system in 2010, including both collective (public health interventions with large externalities) and individual health services, financed from public and private sources, with public finance focused on collective health and subsidies for the poor (Table 3-1). This vision was the basis for the 10-year Health Reform Program financed in its first phase by the US$239.3 million Health Reform Project, to which the Bank contributed. The Bank also supported the vision and objective of improving health care for the poor through approval of four Programmatic Social Reform Loans over the period 2001-4.

Table 3-1: Vision of the Peruvian health system in 2010

		Individual Health	
Characteristic	**Collective Health**	**Subsidized Group**	**Contributing Group**
Population Coverage	Universal	Poor population	Population with the ability to pay (dependent workers and retirees, independent workers and professionals)
Benefit Plan	Public Health interventions (public well-being, interventions with high externalities)	Guaranteed Health Plan (which starts with SMI and SEG)	Social and Private Insurance requiring individual or family contribution. The Social Security Modernization Law offers the basis for a competitive social insurance environment
Financing Health Demand	Public Treasury	Public treasury and own revenue. Possible evolution of a National Health Fund	Contribution of affiliates
Provision of Health Supply	Responsibility of the State which can delegate the execution to other entities	Public and private facilities, including community managed health services (CLAS) organized in a service network operating by means of contracting mechanisms (contracts or management agreements)	

Source: Adapted from World Bank (1999a, p. 2)

OBJECTIVES AND DESIGN

3.3 The Health Reform Project, Phase I, Mother and Child Insurance and Decentralization of Health Services, henceforth PARSALUD, was to be funded by the government (US$64.3 million), the World Bank (US$80.0 million loan), the Inter-American Development Bank ($87.0 million loan) and the OPEC Fund (US$8.0 million grant). The financial instrument of the World Bank's contribution was a three-phase Adaptable Program Loan (APL).

3.4 **Objectives.** According to the Project Appraisal Document (PAD), the medium term goals of the ten-year Health Reform Program (2000 – 2010) were to: (a) improve maternal and child health; and (b) help reduce morbidity and deaths of the poor from communicable diseases and inadequate environmental conditions. The targets set for 2010 were to reduce the infant mortality rate from 43 to 20 per 1000 live births and to reduce perinatal mortality by 50 percent. This overall goal would be achieved through increasing the access of the poor to, and improving the quality and efficiency of health systems in Peru.

3.5 The development objective for first phase (2000-2003), the subject of this assessment, was to "contribute to the medium-term health goals of the Reform Program by increasing the access of the poor to better quality health programs and services."[41] Phase I thus focused on strengthening the demand side, while improving the quality of the supply side of health programs and services. The strategy for achieving the Phase I objectives of better access and quality for the poor was to: (a) reduce the economic barriers to utilization of health services, primarily through the implementation of the maternal and child insurance program (SMI); (b) enhance the decentralization of the health system through: (i) increased participation of communities (through CLAS), municipalities, and local health entities in planning, management and monitoring health programs and services; and (ii) redefining the role of the MOH, including streamlining its mother, child and environmental health programs; and (c) adapt investment to local health problems, particularly to cultural aspects of health promotion, and service utilization, as well as to the prevalence of communicable diseases and environmental health problems. The project also adopted specific outcome targets, in terms of program coverage and increased utilization (Box 3-1), although it is notable that none of these indicators were to be measured specifically among the poor. [42]

3.6 Subsequent phases of the APL envisaged the following support: Phase II (FY-2004-2007, US$172 million financed by an IBRD loan of US$50 million) to support the continuation/adjustment of Phase I reforms and to address the issues of health insurance, health manpower, and autonomy of hospitals; and Phase III (FY2007-2010, US$128 million financed by an IBRD loan of US$50 million) to consolidate the lessons from the previous phases and support public hospital reforms, continued strengthening of health care networks; unification of health insurance schemes, and chronic diseases. The APL intentionally began by addressing the issues that were least controversial (access, quality, decentralization) and launched analytic work on the potentially more complex and

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[41] The PARSALUD Loan Agreement said that the objective is the "improvement of maternal and child health…in particular through the reduction of perinatal, infant, child morbidity and mortality, and the reduction of mortality as a result of communicable diseases and inadequate environmental conditions, especially among the poor." It does not mention specific objectives for Phase I

[42] The Project also had trigger indicators that needed to be satisfied to determine the readiness for launching phase 2 of the APL: SMI implemented nationally; at least a third of health posts and health centers administered by CLAS; mother and child programs and environmental health programs streamlined; distributional impact studies of phase I; loan fully committed and 80 percent disbursed; and satisfactory performance of complementary projects in the sector which have relevance to the achievement of the health reform development objective. Three policy actions were expected to be taken: a legal framework for provision of services by ESSALUD and MOH hospitals; studies on separation of funding and service provision in ESSALUD; and studies on health manpower issues.

politically controversial issues (like individual health insurance, health manpower, and hospital efficiency) to be tackled in the second and third phases.

Box 3-1: PARSALUD Targets for 2003

- 60 percent increase in the number of pregnant women with 4 or more prenatal care visits.
- 33 percent increase of births in the project area attended by skilled health personnel
- At least 3.7 million cases of acute respiratory infections (IRA) in children under age 5 treated
- At least 780,000 cases of acute diarrhea (EDA) in children under age 5 treated
- Maintain coverage of DPT3 immunization in 95 percent of the children under age 1
- 44 percent increase in municipalities with DPT3 coverage for children under age 1
- At least 80 percent of yellow fever cases treated
- At least 17 million beneficiaries receive care in the primary facilities of MOH annually
- At least 80 percent of the regional health boards (DISAs) are implementing regional and local health plans that respond to communicable diseases and environmental health problems prevalent in their localities

Box 3-2: Original Component and Activities

Component[a]	Activities
Strengthen health demand ($149 million, 62 percent of total estimated cost)	Implement SMI to benefit low-income mothers and children especially from the poorest rural areas of Peru. Finance: (a) the reimbursements for services provided by eligible health facilities under the SMI in the project areas; (b) SMI administration at the central level (MOH) and the local level DISAs; and (c) monitoring and evaluation of SMI implementation activities.
Strengthen decentralization, policy development and institutional modernization ($22.8 million, 9 percent of estimated cost)	Provide technical assistance for decentralization: (a) CLAS expansion and empowerment of communities; (b) Strengthening capacities of municipalities and DISAs; (c) Reorientation of the role of MOH and public/private health providers: including: streamlining of environmental health programs; development of studies, workshops and action plans related to second generation reforms. (d) Monitoring and evaluation.
Improve the quality of health programs and services ($49 million, 20 percent of estimated cost)	Finance investment subprojects addressing the health priorities of the regional departments, such as investment and technical assistance for integrated health interventions to support the SMI; health education; improving quality of existing water and sanitation services; community water provision in areas where there are no other sources of financing; area requirement for diagnostic and testing of vector borne diseases of malaria, yellow fever, dengue, HIV/AIDS, hepatitis and tuberculosis.
Project coordination ($8 million, 3 percent of estimated cost)	Finance a Project Coordination Unit (PCU) to coordinate project implementation.

a. There was an additional loan fee of $10.5 million that represented 4.4 percent of the cost. $9.7 million of this amount was interest payment for IDB loan. Amounts are in US dollars.

3.7 **Components**. The first phase included four components (Box 3-2). Nearly two-thirds of project costs were for strengthening demand by extending SMI coverage.

3.8 The Bank's finance for the APL's first phase was to concentrate on 10 geographic areas in 10 departments (Puno, Apurimac, Cajamarca, Cuzco, Lambayeque, Piura, Tumbes, La Libertad, Madre de Dios, Lima Norte and Lima Sur). The IDB was to provide similar support in 17 other departments. Technical assistance for policy and institutional development was to be national in scope and benefit the national level, municipalities, local health departments, and communities participating in the CLAS expansion.

3.9 **Implementation arrangements.** Addressing a government request, the project was jointly prepared as a combined operation with the IDB. There was agreement on a common development objective focused on maternal and child mortality and a single Project Coordination Unit (PCU) within the MOH for both operations. The project established a special unit to coordinate and supervise the SMI Program implementation, with a central office in Lima and a network of field offices for payment and audit through the territory. The project also proposed and established a task force for the implementation of the streamlining of the MOH's mother and child programs. The DISAs in the regions were responsible for the preparation and implementation of health investment subprojects.

3.10 **Monitoring and evaluation**. The monitoring and evaluation of health interventions was to be based on administrative data from MOH (strengthened by the project) and annual coverage surveys also to be supported by the project (National Household Survey, ENAHO).[43] The evaluation of the impact of health outcomes was to be based on the Demographic and Health Survey (DHS): A 2000 survey was going to provide a baseline and a second one in 2003 was going to measure progress in health conditions, including infant and maternal mortality.[44] The PCU was responsible for developing the project M&E component to measure its intermediate and final outcomes, including the impact of sub-projects, for which a baseline and control were to be established during the first year (World Bank 1999a, p. 49).

IMPLEMENTATION

3.11 **The project was approved by the Board on December 16, 1999 but not signed by the GOP until sixteen months later on April 3, 2001**. A large share of the World Bank's and IDB's contribution was supposed to finance the SMI reimbursements. Between Board approval and signing, the government of President Fujimori collapsed and there was an interim government in charge. The new government thought that there were constitutional limitations to funding current expenditures with debt sources. The GOP decided to finance with its own funds the reimbursements for utilization of maternal and child health services under the SMI. The Ministry of Economy and Finance (MEF) did not want to increase significantly the credit quota for the health sector for fiscal reasons[45] and because of concern about the capacity of the health sector to spend that amount of resources. **Thus, the government reduced the amount of the World Bank loan from US$80 million to US27 million, and the IDB loan from $87 million to $28 million, deciding to fully support the SMI with GOP funds.** The total cost of the project was unchanged, however, and it became effective on July 2, 2001.

3.12 **During PARSALUD's first three years, loan disbursements were slower than originally planned:** The first disbursement (US$1 million) took place on January 2002, about 25 months after project approval and six months after effectiveness (Annex C,

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[43] The *Encuesta Nacional de Hogares*, to implemented by the National Statistics Institute (INEI)
[44] DFID was going to support a participatory monitoring and evaluation approach, but in the end it was not involved.
[45] An agreement with the IMF restricted the amount of allowable external debt.

Table C-6).[46] Between September 1999 and March 2002 very few project activities were implemented. Disbursements in 2002 and 2003 were also slow.

3.13 **The slow project launch was due to political and administrative factors.** In addition to the resignation of President Fujimori in 2000 and the transition government in office until July 2001, there were frequent leadership changes in the MOH[47] and turnovers in technical positions. The PCU that implemented BHNP and designed PARSALUD was dismantled. In 2001, several organizations protested against what they thought was forced sterilization in Andean communities during the Fujimori government. This issue – not health reform -- became the focus of much of the health debate during the early days of President Toledo. Beyond these political impediments, the implementation of a new Budgetary System (*Sistema Nacional de Inversion Presupuesta,* SNIP) delayed the approval of civil works and acquisition of project goods. Counterpart resources were not released in a timely manner because of budgetary restrictions during the project's first years.[48]

3.14 **Government absorbed the SMI into an Integrated Health Insurance plan, implementing it ahead of schedule and nationwide.** Shortly after the project became effective, the transition administration decided to combine the Free School Insurance (*Seguro Escolar Gratuito*, SEG, administered by its own management team) and the SMI (managed by PARSALUD). In 2002, the new Toledo government launched the Integrated Health Insurance (SIS), managed by an autonomous agency independent from PARSALUD.[49] SIS is a state-funded insurance scheme that pays for some services to some of the poor; its ultimate objective is to become means-tested universal health insurance. Following these changes and the cancellation of loan resources to fund the insurance scheme, the influence of the project management on the implementation of SIS was reduced. However, the Bank had already played an important role in helping to launch the program by supporting the GOP on the design and implementation of a demand subsidy as the basis for an insurance system, and PARSALUD continued to support the insurance component through technical assistance and incentives to target the program on mothers and children and the poor.

3.15 **The proposal for comprehensive health reform lost relevance for the new administration.** There was some resistance both from ESSALUD to changing the status quo and from health workers, who opposed the labor conditions, particularly in the CLAS model. The Toledo government was not willing to support the reforms given the political costs; other priorities such as corruption, transparency and accountability took front stage. The new administration distrusted the former government's initiatives, including PARSALUD.

3.16 **Decentralization also followed a slower path than was planned.** In 2002 critical laws were enacted to create regional governments, strengthen local capacity and

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[46] In March 2002 a reimbursement of US$1.07 million was made by the Bank against retroactive financing for eligible expenditures incurred after the November 1999 appraisal mission.
[47] There were six Ministers and eight vice-ministers during the project period.
[48] This was also MEF's decision as a result of the project's low implementation during the first years.
[49] Law 27657, 2004

ensure fiscal responsibility, and in 2004 the MOH elaborated a proposal to transfer responsibilities to regional governments. Nevertheless, decentralization of health service delivery was slow because the delegation of functions to the local levels was unclear and the central government slowed down the transfer of responsibilities and resources because it had better management and control systems in place.[50]

3.17 **The mid-term review resulted in scaling back the scope of the project and focusing on health services to reduce maternal and perinatal mortality**. By the time of the original closing date in December 2003, only one third of the loan had been disbursed. In November 2003, following the mid-term review, the project components and logical framework were redefined and focused on interventions to reduce three main sources of maternal and perinatal mortality, based on strategies recommended by WHO:[51] universal use of oxytocin to deal with the problem of hemorrhage; use of magnesium sulfate to deal with eclampsia-preclampsia emergencies; and increasing the number of hospitals and health centers able to perform surgical procedures, to reduce the toll of obstetric emergencies requiring cesarean intervention.[52] The interventions were targeted within the eight regions with the highest incidence of maternal and neonatal mortality. The three original substantive components were re-configured into two: (1) Strengthening health demand; and (2) Supply interventions (Table 3-2). Procurement was centralized in the PCU. The investment component based on demand from the regions was dropped because it was difficult to implement. It was changed to support a system of investment planning controlled by PARSALUD at the central level and based on technical criteria developed by WHO to support a model of referral systems. For the supply interventions component, the project area was reduced from ten to three departments: Apurimac, Cuzco and Puno.[53]

3.18 **Changes in labor contracts reduced the management autonomy of CLASs.** In December 2004, after successful efforts by health union workers, physicians contracted by CLAS became civil servants. Their hours of work per day and days per month were reduced without a salary adjustment and, even more important, CLAS lost some of the autonomy to manage them. Further pressure came from other CLAS health professionals asked for the same benefits. The change in the job status of physicians has been a major limitation for the expansion of the CLAS model.[54]

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[50] The current government of President Alan Garcia has given a renewed emphasis to the decentralization process and by 2007 the transfer was occurring at a faster pace.

[51] Since 1996, USAID, through Project 2000, had launched actions to increase institutional deliveries and therefore improve maternal health.

[52] The new indicators were the percentage of attended deliveries that received oxytocin in the project area, percentage of deliveries financed by SIS in the first two quintiles of population in the Project area, number of health facilities refurbished to comply with Essential Obstetric Function (EOF), Basic Obstetric Function (BOF) and basic maternal and child services capacity and percentage of references with respect to the number of attentions.

[53] They included four DISAs: Apurimac 1, Apurimac 2, Cuzco and Puno.

[54] Peru has a very complex labor regime for health workers. Any given health facility may have workers subject to entirely different labor regimes with different remuneration, protections and benefits. The government attempted to increase coverage by providing short-term contracts with no benefits to some workers, and CLAS was a case where this model was introduced. This situation provided labor flexibility

Table 3-2: Revised Components and Activities	
Component	**Activities**
Strengthen health demand (US$149 million, 64 percent of actual cost)	Improve SIS targeting on the two poorest quintiles.[a] Include an intercultural strategy to reduce linguistic and cultural barriers among pregnant women belonging to ethnic groups.
Supply interventions (US$71.8 million, 31 percent of actual cost)[b]	Equip 79 health facilities[c] and implement a system for case referrals that included provision of ambulance vehicle units and radio equipment so that lower facilities that lack the capacity to handle obstetric emergencies could refer complicated cases to an adequate higher facility. Specialized training for handling obstetric and neonatal emergencies was provided. Improvements in the infrastructure of health facilities through investments to build new rooms or refurbish existing ones were also included.
Project coordination (US$8 million, 3.5 percent of actual cost)	Finance a PCU to coordinate project implementation

Notes: a. The original reimbursement component for SIS was cancelled as requested by the Government. b. Components B and C were consolidated. c. 54 of them were facilities with basic obstetric and neo-natal equipment (BONF) and 20 were facilities with - essential obstetric and neo-natal equipment (ENOF)

3.19 **The bulk of project implementation occurred during the last two years, after the scope was narrowed following the mid-term review**. Following the 2004-5 action plan prepared after the mid-term review, annual disbursements grew to about US$8.4 million. Refocusing the project more narrowly around only maternal and perinatal health care meant reducing the original thematic scope of the program, leaving out child morbidity and mortality, communicable diseases and inadequate environmental conditions. The focus on maternal mortality prioritized institutional delivery and did not include family planning interventions or other actions such as birth spacing or reducing pregnancy rates among adolescents. The project closed on June 30, 2006, two and a half years after the original closing date, with the US$27 million IBRD loan fully disbursed.[55] The actual project cost was US$231.8 million, 97 percent of the original estimate at appraisal (Annex C Table C-7). The GOP funded almost three times the appraisal estimate and the OPEC Fund did not provide financing as originally planned.[56]

3.20 While the emphasis of PARSALUD I on health reform diminished during the course of project implementation, the Bank continued to support health reform with complementary actions through a series of four Programmatic Social Reform Loans (PSRLs) implemented in 2001-5 (Box 3-3).

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and CLAS control over personnel. However, this situation also produced inequity among health care workers and high turnover rates, especially in rural areas.

[55] This amounted to a third (34 percent) of the original appraisal estimate of the Bank's planned contribution of $80 million.

[56] In 2006, the Belgian Cooperation approved a $6 million Euro grant to support SIS in the Ayacucho, Apurimac and Cajamarca departments.

Box 3-3: Four Programmatic Social Reform Loans complemented investment lending to support health reform objectives

The objectives of the ***Programmatic Social Reform Loans I-IV*** (US$450 million, 2001-2005) were to improve the antipoverty focus of public expenditure, increase the access of the poor to quality health and education services, and enhance the transparency of social programs, while empowering beneficiaries in their design and implementation. They supported health reform among other objectives, including trying to promote the reform of ESSALUD. The following targets were met:

- Expansion of SIS and CLAS
- A greater emphasis by SIS on the maternal and child package, targeting the poorest 40 percent, with care offered through primary health posts and centers
- Unification of the MOH mother and child programs
- Laws approving a benefit plan, enacting a system under which reimbursements can be made directly to health providers.
- Approved an action plan for ESSALUD, though only partially implemented.
- Set targets for use of professional medical care in delivery and to direct STI finances toward health posts and health centers
- Annual management agreements between the MOH and Regional Health Departments

However, there was no progress on a proposed package of nutrition interventions to be delivered through rural public health facilities and less progress on rationalizing health expenditure and hospital capacity (PSRL II). Efforts to reform ESSALUD and improve collaboration with the MOH continued to be frustrated by political and bureaucratic resistance and managerial instability in ESSALUD.

3.21 **Implementation of monitoring and evaluation.** M&E was absent during the first years of project implementation, but by 2004 it was put in place for the last 18 months of the project. The system was focused on the maternal mortality interventions. Administrative records from both the program and the SIS provided rich data sets for the monitoring of the intervention. The project was important in having ENAHO include in its annual survey information on maternal and perinatal health and in having the ENDES implemented on an annual basis instead of every five years.[57] Other elements that were initially designed were not implemented such as the DFID qualitative evaluation; a baseline survey in 2000 followed by a second one in 2003, the inclusion of instruments for M&E that included the distributional effects of health programs and services and the integration of MOH's monitoring systems.

3.22 **Use of the data.** The monitoring system implemented by PARSALUD (*cubos*) was reported to have been used widely and allowed for analysis of health indicators at the central, regional and local level. The availability of this information was mentioned as a stimulus to focus on results, analyze the data, and led to enhanced accountability. However, it was in place only at the end of the project and it has not been appropriated at the central level. There is a need to continue to strengthen monitoring systems at all levels and to ensure that the collection and utilization of data in decision-making is institutionalized. The system focused on outputs related to the maternal interventions and it did not expand to other project components such as intercultural interventions.

[57] USAID provided important financial support for the ENDES.

ACHIEVEMENT OF OBJECTIVES

3.23 The over-arching objective of PARSALUD was to improve maternal and child health, especially among the poor, through the reduction of perinatal, infant, and child mortality and the reduction of mortality from communicable diseases and inadequate environmental conditions. The objective for the first phase was to improve access of the poor to better quality services. This was to be achieved by: reducing the economic barriers to utilization of health services; decentralizing the health system and strengthening the MOH; and adapting investments to cultural aspects of health promotion and service utilization. The achievement of the first-phase objective as well as progress toward the over-arching objective will be assessed.

Improve access of the poor to better quality health programs and services (first phase objective)

Outputs

3.24 **Expansion of SIS.** The SIS was implemented in 2002, ahead of the planned date of 2003, and its coverage was expanded from five DISAs to the entire country.[58] By 2005, SIS reached about 11 million people (41 percent of the Peruvian population) in five plans (Table 3-3). It made efforts to prioritize funds on Plans A and C, as they cover maternal and child health services. In 2005, these two plans reached over 4 million people and financed 1.2 million deliveries. Seventy percent of SIS transfers were directed towards them (Table 3-4, line 3). Coverage of SIS with respect to pregnant women and children under five increased significantly and surpassed the PAD targets (Table 3-5).

Table 3-3: SIS Consultations, Enrollment, and Expenditures, 2002-2005

Utilization and expenditures	Plan A: Age 0-4	Plan B: Age 5-17	Plan C: Pregnant & postpartum women	Plan D: Adult emer-gencies	Plan E: Special groups[a]	Social cases[b]	Total
Utilization							
Consultations (000)	28,462	18,417	14,056	199	620		61,758
Enrollment (000)	3,444	6,703	649		231		11,027
Expenditures							
Transfers[c] (000 Soles)	321,953	239,872	307,157	22,509	10,010	3,693	904,944

Source: SIS 2006, p. 102.

Notes: a. Special groups defined by law, such as food kitchens, *vaso de leche* (glass of milk) organizations, and others. b. Transfers for poor patients over 17 who do not belong to any priority group, but had to be treated. c. In addition, 59.5 million soles was spent on administration.

[58] SIS was part of the project that was funded with treasury funds by the GOP.

Table 3-4: SMI/SIS beneficiary population (thousands)

	Appraisal Estimates (SMI)		Actual Estimates (SIS)	
Year	Pregnant women	Children under 5	Pregnant women	Children under 5
2000	148	445		
2001	281	760		
2002	446	1,140	545	2,014
2003	503	1,250	726	2,496
2004			656	3,069
2005			649	3,444

Source: ICR, based on PAD targets (related to SMI) and the SIS data base.

3.25 **Intercultural strategies.** During the last two years of the program, there was an effort to develop an intercultural strategy leading to ensure better quality of care for indigenous, mostly non-Spanish speaking beneficiaries. Access was promoted by introducing programs to remove linguistic and cultural barriers. Two regional universities (San Antonio Abad in Cuzco and Huamanga in Ayacucho) trained staff of all the 74 health facilities in the project area on intercultural issues, including an awareness training program and Quechua language courses. The program included the production of tapes and manuals to support a distance learning program. However, the brief intercultural training modules were insufficient in both their coverage and their content. Among other aspects, curricula in medical and other health professional schools need to incorporate concepts of interculturality and cultural competence (Physicians for Human Rights, 2006). The experience gained in PARSALUD I informed the design of PARSALUD II, which now has a larger component in this area.

3.26 **Expansion of CLAS.** By the end of the project, one third of primary care clinics were administered by CLAS. Evaluations show that the quality of services in those centers is better as a result of greater productivity per employee, longer hours of operation, higher levels of patient satisfaction, and increased community participation (Altobelli 1998 and 2004; Cortez 1998). However, expansion targets were eventually met as a result of the PSRL policy matrix, not PARSALUD. CLAS received little consideration from the project, particularly after the strategy was changed in November 2003. Neither the MOH nor the project director gave clear support to the model. As a result, CLAS health centers were not particularly targeted as investment priorities for the supply component of the project. The proposed activities of strengthening CLAS management and community capabilities to participate were not implemented.

3.27 **Quality of health care.** The project financed a number of improvements in the quality of health care, particularly for mothers and children.

- The project funded 188 ***civil works***, including construction of 17 complete maternal or perinatal facilities, 40 new health facility rooms and the rehabilitation of 27 existing facilities. Maintenance, however, was a problem reported both by the ICR and encountered during field visits. The responsibility for and the allocation of resources to maintain both infrastructure and equipment are not clear. Rehabilitation

or construction of "Casas de Espera"[59] (waiting homes) and equipment to support practices of vertical birth were also financed (Annex Table C-9).

- Seventy-four facilities received basic and essential ***equipment*** for childbirth, maternal and perinatal emergencies, laboratory and pre-natal and post-natal visits for pregnant women and their children. Technical assistance was provided at the regional and local levels through the establishment of local health management teams, who played an important role analyzing M&E information, agreeing with local and regional stakeholders on the activities to be carried out, providing technical assistance, and monitoring activities.

- The staff assigned to the Project area health facilities, received ***training*** related to medical protocols regulating the Basic and Essential Obstetric Functions, including: (i) short courses or seminars on topics associated with maternal and newborn health care, typically conducted at the regional level; and (ii) internships that spanned several weeks to three months in hospitals specializing in maternal care, often in Lima. The first type of training included staff from both intervention and non-intervention facilities. The internships, however, were more selective and 79 percent of those realizing internships were from intervention facilities. Almost 90 percent of the staff of the 20 facilities with Essential Obstetric Functions and of the 59 facilities with Basic Obstetric Functions received an average of 13 training sessions per facility.

- The project supported the issuance of regulations on maternal and perinatal protocols, technical assistance for the strengthening of the MOH Management Information System (MIS) for the Handling of Medical Supplies to ensure a three-month supply of basic and essential obstetric functions, and for the MOH Epidemiology Information System. By the end of 2004, the MIS was in operation and was an important instrument for monitoring and decision-making, particularly at the local level.

Outcomes

3.28 **The access of the poor to health care expanded through the extension of SIS.** In 2005 over 60 percent of SIS enrollees belonged to the lowest two quintiles of the population (the bottom 40 percent, SIS, p.43).[60] Between 2002 and 2006, the share of institutional deliveries financed by SIS increased nationwide from 38 to 65 percent and in the project area from 19 to 60 percent. The share of deliveries financed by SIS in the two poorest quintiles in the project area rose from 44 to 56 percent. The share of newborn children covered by SIS weighed within the first 24 hours of birth rose from 73 to 83 percent nationwide and in the project area from 64 to 74 percent. However, they still fell short of the (nationwide and project area) target of 95 percent (World Bank 2007). The

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[59] The "Casa de Espera" is a model developed by UNICEF. In Andean regions, these houses are provided for rural pregnant women, their families, and even their animals, close to the health post or health center, shortly before delivery.

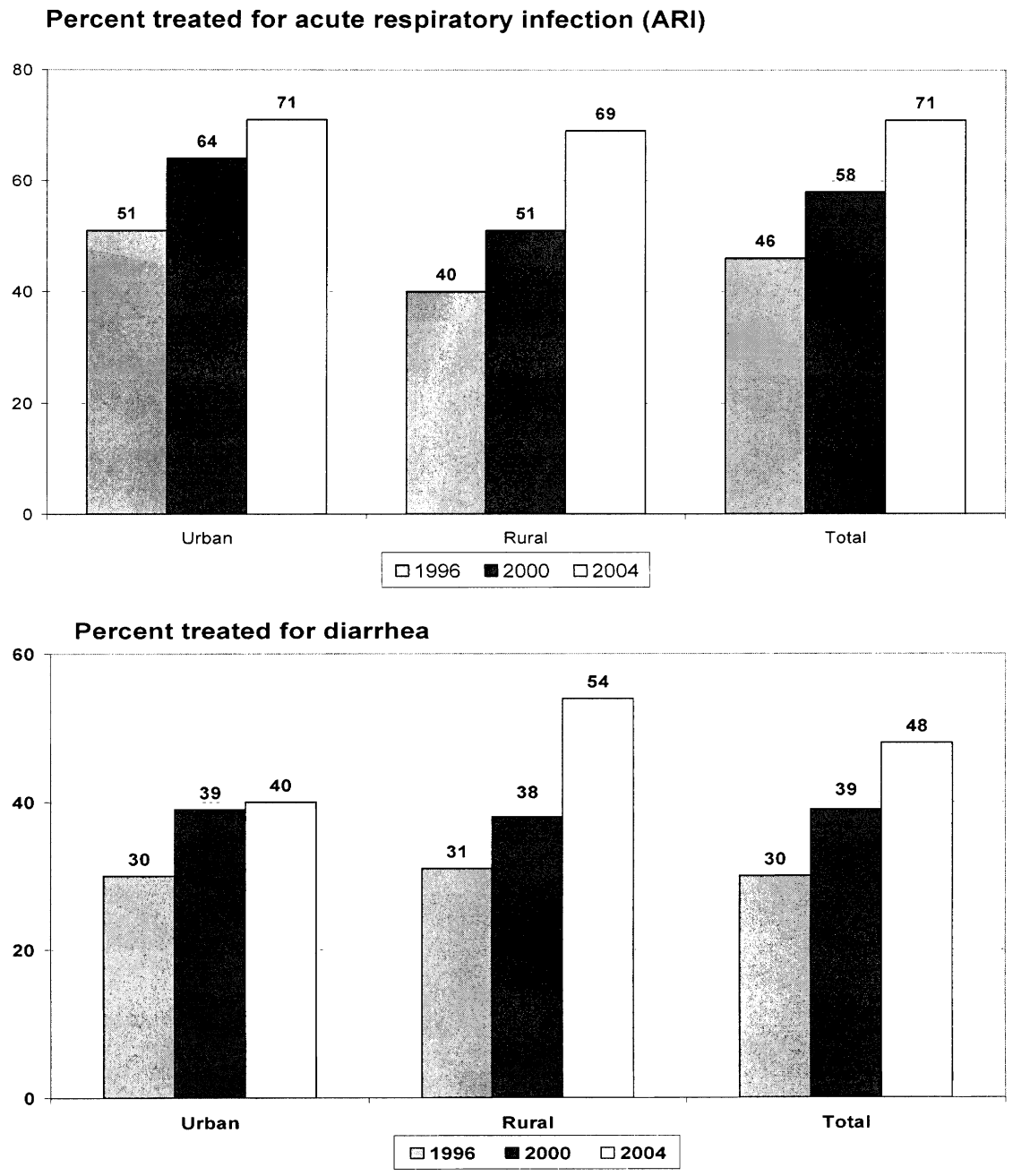
[60] In contrast, 80 percent of ESSALUD affiliates belonged to the two highest quintiles and 90 percent of affiliates to private insurance belong to the fifth quintile (Alvarado 2007).

percent of children under five who received treatment for acute respiratory infections (ARIs) increased overall from 58 to 71 percent from 2000-2004; it increased in both urban and rural areas, but the rate of increase in rural areas was greater and by 2004 the urban/rural disparity had virtually disappeared (Figure 3-1a) The percent of children treated for diarrhea increased from 39 to 48 percent from 2000-2004, and by 2004 rural children were *more likely* to get treatment than urban children (Figure 3-1b).

3.29 **Access to institutional deliveries among ethnic minorities also improved** (Figure 3-2)**, but this was observed *before* PARSALUD's main investments in intercultural interventions and likely reflects other measures that targeted the poor.**[61] Within the project area, the percentage of institutional deliveries of all women rose and for women in the first quintiles it rose from 44 to 56 percent (World Bank 2007). A recent evaluation found that PARSALUD developed a– provider training model that played a major role in improved access to institutional births (Box 3-4). **The gap between the poor and non-poor, rural and urban women in terms of the percent of deliveries attended by a skilled health professional was reduced but remains large nationally** (Figure 3-3)**.** Unfortunately, the monitoring and evaluation of the project was not designed to assess the extent to which the poor or disadvantaged were disproportionately reached *within* the project areas, relative to the baseline, or to assess the extent to which the results in the targeted project areas with quality and infrastructure improvements differed from other similar areas that also benefited from SIS alone but not these other improvements.

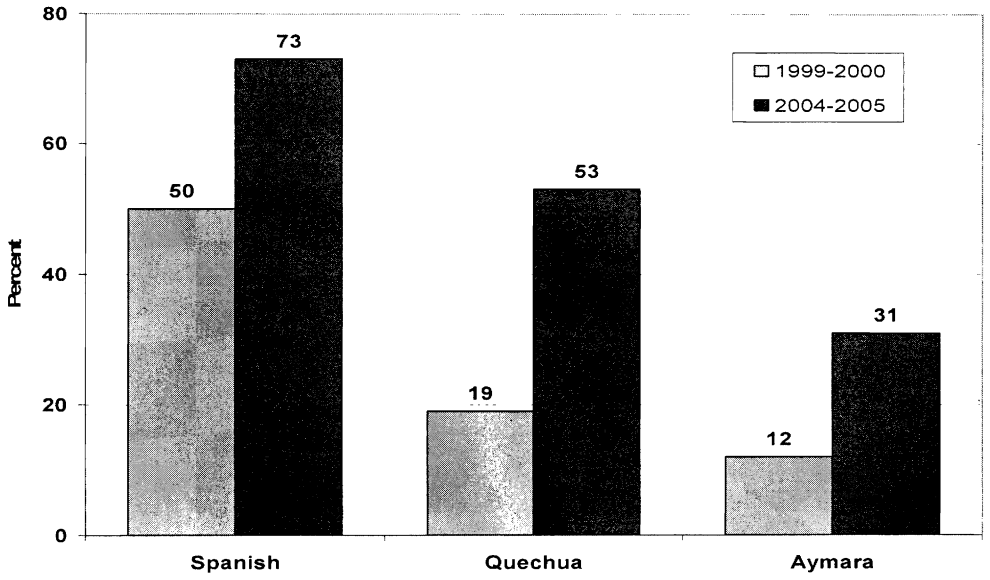
[61] Although these achievements are important, there is not a comprehensive strategy to assess and improve upon traditional birth practices.

Figure 3-1: Percent of children under 5 seeking treatment of ARI and diarrhea



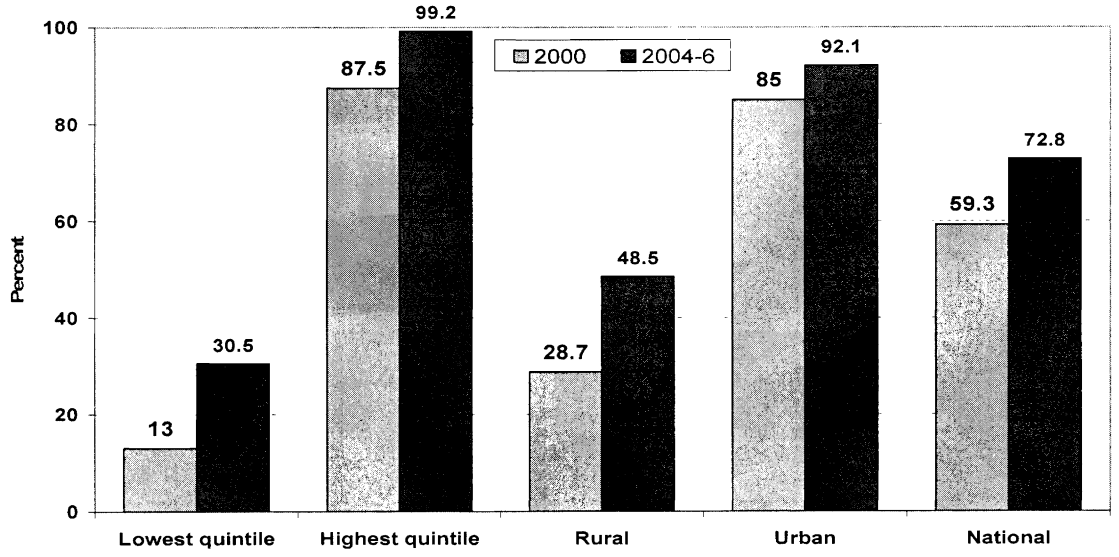
Source: SIS 2006, p. 106.

Figure 3-2: Institutional Delivery According to Mother Tongue 1999-2000 and 2004-2005



Source: PARSALUD final report based on DHS 2000 / DHS 2004-2005

Figure 3-3: Increase in the percent of deliveries attended by a skilled health professional, by wealth quintile and area of residence



Source: DHS 2000 and 2004-6, as reported in Annex Table D-2.

Box 3-4: Impact of PARSALUD on institutional births

Preliminary results from a recent evaluation (Jaramillo, 2007) suggest that PARSALUD's training program had significant impact on the number of institutional births and the nature of the services provided to the mothers. The study's three main findings are:

1. Training provided by PARSALUD had a positive and significant impact on the number of deliveries performed in institutions, the number of cesarean interventions, and the number of deliveries attended using oxytocin. The size of the effects are important, amounting to an additional 20 percent in comparison to the no intervention counterfactual in the case cesarean interventions and to 29 percent in the case of deliveries using oxytocin;
2. Results regarding infrastructure investments are ambiguous. It is possible that infrastructure investments did not significantly affect the capability of facilities to perform deliveries across the board. However, it could be the case that the resolution capacity of the facility was improved as a consequence of these investments; and
3. Different types of training had different effects: training in perinatal technology tends to have positive effects on all outcome variables, but that on obstetric emergencies tends to be negative, though often statistically insignificant. In the case of specialized or laboratory training results are not consistent. As far as the type of participants, training MD doctors tends to have positive results while training technicians tends to have negative results. Results for nurses are ambiguous.

An issue that will require further exploration is the lasting effect of PARSALUD training on these rural facilities where there is a high turnover in medical personnel.

Source: Jaramillo 2007

3.30 **However, while access of the poor to insurance has improved, overall coverage of the poor is still low – only about a third of the extreme poor and a quarter of other poor people are enrolled in SIS** (Figure 3-4). SIS suffers from a number of problems, including failure to cover all the costs of treatment,[62] inefficient management,[63] and lack of overall funding: in 2006, the SIS budget was only 7 percent of MOH's budget (SIS 2006). Although SIS has improved targeting, particularly after 2003 when it emphasized enrollment of the two lowest quintiles and covering maternal and child health interventions, there is still room for improvement. The highest quintiles still use more of the resources, probably as a result of higher user rates and access to higher cost interventions (Alvarado, 2007). Geographical and linguistic barriers also explain the lower use by women who belonged to the poorest groups of the population, particularly in Andean communities (Parodi 2005).

Improve maternal and child health, especially among the poor (overarching objective)

3.31 While the original strategy for improving maternal and child health was through the reduction of perinatal, infant, and child mortality and of mortality from communicable diseases and inadequate environmental conditions, the project as implemented focused more on reducing the sources of maternal and perinatal mortality,

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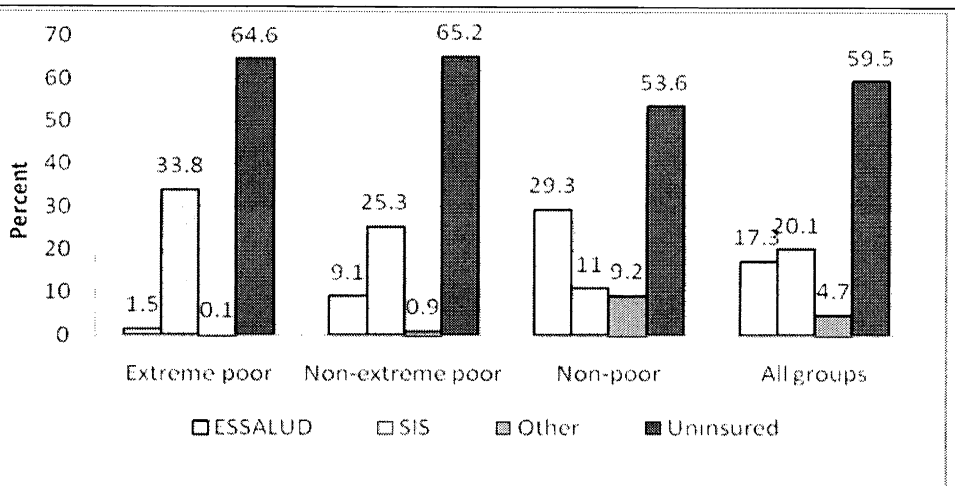
[62] From the field trip visits, two of the main issues cited by respondents as important barriers were the fact that SIS does not cover food or transport, which is a major economic barrier in Andean communities.

[63] There are still problems with the delays in reimbursements. The number of days between the submission request to SIS and the reimbursement to the health facility has improved from 180 days in 2002 to 91 days in 2006. However it is still short of the target of a maximum 25 days. There are delays at two stages: (i) the time it takes for SIS to deposit funds to DISA, and (ii) the time it takes the DISAs to send the funds to the health facility. The second delay seems to be more substantial.

in accordance with the restructuring of the components and activities at the mid-term review.

Figure 3-4: Percent of the poor and non-poor with access to insurance, 2004



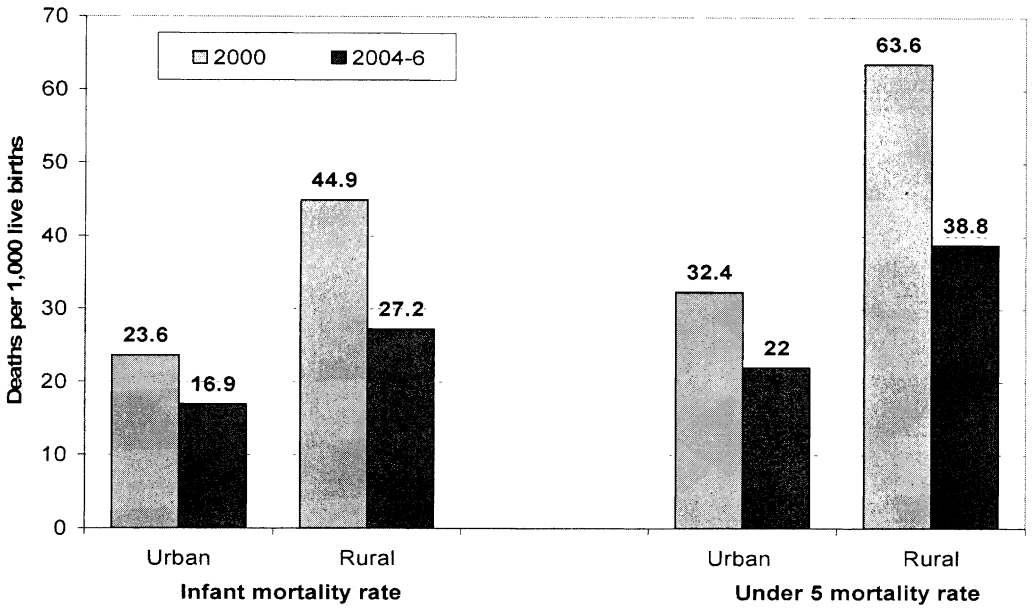
Source: INEI

3.32 Nationwide infant mortality fell from 43 deaths per 1000 live births in 2 000 to 22 per thousand in June 2006, surpassing the 2003 target of 29.2 per thousand. Both infant and under-five mortality fell by more in absolute and relative terms in rural than in urban areas (Figure 3-5). Moreover, infant mortality in the project area fell from 48 in 2000 to 28.3 in 2006, surpassing the 2003 target of 34.4 (World Bank, 2007, p.42). Unfortunately, it is difficult to track trends in maternal mortality for this period with any precision, as it remains a relatively rare event and the confidence intervals around any survey estimate are very large.

3.33 It is important to point out that while PARSALUD may have contributed to these improvements in health outcomes, better education, water and sanitation, income,[64] infrastructure and environmental changes can play a major role in reducing infant mortality. The investments of the GOP, projects implemented by other donors and international organizations, PSRLs and policy dialogue, in addition to the outputs of the project could contribute to the improvements. As shown in the previous section, the gap in access to services and insurance between the poor and non-poor, rural and urban, was reduced, but nevertheless remains substantial. Unfortunately, the project did not include an impact evaluation. Nor did it include any collection of data that would allow tracking of health outcomes among the poor in relation to the nonpoor, even though that was an integral part of the objective of the project.

[64] Note, however, that improvements in water supply and income would be expected to reduce malnutrition, but it was unchanged over the project period (see Annex D, Table D-1).

Figure 3-5: Infant and Child Mortality declined by more in rural areas, which are poorer



Source: DHS surveys, 2000 and 2004-6, as reported in Annex D, Table D-1.

RATINGS

3.34 **The project's overall outcome rating is "satisfactory"** based on high relevance, substantial efficiency and substantial efficacy (Table 3-5). It is important to note that although PARSALUD by name was a "Health Reform" project, both the first phase and over-arching objectives of the APL were to improve access, quality, and health outcomes among the poor. These are the objectives against which PARSALUD is assessed, even though many of the health system reform elements (e.g., reform of ESSALUD) were ultimately postponed or only partially implemented. The restructuring of the project activities were oriented toward achieving the objectives.

Table 3-5: PARSALUD ratings, by objective

Objective	Relevance of objectives and design	Efficacy	Efficiency	Outcome
1. Increase the access of the poor to better quality health programs and services (Phase I objective)	High	Substantial	Substantial	Satisfactory
2. Improvement of maternal and child health and reduction of mortality due to communicable diseases and inadequate environmental conditions, especially among the poor (Over-arching APL objective)		Substantial		Satisfactory
Overall outcome rating				**Satisfactory**

3.35 **Overall relevance of objectives and design is rated *high*. The relevance of the project's objectives remains *high* in 2009**. The objective of improving maternal and child health, especially among the poor, by reducing the economic barriers through the utilization of health services primarily through SIS and the decentralization efforts, are a priority of the current national health plan (*Plan Nacional Concertado de Salud*); they are included in the 2006 Country Partnership Strategy and remain a topic of the policy dialogue promoted by the Bank in Peru. The targets are also consistent with the Millennium Development Goals for the country. **The relevance of the design is *substantial***. The project was focused toward the poor and addressed both demand and supply constraints. The consolidation and expansion of SIS in the poorest areas is a current government priority; decentralization is on top of the agenda and the need to further develop an intercultural strategy is critical to improve access for Andean communities. However, the overall APL as well as the first phase was overly ambitious given the political uncertainty and the interests of different stakeholders.

3.36 **The overall efficacy of the project is *substantial.*** There was substantial increase in *access* to services, primarily as a result of wider adoption of SIS, which reduced the economic barriers to utilization of health services (para 3.26). Although there are problems and overall coverage of the poor is still low (para 3.28), the achievements were impressive. The *quality* of services also improved in project areas due to project outputs (para 3.25). Improved access and quality were promoted by a lesser extent by enhancing the decentralization of health systems and adapting investment to local health problems. Although there is not enough evidence regarding the impact on the poor, it seems that the gap between the poor and non-poor has narrowed, even if it is still great (para 3.27). The project had a substantial impact on the overall objective of improving maternal and child health within the project area (para 3.30).

3.37 **The project's efficiency is *substantial***. The project targeted the poorest regions and those with major maternal and infant mortality problems. Gains in efficiency were achieved through improved targeting, increased coverage of the SIS (mothers and children in poorest income quintiles), improvements in institutional birth coverage that positively affected infant mortality rates and low fiscal impact. The project incited greater demand for and utilization of services (generated by SIS) and achieved higher levels of productivity in previously underutilized facilities. While the project financed public facilities in eight regions, human resources did not expand significantly. SIS contributed to improvements in the targeting of public health expenditure, although as noted more than half of the poor still had no access to SIS and a rather large share of resources was being spent on the non-poor. However, SIS has made some progress on improving the distribution of expenditures among MOH facilities, helping to increase resources directed to the provision of essential health services for women and children covered by Plans A and C. A benefit analysis of all the large social programs in Peru (carried out by RECURSO) found SIS to be the most efficiently targeted program in health. There was also substantial progress in redefining the role of MOH in several areas that improved efficiency, including: (i) the integration of vertical programs by restructuring primary health care into age-based groups; (ii) the ongoing establishment of the Integrated Health Model; and (iii) budgetary integration of health programs and the maternal and child health interventions at the facility level. However, this was not the case for other vertical programs such as vaccination, malaria or tuberculosis. Monitoring

systems were not integrated. The joint PCU between IDB and the World Bank improved implementation efficiency. Although the project had a slow start, the measures taken in 2003 to focus the project on maternal and perinatal morbidity and mortality improved efficiency. Regarding the fiscal impact of the project, it represented only about 0.2% of public expenditure during the period and 4.8 percent of SIS Plans A and C (World Bank, 2007).

3.38 **The risk to development outcome is *moderate.*** SIS implementation is a mainstream health program in Peru and a consolidated reform, but it still has problems of administration, targeting and efficiency, and is still a demand subsidy. Decentralization is also a mainstream policy in Peru, however the CLAS as a model of accountability, participation and decentralization faces considerable risks. Those risks are explained by changes in human resources policies but also because it needs to be redefined as part of the decentralization policies. Cultural relevance continues to be a priority in Peru, although it will need more support from the GOP and all the institutions working on health issues if a meaningful change is to be achieved among the Andean communities that have been excluded. The fiscal impact of the project is also low, there was no significant expansion in human resources and funds for maintaining infrastructure and equipment do not seem significant. After a gap of more than 30 months, PARSALUD II was approved by the Bank's Board in February 2009. PARSALUD II will continue the focus on the health of poor women and children. However, many of the ambitious, system-wide reforms have been dropped and a strategy of more incremental reform has been adopted (Box 3-5).

Box 3-5: PARSALUD II (Second Phase)

After a gap of more than 2½ years, the second phase of the PARSALUD APL was approved by the Bank's Board in February 2009 -- US$15 million in support of a US$162.4 million project, co-financed with US$15 million from the IDB. Originally conceived as a three-phase program, it is now reduced to two phases, with this second phase (2009-2015) pursuing the time frame of the original third phase. The overarching objectives of the PARSALUD II remain the same – to improve maternal and child health, and to help reduce morbidity and death of the poor due to communicable diseases and inadequate environmental conditions (World Bank 2009, p. 9). According to the appraisal document, one of the lessons of PARSALUD I was the need to prioritize. The original APL planned to undertake ambitious system-wide reforms in the second and third phases, but coverage of health services for the poor is still an issue and there have been legal and administrative developments (or ambiguities) concerning ESSALUD and MINSA hospitals. Instead, the project has focused on a more narrowly defined number of "incremental reform elements" (*Ibid,* p.11). The objectives of the second phase are to:

1. Improve family health care practices for women (during pregnancy, delivery, and breastfeeding) and children under three
2. Strengthen health services networks with capacity to solve obstetric, neonatal and infant emergencies, and provide comprehensive health services to women (during pregnancy, delivery and breast-feeding) and children under three
3. Support MINSA's governance functions of regulation, quality, efficiency, and equity for improving the new health delivery model of maternal and child health care in a decentralized environment.

Among the targets of PARSALUD II are an increase in the share of antenatal care and institutional deliveries in rural areas of poor regions, a reduction in anemia among pregnant women and children under three and of neonatal mortality in those regions, and to increase the share of children exclusively breastfed.

The project will include PARSALUD I's 7 regions (Amazonas, Huanuco, Huancavelica, Ayacucho, Apurimac, Cusco, Puno), plus 2 with high infant and maternal mortality rates – Cajamarca and Ucayali.

3.39 **The Bank's overall performance is rated *satisfactory*.** *Quality at entry* was *satisfactory.* The Bank's performance during preparation and appraisal was well founded on the experience of the BHNP project, the country's institutional modernization strategy and lessons from health reforms in other Latin American countries. The design of the project took advantage of the team familiar with BHNP and with Bank operations, procedures, procurement and financial management. The project (as well as the PSRL series) was an operational follow-up to the recommendations of the World Bank health report, *Peru: Improving Health Care of the Poor* (World Bank 1999). However the Bank could have assessed the political risks better (although some events were unforeseen, the project was approved at the end of a political cycle) and it did not take into sufficient consideration the difficulties in obtaining information systems and the loan effectiveness conditions required, actions that took much longer than expected to be met.

3.40 *Supervision* was *satisfactory.* The Bank played a key role in trying to uphold policies and maintain a cluster of activities that have been important for health outcomes in Peru. The Bank was flexible to adjust the project to changing conditions resulting in reducing the size of the loan, two amendments to the loan agreement and two extensions of closing dates. The day-to-day supervision benefited from the presence of sector-related Bank staff in the Lima office. Strong communication between the IDB, World Bank and MOH was highlighted as key factor contributing to effective coordination under PARSALUD. The Bank also supported the GoP though the PSRL DPL series with the same technical team. However, the Bank could have done a better job supervising the implementation of the M&E: there were delays in the development of this component and only after 2004 (when the components were restructured) were efforts stepped up to improve the collection and regular analysis of information. Further, the provisions for monitoring outcomes among the poor were weak.

3.41 **The overall borrower performance is rated moderately satisfactory.** *Government performance* is *moderately satisfactory.* MOH was fully involved in preparation activities and project design. The government assumed the funding of the SIS, and allocated enough resources to that component. This has been instrumental in helping to consolidate this important innovation in the Peruvian health sector. During implementation, government performance was uneven. Between Board approval in December 1999 and the election of President Toledo in July 2001, there were frequent changes in managerial positions at the MOH and health policy uncertainties. Borrower performance during this time was rated by the Bank as highly unsatisfactory. From July 2001 to November 2003 implementation was very slow and the activities of the project were unfocussed and carried out in a context of lack of priorities. Following a refocusing of the Project interventions, after November 2003 there were significant improvements in implementation and considerable physical and financial progress.

3.42 **The implementing agency's performance (the PCU) is rated moderately satisfactory**. The project had five different coordinators, two of them lasting less than 7 months. The frequent changes compounded with the political difficulties and the broad objectives of the project, resulted in delays for the implementation of the project. Initially the PCU performance was negatively affected by continuous political changes and between July 2001 and November 2003 the implementation was unsatisfactory in

physical and financial aspects. During the last three years of implementation, the PCU performed well and made substantial effort to speed up implementation.

3.43 **Monitoring and evaluation** was *modest*. M&E Design was substantial, involving administrative data, annual coverage surveys, household surveys, and repeat DHS (para 3.10). However, both implementation and use of the data were modest. Administrative records proved a rich source of information, but the M&E system was not put into place until the last 18 months of the project and neither baseline or end surveys were done (para 3.21).The PARSALUD monitoring system was reported to have been used widely for analysis of health indicators, but was available only at the end of the project.

4. LESSONS AND VALUE-ADDED OF THE BANK

4.1 This chapter provides a 10-year perspective on the Bank's objectives and continued value added in HNP in Peru, as well as lessons on some of the key themes of the broader IEG evaluation of Bank support for HNP. The period of analysis spanned four CASs (1994, 1997, 2002, and 2006). The first three included health as a key strategy to improve human capital, while the last[65] prioritized new sectors, such as water and sanitation, electricity, housing and property rights, but continued to emphasize efforts to reform the health system and to improve service quality through a new social contract based on better information and accountability in the social sectors.

4.2 During this period, Peru's economy improved remarkably due to fiscal discipline and economic reforms, yet poverty and inequality persisted and public administration was weak and centralized. The country moved from a period of collapsing infrastructure that affected the health sector, to achieving important improvements both in terms of health facilities and coverage. However, the quality of social services was poor and marked by inequality in access. There were improvements in access and health outcomes among the poor and the gap between the poor and non-poor has narrowed, but in absolute terms the gap remains large

HEALTH OUTCOMES AMONG THE POOR

4.3 **The Bank's experience in Peru demonstrates how an emphasis on pro-poor health policies can be sustained through multiple instruments in a constantly changing political environment.** In addition to the two health investment projects assessed here, the Bank invoked policy dialogue, policy notes, analytical work, and policy lending. Respondents reported that analytical studies such as *Peru: Improving Health Care for the Poor* (World Bank 1999b) and *An Opportunity for a Different Peru* (Giugale and others 2007) were highly influential in helping to assess the options. The PSRL series was complementary to health investment lending, including as one of its main objectives to protect critical anti-poverty expenditures from budgetary cuts and to improve access of the poor to health programs such as SIS and CLAS. All of these actions were consistent with the poverty reduction objectives of the four CASs. Even as

[65] The fourth CAS was also referred to as a Country Partnership Strategy.

the health investment projects' activities were adapted over time, the poverty focus did not change.

4.4 Geographical targeting can achieve a general pro-poor focus, but in a country with large inequalities in both urban and rural areas such as Peru, more precise targeting mechanisms are needed to ensure that resources disproportionately reach the poor. While both BHNP and PARSALUD had a pro-poor focus, the targeting mechanisms for the poor were relatively crude. BHNP took place in 13 provinces classified at the time as the "most deprived" and in two classified as "deprived". PARSALUD's initial targeting focused on rural and Andean populations. While SIS was applied nationwide, it lacked precise targeting mechanisms for beneficiaries. Respondents for this evaluation suggested that the Bank prioritized the expansion of coverage first, while quality and targeting were seen as steps to be taken once the program had sufficient strength and coverage. After the reorganization of components in 2003, efforts were made to support actions directed towards improving the targeting of SIS. Although in rural areas SIS registered and provided services to all beneficiaries, in urban areas, a socioeconomic assessment was carried out to determine whether the beneficiary qualified for the SIS subsidy. This socioeconomic assessment was then used for the implementation of the SISFOH (the Household Targeting System in Peru), which is used to improve targeting of various social programs in the 30 largest cities in the country.

4.5 **The failure of monitoring and evaluation design and implementation to focus explicitly on the poor weakens the ability of programs to assess impacts and to learn from and perfect pro-poor targeting.** The two investment projects explicitly addressed HNP outcomes among people in poor regions and the poorest groups in the population, but evidence was collected in most cases on *average* health outcomes. Neither project set targets for outcomes or impacts specifically for the poor, nor were outcomes or access for the poor to be monitored. While access and outcomes can be tracked through the national DHS surveys for those in urban and rural areas and by wealth quintile, and to some extent in project regions compared to the rest of Peru, there was no mechanism or evaluation design for assessing the marginal effect of the specific interventions supported by the projects on the outcomes of the poor. During the implementation of PARSALUD, the SIS component included specific intermediate outcomes for the first two quintiles of the population. However, there is still scope for better specified outcome goals for specific groups that are living in poverty.

HEALTH REFORM

4.6 **Health system reforms that proceed in a piecemeal way can nevertheless result in improvements in access and efficiency.**[66] Although not comprehensive, incremental reforms in Peru have resulted in: (a) creation of a targeted insurance scheme (SIS) that has improved access and improved efficiency in the allocation of resources; (b) introduction of some market competition for ESSALUD in the provision of services; (c) development of community-managed services such as CLAS, with greater local accountability; (d) the beginning of a decentralization process; (e) the introduction of

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[66] Ewig (2004)

individual targeting mechanisms; and (f) reorganization of the MOH. These piecemeal reforms have been supported by small groups within the MOH, supported by the Bank, and by economic officials interested in rationalizing public expenditure and in a broader effort to support modernization efforts. However these teams have been dismantled several times and there has not been continuous support from high-level health officials or other sectors of society to broaden the reform.[67] Thus, elements included in the vision for health reform for 2010 have been implemented only partially; the establishment of universal health insurance funded with subsidies for the poor and contributions from the non-poor and enlistment of private and public institutions both as insurers and in service provision remain part of the unfinished agenda.

4.7 **Creating new institutions can be less difficult than reforming existing ones.** The transformation of ESSALUD and the health care units of the Armed Forces and the National Police have proved to be more difficult than the creation of new organizations such as SIS. Resistance to change within ESSALUD and the health sector bureaucracy and the complexity of comprehensive health reforms have been significant obstacles for the reform.

4.8 **The Bank can contribute to sustaining health reform efforts through the use of multiple instruments and analytic work.** The strategy of using multiple lending instruments and analytic work to maintaining a focus on the poor was equally important in Peru in maintaining a focus on health reform. The PSRLs, which disbursed US$450 million, were effective means to maintain the reform agenda despite the political cycle. The conditions included in each PRSL were to be met prior to loan approval and involved no borrower counterpart funds. They provided incentives for both the MOH and the MEF to work toward the same goals. The most recent policy note on Peru (World Bank, 2006b) keeps the reform on the agenda. It proposes the creation of a means-tested universal health insurance – expansion of SIS; to subcontract all public health clinics to CLAS, and to force all publicly founded health systems to coordinate. Decentralization and accountability are also part of the Agenda. The Bank has the flexibility needed during those transitions and it's able to adapt the projects while retaining the objectives.

4.9 **Health reform projects need a realistic ex ante assessment of political and institutional risks – including analysis of the interests of specific key stakeholders in the health system – and mitigation strategies.** Decisive support from the government and political support from stakeholders are key to the potential success of innovations. While the SIS model (with political dividends for the government) is now a part of the health system in Peru, the CLAS model, which has support at the local level and from Peruvian health analysts, it is still at risk of being undermined. Opposition from the ESSALUD bureaucracy has stalled progress on reform of health insurance for the formal sector. Although the APL instrument was adopted for PARSALUD and provided flexibility for the long-term support of reforms, the implementation of its first phase was difficult and the health reform initiative was refocused on health service delivery. In the

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[67] Respondents for this evaluation characterized this progress as transformation of the health sector "Peruvian style". One respondent said, "it's the only way to make change in Peru: incremental and slow. It helps to sustain changes". However, other respondents argued that this slow change is inefficient and has a high cost for the country.

recently approved PARSALUD II project, political issues with labor contracts in the CLAS and the reforms of ESSALUD have led again to a project primarily concerned with health service delivery and "incremental" reforms.

4.10 **Confronting human resource issues is fundamental to sustain progress in the health sector and the focus on the poor.** After the economic collapse of the eighties, Peru was forced to reduce real wages for all civil servants. Health workers developed coping strategies based on second jobs, parallel businesses, misappropriation and corruption. The situation resulted in low productivity, low quality and a bias against the poor. The CLAS model made an effort to avoid these conflicts, by providing different kinds of contracts to its health workers. However, this innovation was effectively reversed in the case of the physicians.

DONOR COORDINATION

4.11 **Donor coordination and elimination of parallel structures can be enhanced by joint management units.** At the time of the BHNP, there was little coordination by the government or between the donors of large projects funded by USAID and the IDB. This resulted in the projects creating, and the MoH supporting, parallel structures for project implementation. Following a government request, PARSALUD combined financing from the World Bank and IDB and worked through a joint PCU, helping to eliminate parallel project structures and improve inter-agency coordination in support of the government's agenda.

VALUE ADDED OF THE WORLD BANK

4.12 **The World Bank's evolving value added and contributions to Peru's health sector between 1994 and 2006 can be divided into three phases.**

- In the early nineties, the Bank supported the GOP to alleviate the impact of a severe macroeconomic stabilization package with emergency programs to protect the poor. In the health sector, Bank efforts were concentrated on reconstruction of services and infrastructure, mainly through the BHNP, and focused on maternal and child health among the poor. This was also the focus of the government *Programa de Salud Basica para Todos*, and other international donors and development agencies working on health issues at the time such as USAID and IDB.

- By the mid-nineties, indicators were improving and the country's economic situation stabilized. There was a shift towards supporting the GOP in defining a medium-term strategy to develop social sector policy and institutions, including support for health sector reform, primarily in the way the sector was funded. The main instrument was the insurance program, intended to reduce economic barriers to access.

- More recently, the Bank renewed its emphasis on support for health service delivery focused primarily on maternal and child health and mortality, especially among the poor. The multilateral donors have become more of a complementary source to government financing, as exemplified by PARSALUD where the government funded almost three times what was estimated at appraisal and the contributions of the Bank

and IDB were scaled back by two-thirds. Nevertheless, the Bank's HNP investment loans have served as instruments to maintain policy dialogue on health reform and health services, which has positively impacted health outputs and outcomes in Peru. In recent years, the Bank's knowledge, technical assistance, ability to convene various development actors, and ability to foster innovative interventions have gained relevance over lending interventions.

4.13 **The two main areas of substantive impact of the Bank in terms of improving access to health services for the poor have been its support for the design and better targeting of the SIS and for improved quality and coverage of maternal health care in Peru.** Although SIS has been an important innovation, further efforts are needed to reduce direct and opportunity costs for health care for the poor. SIS could also reduce resource allocation to tertiary care and focus on the primary and secondary levels where the poor make higher use of services.

4.14 **Government officials consider the Bank's ability to mobilize financial and human resources and to connect technical assistance with financial services to be an added value that few other donors can match**. In addition, the Bank is valued for its wide experience and ability to share lessons from similar programs in other countries;[68] its poverty focus, underscored by highly effective analytic work providing an outsider's perspective; its long-term relationship that has helped to maintain a medium-term agenda and dialogue on health in the face of high turnover in the sector;[69] and its institutional culture that has emphasized outcome-oriented projects, efficiency, and transparency in the allocation of resources. The Bank is seen by both the Government and other members of the assistance community as an intellectual leader and a major source of advice on development policies and structural change in the health sector. The Policy Notes, in particular, are valued by policymakers as a considerable intellectual effort to understand local conditions and address a wide range of health topics in Peru.[70] The active role of the Resident Mission on health issues in Peru is seen as positive. Respondents also perceived a greater willingness of the Bank to take into account country priorities.[71] However, development partners and members of civil society interviewed by the IEG mission also offered a critique (Box 4-1).

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[68] Respondents particularly valued the transfer of knowledge through the Bank, regarding health reform experiences of Argentina, Bolivia, and Colombia.

[69] Respondents indicated that the dialogue has been pursued mainly with government and to a lesser extent with other development and assistance agencies, research centers, universities and NGOs.

[70] One of the most valued is World Bank (1999b), "Improving Health Care for the Poor", which is widely used and cited both by academics and health officials. This piece was used as one of the main sources to design the PARSALUD project and the PSRL series. However, respondents suggested that dissemination of the Policy Notes is too restricted to small circles and that technical analysis can rely more on local knowledge.

[71] Two examples cited by respondents were the inclusion of hospitals as part of PARSALUD interventions (taking into account the role of regional hospitals as part of a referral system for reducing maternal mortality), and the focus of PARSALUD interventions on the time of delivery and post-partum period instead of the prenatal period. In both cases, the initially proposed design by the Bank was adapted to local suggestions.

4.15 **The World Bank support should reinforce country priorities; however it also needs act to ensure that key HNP priorities remain on the national agenda.** Although nutrition interventions were introduced late in the project cycle of BHNP, PARSALUD did little to address nutrition and nutrition indicators stagnated (Annex D, Table D-2).[72] Additionally, the World Bank has been absent on population issues in Peru; the use of modern contraceptives has actually declined since 2000, overall and in both urban and rural areas (Annex D, Table D-2).

Box 4-1: Partner, civil society and NGO views of the World Bank's role in HNP

There seems to be a general agreement on the main issues. However, some of the main points where the opinions vary are the following:

- Some former government staff, academics and NGO staff, think the Bank could have been more decisive on maintaining a comprehensive health reform agenda.
- The Bank's analytic products seem to be more valued by government officials, who find them useful to support technical dialogue and policy initiatives, than by university professors and researchers.
- Some respondents were critical of what they see as a predominantly economic focus of the Bank on health issues. The reforms promoted by the Bank are seen as efficiency-oriented, while some respondents would like to see a more comprehensive reform to improve health as a basic human right.
- Staff from NGOs and civil society organizations critiqued the Bank for declining to get involved in difficult political issues, particularly family planning.
- NGO staff think the Bank could play a stronger role in terms of strengthening civil society, improving accountability and helping to promote anti-corruption efforts
- Some staff from donor agencies and international organizations expressed concern about a lack of coordination with other actors who have technical know-how and experience that could benefit project design. As with civil society, they view the Bank's dialogue as mainly with the government.

[72] The neglect of nutrition has been acknowledged and new economic and sector work has been launched.

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Annex A. Basic Data Sheet

BASIC HEALTH AND NUTRITION (LOAN 3701)

Table A- 1. Key Project Data (amounts in US$ million)

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Total project costs	44.5	44.3	99.6
Loan amount	34	33.8	99.4
Cofinancing	0	0	
Cancellation		.20	

Table A-2. Project Dates

	Original	*Actual*
Project concept note review	02/21/1992	02/21/1992
Negotiations	11/29/1993	12/31/1992
Board approval	02/03/1994	02/03/1994
Signing	04/05/1994	04/05/1994
Effectiveness	06/02/1994	06/02/1994
Closing date	06/30/2000	12/31/2000

Table A-3. Staff Inputs (staff weeks)

	FY93	*FY94-00*	*FY01*	*Total*
Preappraisal	45:9			45.9
Appraisal and negotiations	88.2			88.2
Supervision		361.36		361.36
ICR			6.75	6.75
Total	134.1	361.36	6.75	502.21

Table A-4. Mission Data

Purpose	*Date (month/year)*	*No. of persons*	*Specializations represented*	*Performance rating*	
				Implementation progress	*Development objective*
Identification/ Preparation	1/93	4	Task Manager, Senior Population Health Specialist (2), Consultant		
Appraisal	3/94	3	Task Manager, Health Specialist, Consultant		
Supervision	12/94	2	Task Manager, IEC Specialist	S	S
	6/95	3	Task Manager, IEC Specialist, Consultant	U	S
	12/95	2	Task Manager, Economist,	U	S
	3/96	4	Task Manager, Health Specialist, Consultant (2)	U	S
	8/96	6	Task Manager, Procurement Specialist, Health Economist, Consultant, Social Sector Specialist, NGO Specialist	U	S
	12/96	4	Task Manager, Health Specialist, Economist, Social Sector Specialist	U	S
	4/97	4	Task Manager, Economist, Social Sector Specialist, Financial Management Specialist	S	S
Mid-term review	6/97	7	Task Manager, Health Specialist, Procurement Specialist, Social Sector Specialist	S	S
	2/98	7	Task Manager, Health Specialist, Consultant, Public Health Consultant		
	10/98	5	Task Manager, Procurement Specialist, Health Consultant, Public Health Consultant		
	4/99	4	Task Manager, Health & Nutrition Specialist, Health Specialist, Procurement Specialist	S	S
	11-12/99	3	Task Manager, Health and Nutrition Specialist, Consultant	S	S
	5/00	6	Task Manager, Health and Nutrition Specialist, Project Assistant, Consultant, Financial Management Specialist	S	S

Purpose	Date (month/year)	No. of persons	Specializations represented	Performance rating	
				Implementation progress	Development objective
	7/00	4	Disbursement Specialist	S	S
	11/00	2	Task Manger, Health and Nutrition Specialist, Project Assistant, Consultant, Procurement Specialist, Project Assistant		
Completion (ICR)	12/00	2	Task Manger, Health and Nutrition Specialist		

HEALTH REFORM PROGRAM, FIRST PHASE (LOAN 4527)

Table A-5. Key Project Data (amounts in US$ million)

	Appraisal estimate	Actual or current estimate	Actual as % of appraisal estimate
Total project costs	239.3	231.8	96.9
Loan amount	80.0	27.0[a]	33.8
Co-financing (IDB)	95.0	28.0	30.5
Counterpart funding (Borrower)	64.3	176.8	275.0
Cancellation		0	

a. The PAD appraised the loan for US$80.0 million, however the final loan agreement was for US$27.0 million.

Table A-6. Project Dates

Milestone	Original	Actual
Concept Note Review	11/30/1998	11/30/1998
Negotiations	01/15/2000[73]	09/19/1999
Board approval	12/16/1999	12/16/1999
Effectiveness	03/01/2000	07/02/2001
Closing date	12/31/2003	6/30/2006

[73] Discrepancy in data entry, planned negotiations date later than planned Board approval

Table A-7. Staff Inputs (staff weeks)

	FY99	*FY00*	*FY01*	*FY02*	*FY03*	*FY04*	*FY05*	*FY06*	*FY07*	*Total*
Preappraisal	n.a.	0.45								0.45
Appraisal/negotiations/Board		26.78	0.6[74]							27.38
Supervision/ ICR		3.66[75]	4.38	14.68	55.98	40.23	32.61	21.24	12.20	184.98
Total		30.89	4.98	14.68	55.98	40.23	32.61	21.23	12.20	212.81

Table A-8. Supervision report ratings

ISR no.	Date archived	Development objectives	Implementation progress
1	06/27/2000	Satisfactory	Satisfactory
2	11/30/2000	Satisfactory	Satisfactory
3	05/19/2001	Satisfactory	Satisfactory
4	06/28/2001	Satisfactory	Unsatisfactory
5	12/19/2001	Satisfactory	Unsatisfactory
6	06/03/2002	Satisfactory	Satisfactory
7	12/10/2002	Satisfactory	Satisfactory
8	12/11/2002	Satisfactory	Satisfactory
9	6/10/2003	Satisfactory	Satisfactory
10	6/11/2003	Satisfactory	Satisfactory
11	12/05/2003	Satisfactory	Satisfactory
12	06/14/2004	Satisfactory	Satisfactory
13	11/29/2004	Satisfactory	Satisfactory
14	04/26/2005	Satisfactory	Satisfactory
15	07/01/2005	Satisfactory	Satisfactory
16	03/28/2006	Satisfactory	Satisfactory

Table A-9. Other Project Data

Borrower/Executing Agency: GOP

FOLLOW-ON OPERATIONS

Operation	*Credit no.*	*Amount (US$ million)*	*Board date*
Health Reform Program, Phase II		15.0	02/17/2009

[74] Staff mistakenly charged time to a code that should have been locked year ago.
[75] Staff weeks charged to the preparation BB (Lending) after project was approved by Board, should have been charged to the supervision BB. WBS should have been locked as soon as the project was approved.

Annex B. Persons Interviewed

Washington, DC

World Bank

- Rafael Cortez, World Bank, CLAS evaluation as a researcher from Universidad del Pacifico, Lima
- Daniel Cotlear, World Bank, Sector Leader, PARSalud, RECURSO
- Theresa Jones, World Bank, TTL at PSNB approval but not involved in implementation

Other donors/NGOs

- Chris Drasbek, Regional IMCI Advisor, Child and Adolescent Health, Family and Community Health, Pan American Health Organization
- Amanda Glassman, Brookings Institute, worked for IDB PARSalud design team
- Susan Kolodin, IDB, IDB TTL at the Peru resident mission in Lima during PARSalud implementation

Lima, Peru

World Bank

- Livia Benavides, World Bank, Senior Social Sector Specialist, TTL PSNB (1996 - 2000), TTL PARSalud

Government

- Prof. C.P.C. Moisés Acuna, Director, Seguro Integral de Salud, 2001-2006
- Mario Arróspide, BHNP Coordinator 1994-1996 and Ministry of Economics and Finance
- Luís Cordero, PARSalud, Monitoring and Evaluation
- Marino Costa Bauer, Minister of Health 1996-1999
- Angela Flores Salgado, Advisor to the current Minister of Health
- Dr. Alvaro Gaillour, Manager of PROFONANPE. BHNP and PARSALUD Coordinator 1996 – 2001
- Jaime Johnson, MOH Health Sector Modernization Program Director 1996-1998
- Dr. Francisco Lazo Montoya, Executive Director at the MoH Office of Projects and Investment
- Dr. Luis Miguel León García, Director Atención Integral de Salud, MoH , BHNP Piura Regional Coordinator
- Dr. Ariela Luna, MOH Director of Health Promotion, PARSALUD Technical Director, BHNP
- Dr. Pilar Mazzetti, Minister of Health, 2004-2006
- Wilma Montanez, PSNB implementación and PARSALUD designó
- Dr. Milagros Núñez, PCM (Presidencia Consejo de Ministros) – CIAS (Comisión Interministerial de Asuntos Sociales), BHNP Nutrition team

- Pilar Prieto, PARSalud Coordinator 2007
- Julio Puntriano, Advisor to the Minister of Health
- Dr. Carlos Ricse, PARSalud Coordinator 2004-2006, Ministry of Economics and Finance
- Maria Ines Sanchez-Grinon, CENAM Director (National Health Institute – National Center for Food and Nutrition), BHNP-Nutrition

Civil Society

- Dra. Laura Altobelli, Director of Future Generations Peru, CLAS Specialist, BHNP Nutrition and ICR
- Betty Alvarado, Universidad del Pacifico, Health Finance Specialist
- Carlos Aramburu, Pontificia Universidad Católica del Perú, former Director of Centro de Investigación Económica y Social (CIES)
- Susana Chávez, Director of Promsex (NGO focused on sexual and reproductive rights), worked on health promotion with PARSALUD
- Dr. Danilo Fernández, CARE, MoH Salud Básica para Todos.
- Miguel Jaramillo, GRADE, PARSalud Evaluation financed by Global Development Fund, Human Resources Evaluation
- Martin Valdivia, Research Director of GRADE (Group for Analysis of Development)

Donors

- Midori de Habich, Director of USAID-funded projects: PRAES and Proyecto 2000
- Ian McArthur, IDB, PARSalud TTL (2005- present)
- Julio Pedraza, Belgian Technical Cooperation, Financial support to SIS 2005 - 2008
- Dr. Luis Seminario, USAID, Health Office, Project Management Specialist

Cuzco Region, Peru

- Dr. Alberto Caro, Cusco DIRESA Director (Dirección Regional de Salud)
- Regidora Dina Pilares Huaman, Former President of Combapata CLAS, BHNP facility Combapata, Canas Province, Cuzco Region
- Dr. Lydia Moquilloza, Hospital Lorena Director, PARSalud facility
- Hector Quiroz, Hospital Lorena Projects Director, PARSalud facility
- Francisco Rojas, Pisac CLAS President, PARSalud facility, Pisac, Cuzco Region
- Dr. Zonia Rozas, Regional PARSALUD Director in Cuzco and Puno
- Dr. Jose Rueda, CLAS Combapata Director, BHNP facility, Combapata, Canas Province, Cuzco Region
- Dr. Santiago Saco, San Antonio Abad del Cusco National University , Intercultural Strategy BHNP and PARSalud
- Dr. Miguel Ucannani, Yanaoca CLAS Director of PARSalud facility, Yanaoca, Cuzco Region
- Dr. Freddy Villalba, Pisac CLAS Director, PARSalud facility, Pisac, Cuzco Region
- Dr. Elbia Yepes, Techo Obrero Health Center Director, PARSalud facility, Sicuani

San Juan de Lurigancho, Peru

- Dionisia Salcedo, Women's health specialist, San Juan de Lurigancho región, PSNB facility
- Dr. Esther Sanchez, Regional PSNB Director San Juan de Lurigancho (Lima Norte), PARSalud, Apurimac región
- Fortunato Valle, San Benito Health Center, San Juan de Lurigancho región, PSNB facility

Annex C. Inputs and Outputs

BASIC HEALTH AND NUTRITION (LOAN 3701)

Table C-1. Cumulative Estimated and Actual Disbursements (in US$ millions)[a]

Fiscal Year	*FY94*	*FY95*	*FY96*	*FY97*	*FY98*	*FY99*	*FY00*	*FY01*
Estimated	2.0	7.8	15.2	22.0	27.6	32.1	34.0	
Actual	3.11	4.09	7.46	13.78	20.87	26.55	33.09	33.79
Actual as % of appraisal	155.6	52.4	49.1	62.6	75.60	82.7	97.3	99.4

a. Appraisal estimates from SAR, actuals from BHNP Final Report.

Table C-2. Planned and Actual Financing by Component (in US$ millions)

Component	*Planned* [a]	*Actual*	*Actual as a % of planned*
Original components			
Maternal and Child Health	20.1		0
Nutrition	3.2		0
Tuberculosis Treatment	0.1		0
IEC	18.8		0
Management and Evaluation	2.3	1.7	72
Total	**44.5**		
Revised components			
Health Services Provision	22.3	22.1	99.3
Health Promotion	15.6	14.9	95.7
Management and Financing	5.8	5.6	96.8
Total	45.5	44.3	99.8

a. Planned costs for the original components, including contingencies, from the SAR. Planned costs of revised components from the text of the ICR. The project components were never formally revised; the ICR notes the planned and actual allocations for the revised components but the source of these estimates is not clear.
b. The ICR does not indicate the amount of planned financing for project management.

Table C-3. Planned versus actual financing by loan agreement categories

(Expenses for World Bank loan only in US$ millions)

Category	*Amount* [a]	*Amendment January 2, 2001*	*Actual* [b]
Equipment and vehicles	5.4	6.7	6.7
Instructional Materials	1.0	.04	.0
Training	9.1	.56	.6
Communication services	5.0	.03	.0
Technical Assistance	4.1	21.9	*21.2*
Drugs and Supplies	5.6	.92	.9
Furniture	0.1	.08	.1
Incremental operating costs	3.7	2.3	*2.4*
Civil Works	0	1.5	*1.6*
Total	**34.0**	**34.0**	**34.0**

a. From the Loan Agreement, schedule 1.

b. The categories used to report the planned/actual expenditures in the ICR do not match the categories used in the SAR or Loan Agreement. These figures come from the project data available through the Operations Portal and were found by summing the expenditure category from 3701A and 3701S. All of the planned expenditures from the Amendment match the planned expenditures from the project portal source expect those in italics, and the totals are the same.

c. Up to an aggregate amount disbursed.

Table C-4. Planned versus Actual Outputs *

Component and output			Planned	Executed	Percent Executed
Health Services Delivery					
Integrated Health Care Delivery Strengthening					
	#	Micro-networks with functioning management committees	51	50	98
	#	facilities with infrastructure repairs/ additions	231	219	95
	#	facilities with implemented organization model of consulting rooms	255	247	97
	#	facilities with organized integrated admissions procedures	241	232	96
	#	facilities with implemented laboratory model	252	204	81
	#	facilities with decision manuals and integrated health procedures in women and child consultation rooms	300	466	155
	#	personnel trained in women's health	1194	1223	102
	#	personnel trained in child's health	1236	1372	111
	#	personnel trained in promotion of nutrition in pregnancy	773	962	124
	#	personnel trained in promotion of child nutrition	954	1053	110
	#	tutors and trainers trained in flexible adult education	137	138	101
Information Systems					
	#	facilities with processing centers organized	38	35	92
Equipment					
	#	facilities equipped with truck	54	53	98
	#	facilities equipped with motorcycle	208	208	100
	#	DISAs and network centers with computers installed	9	13	144
	#	facilities with communication equipment installed	329	425	129
	#	facilities with basic medical equipment installed	329	425	129
	#	facilities that received medicines and supplies	332	357	108
Rehabilitation of infrastructure					
	#	facilities with legally registered property rights	260	230	88
	#	facilities with infrastructure improvements	226	184	81

Component and output			Planned	Executed	Percent Executed
Health Promotion					
IEC Capacity Strengthening					
	#	IEC Commissions formed	19	15	79
	#	personnel trained in use of IEC techniques and materials	226	322	142
	#	facilities with personnel trained in IEC	81	79	98
	#	CHW trained in use of IEC techniques and materials	426	506	119
Promotion of Nutrition Practices					
	#	personnel trained in counseling, educational techniques and demonstrative sessions in nutrition	772	743	96
	#	facilities receiving nutrition demonstration kits	233	235	101
	#	demonstrative sessions in nutrition	612	749	122
	#	mothers of children <2 trained to prepare iron-rich foods	259	290	112
Promotion of Health Practices in Tuberculosis			996	1185	119
	#	personnel trained in strategic planning and management of IEC interventions in TB	5679	8952	158
Social marketing of health services					
	#	Personnel trained in empathetic communications and interpersonal relations	90	77	86
	#	facilities with work plans to improve interpersonal relations	721	993	138
	#	personnel trained in diploma for social marketing of health services	75	71	95
	#	facilities with material for social marketing	130	125	96
	#	CHW trained in promotion of health services	556	501	90
Community Health					
Population censes					
	#	communities with censes completed	861	795	92
	#	facilities with list of pregnant women, children under 5, women of fertile age, and families	132	127	96
Community Health Workers					
	#	CHWs with supply kit	834	788	94
	#	CHWs trained in maternal-child health promotion	892	1073	120
	#	CHWs working effectively in MCH promotion	554	664	120
	#	CHWs trained in surveillance control of malaria	177	269	152
	#	traditional midwife manuals distributed	460	985	214
	#	traditional midwives trained	228	204	89
	#	trained traditional midwives working effective in child health and women's health	132	145	110
	#	facilities with community referral system established	141	132	94
	#	CHW with formats for population follow-up	817	787	96
De-parasitization of children					
	#	children 2-7 years old given anti-parasite medicine	45019	89897	200
Quechua and Andean Culture					
	#	personnel trained in Quechua and Andean culture	120	94	78
	#	Personnel trained in educational methodology for Quechua and Andean culture for health personnel	30	31	103
Management and Financing					
Health Service Network Formation					
	#	Personnel trained in network mapping (delimitation)	206	212	103
Quality Assurance					
	#	personnel trained in quality standards and indicators	342	490	143

Component and output			Planned	Executed	Percent Executed
	#	personnel trained in quality improvement projects	367	615	168
	#	quality improvement projects implemented	394	254	64
	#	facilities with quality improvement projects implemented	97	107	110
Health Services Management					
	#	Personnel trained in quality standards and indicators	305	289	95
	#	personnel trained in diploma program for health services management	89	88	99
Programming and Budgeting					
	#	personnel trained in programming and budgeting	233	312	134
	#	regional health departments with completed budgets using SPP	7	6	86
Costing system					
	#	personnel trained in use of costing system	11	11	100
	#	facilities with costing system installed	7	7	100

Note: the BHNP Final Report includes a more extensive list of indicators
*The SAR included a table of indicators, the targets for which were to be determined with data from baseline studies at the sub-regional level. The table reported in the BHNP Final Report includes a few of the same indicators in the SAR but varies due to restructuring of the project's activities.

Table C-5. Major BHNP Contracts with NGOs

Product	*Firm*	*Duration (months)*	*Total cost US$ Million*
Educational communication for healthy behaviors interventions	AED	*28*	1.5
Improving Primary Care Guarantee of Quality	URC	*24*	2. 7
Organizing Health Services	CARE	*18*	1.9
Social Marketing	APROPO	*12*	1.6
Women and Children's Health Training	UPCH - Pathfinder	*12*	1.2
Activities in Maternal and Child Health			
- San Juan de Lurigancho - Lima	INCAFAM	*12*	.54
- Ayabaca – Piura	ESCAES	*12*	.18
- Salitral / Buenos Aires - Piura	ADEC IDEAS	*12*	.26
- Cuzco	CADEP	*12*	.20
- Cuzco	PURISUN	*12*	.14
- Cuzco	CARITAS	*12*	.11
- Chota- Cajamarca	ESCAES	*11*	.15
Quechua Course	UNSA-CUSCO	*10*	.15
Training Program and Promotion of Healthy Behaviors	KALLPA	*12*	.37
Budget Programming System (SPP)			
- SPP training and implementation plan	CIPRODES	*12*	.08
- Complementary Assistance SPP	CIPRODES	*8*	.04
- Developing capacity and technical assistance for SPP	CIPRODES	*12*	.02
Information System for Costs and Aquisitions (Sistema de Información de Costos e Ingresos – SICI)			
- SICI Training and Implementation Plan	CIPRODES	*12*	.21
- Consolidation of SICI in Chulucanas Network	CIPRODES	*6*	.03
Maternal and Child Health Insurance (SMI)			
- Cost estimation study of Basic package for SMI	CIPRODES	*3*	.04
			Total: US$11.4

HEALTH REFORM PROGRAM, FIRST PHASE (LOAN 4527)

Table C-6. Cumulative Estimated and Actual Disbursements of IBRD Financing [a]

	2000	2001	2002	2003	2004	2005	2006	Total
Appraisal estimate (US$M)	3.0	22.0	30.0	18.0	7.0	____	____	80.0
Actual (US$M)	0.0	0.0	2.5	4.4	3.5	10.9	5.6	27.0
Actual as % of appraisal	0.0	0.0	8.3	24.0	50.0			33.8

a. Appraisal estimates from PAD, actual disbursements from World Bank's online project portal.

Table C-7. Planned and Actual Financing by Component (in US$ millions)

Component	*Cost at Appraisal* [a]	*Actual Cost*	*Actual as a percent of planned cost*
1. Strengthening Health Demand	149.0	149.0	100.0
2. Strengthening decentralization policy development and institutional modernization	22.8	22.8	100.0
3. Improving quality of health programs and services	49.0	49.0	100.0
4. Project coordination	8.0	8.0	100.0
Total Project Costs	**228.8**	**228.8**	**100.0**
Front-end fee IDB	9.7	2.7	27.8
Front-end fee IBRD	0.8	0.3	37.5
Total Financing required	**239.30**	**231.80**	**96.9**
IBRD Loan/credit	80.00	27.00	33.75
Co-financing (IDB)	95.00	29.00	30.53

a. Indicative costs taken from PAD, page 11

Table C-8. Allocation of IBRD Loan Proceeds, by category [a]

Expenditure category	*Appraisal Estimate*	*Actual amount*	*Actual as % of appraisal estimate*
1. Civil Works	2.0	7.4	370.0
2. Goods	8.0	8.2	102.5
3. Consultant services and training	17.0	10.3	60.6
4. SMI Program	50.0	0	0
5. Project Administration	1.0	0.9	86.0
6. Front-end fee	.8	0.3	34.0
Total project costs	78.8	27.0	34.0
Unallocated	1.2	0.0	0.0
Total	**80.0**	**27.0**	**34.0**

a. Appraisal estimates from Annex 7, Table C of the PAD, actual amounts from World Bank Project Portal.

Table C-9. Health facilities with cultural interventions

Cultural interventions	Health Center	Health Posts
	N°	N°
Waiting house "casa de espera"	13	8
Training in local language	18	49
Vertical birth delivery infrastructure.	14	18
Vertical birth delivery equipment.	10	20
Total	18	56
Source: PARSALUD final report.		

Table C-10. PARSALUD – Project Development Objectives Indicators

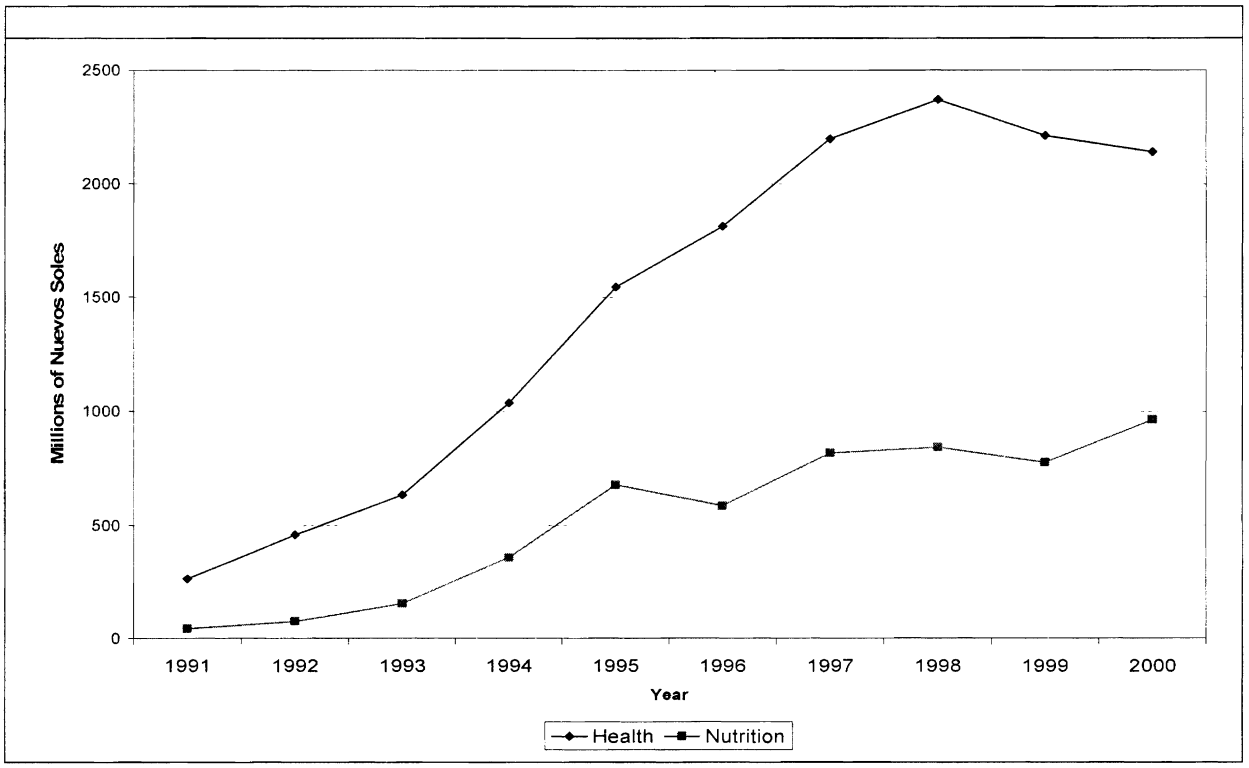
Original indicators	Baseline (2000)	Target	Actual (2005)	Achieved?
Percent of births that had 4 or more antenatal visits by a skilled professional (Project area)[a]	32.2	51.36	57.2	Yes
Percent of deliveries attended by a skilled health professional (Project Area)	27.6	36.7	50.9	Yes
Number of cases treated of acute respiratory infections (ARI) in children under age 5 (annual) *	8,747,589	3,700,000	7,742,457	See below
Number of cases treated of acute diarrhea (EDA) in the children under age 5 (annual) *	4,535,892	780,000	4,531,800	See below
Percent of children between 18 and 29 months vaccinated with DPT3 (Project area) [b]	78.3	95	87.4	No
Number of beneficiaries who receive care in primary care facilities of the MOH annually		17,000,000	28,000,000	Yes
Increase in the number of municipalities with DPT3 coverage for children under age 1			44	See below
Percent of yellow fever cases treated[c]		80	100	Yes
Percent of health departments (DISAs) which are implementing regional and local health plans that respond to communicable diseases and environmental health programs.		80		Yes
Intermediate outcome indicators after the change in components				
Percent of attended deliveries that received oxytocin (Project area)	49.4	90	90.4	Yes
Percentage of deliveries attended institutionally by SIS (Project Area)[d]	18.5	42.4	59.9	Yes
Percent of deliveries financed by SIS in the first two quintiles (Project area)	44.4	50	56.4	Yes
Number of health facilities refurbished to comply with Essential Obstetric Function (EOF), Basic Obstetric Functions (BOF)[e]	0	20 EOF 59 BOF	20 EOF 54 BOF	No
Referrals as a percent of the number of people treated	5	11	5	No
Percent of newborn children covered by SIS who are weighed within the first 24 hours of birth (Project area)[f]	64	95	74	No

Source: ICR, p.18 and v

Notes:

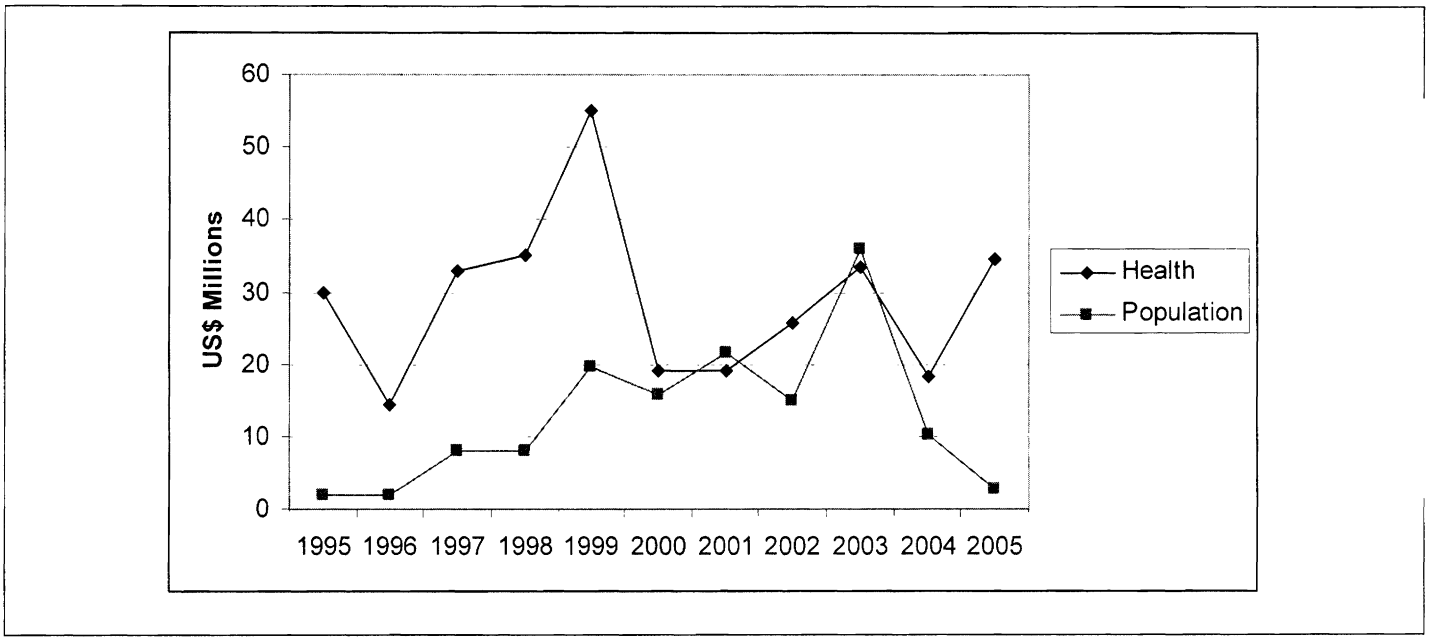
a. The percent of pregnant women with four or more prenatal visits in the project area increased by 78 percent, a much faster rate than national average (26 percent).
b. DPT3 was replaced by a more complex vaccine so that its coverage at the regional level was reduced in the last few years. (The Pentavalent, which includes DPT3, Hepatitis B and Haemophilus Influenzae type b vaccines, is more powerful but is more demanding in its application and logistics.)
c. By law, the reported cases have to be treated
d. The nationwide indicator increased 73.1 percent while the one in the project area increased 223.8 percent
e. Target was met for EOF. 91 percent of the BOF target. This was due do additional costs.
f. The target was not achieved. However it improved faster in the project area (15.6 percent) than the national average (13.7 percent).

Figure C-1. Spending on health and nutrition, 1990-2000



Source: Public Expenditure Review (2003), which used data from the MEF.

Figure C-2. – Development Assistance for Health and Population to Peru 1995- 2005



Source: **OECD/DAC, International Development Statistics online database as of August, 2007**
Note: Population includes HIV/AIDS; Health does not appear to include nutrition programs.

Annex D: Trends in HNP Outcomes

This annex presents trends in indicators of health outcomes (infant, child and maternal mortality, nutritional status of children, and women's fertility) and service use or coverage (immunization, contraceptive use, and deliveries by medical professionals), using data from DHS surveys conducted in 1992, 1996, 2000, and the DHS Continuous Surveys from 2004-05 and 2004-06.

Table D-1. Trends in health outcomes and access to health facilities, 1996 to 2004-06

	Urban				Rural				Total			
	1992	1996	2000	2004-06	1992	1996	2000	2004-06	1992	1996	2000	2004-06
Health outcomes												
Stunting (children < 5 yrs) [a,b]	21.6	16.2	13.4	10.1	48.1	40.4	40.2	39.0	31.8	25.8	25.4	24.1
Wasting (children < 5 yrs)	1.5	0.8	0.7	0.9	1.9	*1.7*	*1.2*	1.1	1.7	1.1	0.9	1.0
Underweight (children < 5 yrs)	*6.4*	*3.9*	*3.2*	3.1	17.6	13.7	11.8	12.4	*10.7*	*7.8*	7.1	7.6
Infant mortality rate (5 yr)	40.0 [c]	*29.9*	*23.6*	*16.9*	78 [c]	61.5	44.9	27.2	54.5	42.8	33.3	21.4
Under-5 mortality rate (5 yr)	56.0 [c]	40.3	32.4	22.0	112 [c]	86.3	63.6	38.8	77.5	59.1	46.7	29.5
Total fertility rate (3 yrs)	3.0	2.8	*2.2*	*2.0*	6.2	5.6	4.3	3.7	4.0	3.5	2.9	2.6
Access to health facilities												
Full vaccination [d] (children 12-23/ 18-29 months [e])	65.1	65.1	60.4/ 71.6	68.8	46.4	59.8	51.1/ 59.6	61.9	57.7	63.0	56.4/ 66.3	65.7
BCG (children 12-23/ 18-29 months [e])	95.5	97.1	98.2/ 98.0	96.5	83.2	90.3	93.6/ *93.9*	*96.1*	90.6	94.3	96.2/ 96.2	96.3
DTP3 (children 12-23 / 18-29 months [e])	*76.3*	*80.0*	88.5/ 89.4	87.2	55.4	72.7	77.1/ 78.8	79.5	68.1	77.0	83.6/ 84.7	83.8
Measles (children 12-23 / 18-29 months [e])	*78.9*	*88.0*	74.0/ 86.1	86.1	66.4	82.7	69.3/ 82.2	85.2	74.0	85.8	71.9/ 84.4	85.7
Modern contraception rate	39.7	47.8	56.1	53.2	15.5	27.4	40.3	37.9	32.8	41.3	50.4	47.6
Mother received medical care at birth [f]	74.4	80.6	85.0	92.1	*18.7*	21.5	28.7	48.5	52.5	56.4	59.3	72.8

Source. Peru Demographic and Health Survey Reports, 1996, 2000, 2004-2005 (for nutrition) and 2004- 06 (http://www.measuredhs.com/) and IEG calculations of t-tests for statistical significance.
Note Shaded cells denote statistically significant trend at p<=.05. Italics indicate statistically significant trend at p<= 10; unable to determine significance for health outcomes between 1992 and 1996 and nutrition outcomes between 2000 and 2004 because standard errors were not reported.

a. Stunting, wasting and underweight statistics are for all children below -2SD from the median (thus, it includes severe stunting/wasting/underweight).
b. Stunting, wasting, and underweight rates for reported for in the 2004-06 column are from the 2004-05 DHS because a different standard was used for the 2004- 06survey
c. No standard errors reported for 5 year infant and under-5 mortality rates in 1992; statistical significance of trend between 1992 and 1996 can not be calculated.

d. Includes BCG, measles, 3 doses of DTP3 vaccine and 3 doses of polio vaccine for children 12-23 months. For 2000, polio vaccine at birth is excluded.
e. The vaccination rates were taken from the Annexes of the DHS Surveys. Beginning in 2000, the DHS Surveys report rates for children 18-29 months due to a change in the vaccination schedule. However, the figures reported in the Annex B of the 2000 Report do not match the 18-29 month rates reported in text and appear to be 12-23 month rates Annex B tables B.3.1-3.3 of the 2004- 06 Report include the 18-29 month rates which are comparable to the rates reported in the 2004- 2006 Report. It is not possible to only report 12-23 month rates because none are available for 2004-06.
f. Includes doctor, nurse-midwife (*obstetriz*), or nurse. Data from 2000 from Annex B tables B 3.1- 3.3 of the 2004-06 Report for comparability.

Table D- 2. Trends in health outcomes and access to health facilities among the poor, 1996 - 2000

	Lowest wealth quintile			Highest wealth quintile			Low/high quintile ratio		
	1996	2000	2004-06[a]	1996	2000	2004-06[a]	1996	2000	2004-06[a]
Health outcomes									
Moderate stunting[b] (children < 5 years)	28.2	29.4	29.4	4.5	4.2	4.4	6.3	7.0	6.7
Moderate underweight[c] (children < 5 years)	14.1	13	14.4	0.9	0.7	1.9	15.7	18.6	7.6
Total fertility rate (3 yrs)	6.6	5.5	4.9	1.7	1.6	1.4	3.9	3.4	3.5
Access to health facilities									
Full vaccination [d] (children 18-29 months)	55.3	57.9	60.8	66	81.1	75.1	0.8	0.7	0.8
BCG (children 18-29 months)	86.6	92.1	94.2	95.6	99.8	93.2	0.9	0.9	1.0
DTP3 (children 18-29 months)	68.2	76.2	79.3	84.7	93	94.6	0.8	0.8	0.8
Measles (children 18-29 months)	78.1	80.8	82.7	91.8	92.3	90.9	0.9	0.9	0.9
Modern contraception rate	24	36.8	32.3	50.3	58	53.8	0.5	0.6	0 .6
Deliveries by trained personnel [e]	13.7	13	30.5	96.6	87.5	99.2	0.1	0.2	0.3

Source: DHS data reported on the World Bank HNP Stats website (www.worldbank.org/povertyandhealth/) and DHS 2004- 05 and 2004- 06.

Note: Shaded cells denote statistically significant trend between 1996 and 2000 at p<=.05. It was not possible to calculate significance between 2000 and 2004.
a. 2004- 2006 rates are from DHS 2004- 2006 and thus, may not be completely comparable to the data from 1996 and 2000.
b. Percent between -2 SD and -3 SD below the median height for age of the reference population. 2004- 2006 rate is from 2004- 2005 reported to allow for better comparison with previous surveys.
c. Percent between -2 SD and -3 SD below the median weight for age of the reference population. 2004- 2006 rate is from 2004- 2005 reported to allow for better comparison with previous surveys.
d. Includes BCG, Measles, 3 doses of DTP3 vaccine and 3 doses of Polio vaccine. Polio vaccine at birth is excluded.
e. Trained personnel includes doctors, nurses and trained midwives. It does not include traditional midwives or traditional birth attendants whether or not they are trained.

Table D-3. BHNP: Utilization rates for project (P) and matched non-project (C) areas

Utilization indicator	Cuzco				Piura				North Lima				South Lima			
	1996		2000		1996		2000		1996		2000		1996		2000	
	P	C	P	C	P	C	P	C	P	C	P	C	P	C	P	C
Women 15-49 with at least one consultation in a health facility	79	75	88	74	61	58	98	68	39	27	54	53	42	42	71	66
Pregnant women who made at least one visit to a health facility for pre-natal care	78	76	97	92	35	37	56	45	58	47	96	77	98	75	117	90
Pregnant women who made four visits to a health facility for pre-natal care	35	26	54	56	6	10	9	27	19	12	49	36	40	33	55	43
Births in health facilities [a]	21	8	44	16	6	6	18	na	na	na	na	na	na	na	na	na

Source: Basic Health and Nutrition Project, "Analysis de Indicadores de Cobertura para Establecimientos PSNB y Control " May 2001

[a] Baseline for births given in health facility is from 1998-99, all others are from 1996.
b Clearly there was a reporting issue with the statistics for consultations for children under 5
Shaded cells denote statistical significance between project and control groups of $p<0.5$, calculated in original study

\

Table D-4. Deliveries in Public and Private Institutions, and Home by Wealth Quintile 1996- 2004-06

	Lowest wealth quintile			Highest wealth quintile			Low/ High quintile ratio		
Place of delivery:	1996	2000	2004-06	1996	2000	2004-06	1996	2000	2004-06
Public Institution	8.5	10.4	30.0	70.9	63.2	74.4	0.1	0.2	0.4
Private Institution	0.4	0.5	0.4	21.0	21.4	22.7	0.0	0.0	0.0
Home	89.3	56.2	68.5	5.5	3.0	1.3	16.2	18.7	52.7

Source: DHS data reported on the World Bank HNP Stats website (www.worldbank.org/povertyandhealth/) for 1996 and 2000. 2004- 06 rates as reported in DHS 2004- 06 Report.

Note: Shaded cells denote statistically significant trend between 1996 and 2000 at p<=.05. It was not possible to calculate significance between 2000 and 2004- 0 6 as the numbers may not be completely comparable since they are from different data sources.

Annex E: World Bank support for HNP outcomes in Peru

Table E-1. World Bank lending for HNP, 1994-2006 (figures in US$ millions)

Date approved- Date closed	Project Name	IBRD Amount Committed	Planned Project Cost	IBRD Amount Disbursed	Actual Project Cost	IEG Rating
12/16/93- 6/30/97	FONCODES I	100.0	495.0	100.0	577.0	NA
11/22/94- 12/31/00	Basic Health and Nutrition Project	34.0	44.5	33.8	44.3	MS
7/16/96- 6/30/00	FONCODES II	150.0	430.0	124.0	355.0	S
6/19/01- 9/28/01	PRSL I	100.0	100.0	100.0	100.0	S
6/26/01- 6/30/06	Health Reform Program (PARSalud, first phase)	80.0	239.3	27.0	231.8	S
9/17/02- 12/31/02	PRSL II	100.0	100.0	100.0	100.0	S
11/11/03- 12/31/04	PRSL III	150.0	150.0	150.0	150.0	MS
12/7/04- 12/31/05	PRSL IV	100.0	100.0	100.0	100.0	MS

Table E-2. World Bank CAS and Sector Work 1994- 2006

Country Assistance Strategy (CAS), progress reports and evaluations	
CAS (Vol I)	1994
CAS 1997- 2001	1997
CAS Progress Report (Vol I)	2001
CAS 2002- 2006	2002
CAS Joint Progress Review	2004
CAS/Country Partnership Strategy 2007- 2011	2006
Economic and Sector Work (ESW)	
World Bank Country Study: Peru, Improving Health Care for the Poor	1999
Poverty and Social Developments in Peru 1994- 1997	1999
RECURSO Peru I: A New Social Contract for Peru	2006
Policy Note: An Opportunity for a Different Peru	2006
Economic Reports	
Public Expenditure Review	1994
Public Expenditure Review	2002

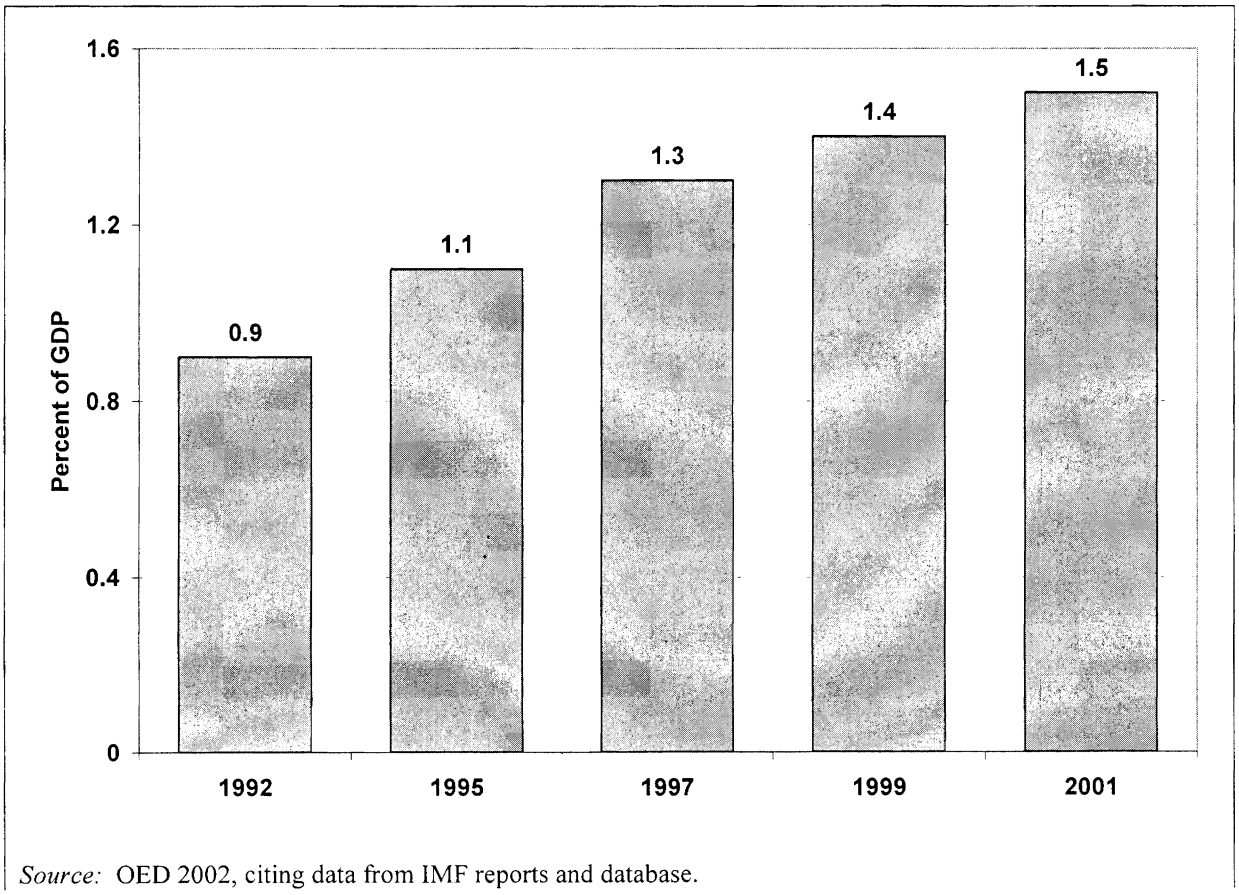
Annex F: Trends in Public Expenditure on HNP in Peru and HNP Spending by Donors

Table F-1. Increase in the number of health facilities by district wealth quintile

	Public			Private			Total		
Quintile	1992	1996	Percent increase	1992	1996	Percent increase	1992	1996	Percent increase
1	483	877	82	0	2		483	879	82
2	680	1094	61	1	13	1200	681	1107	63
3	823	1325	61	8	15	88	831	1340	61
4	870	1316	51	21	46	119	891	1362	53
5	1462	1761	21	264	857	225	1726	2618	52
Total	**4318**	**6373**	**48**	**294**	**933**	**217**	**4612**	**7306**	**58**

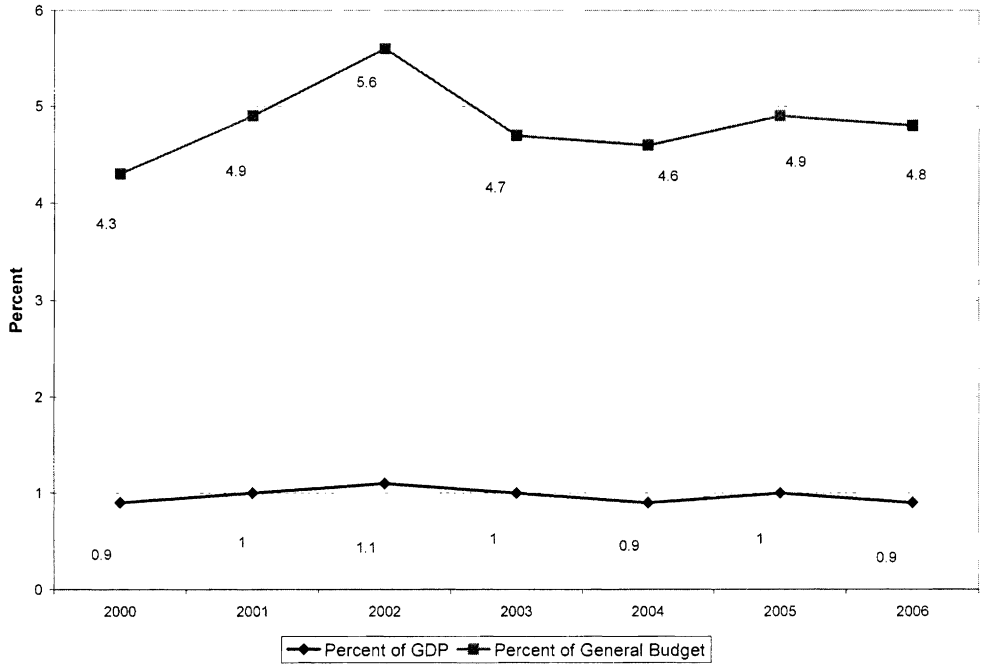
Source: Valdivia and Mesinas, 2002; data from Censo de Infraestrucutura Sanitaria y Recursos del Sector Salud 1992 y 1996

Figure F- 1. Public Expenditure on Health as Percent of GDP, 1992- 2001



Source: OED 2002, citing data from IMF reports and database.

Figure F-2. Health Spending as Percentage of GDP and General Budget, 2000- 2006



Source: Taken from CIES, 2005; data from MEF

Annex G: Timeline

YEAR	Country Events	Peru Health Events	World Bank Events	World Events and Projects by other Agencies
1983	President Fernando Belaunde is in office having been democratically elected in 1980.	Ministry of Health (MOH) begins to offer public family planning services (Coe)	Peru Primary Health Project approved (US$33.5 million IBRD loan; $55.5 total project cost)	Effects of Mexico's 1982 default on international debt triggers Latin American debt crisis (1)
1985	President Alan Garcia elected.	The National Population Law is passed guaranteeing informed choice regarding reproduction and contraceptive access, education, services and use. (Coe)		PAHO launches an initiative to eradicate polio in the Americas by 1990
1986	A perceived "debt trap" limits and eventually stops all foreign debt payments. There is increased protectionism and a high fiscal deficit is financed by money creation. (SAR)	Peru DHS results published		
1987	Inflation, economic output and real wages drop.	The National Population Program is formulated. (Coe)		
1989	Hyperinflation. Central government spending dropped to less than 15% of GDP (1989-1990), although social services were somewhat protected – with expenditures for health (excluding social security) stable at 4-5% from 1970			
1990	President Alberto Fujimori elected. At the time of his election, political violence was claiming more than 3,000 lives each year; tax collection was less than 6 percent of GDP, down from	Decree reduces MOH role in service delivery and refocuses it on policy, planning, technical assistance to the regions and quality assurance. But sub-regional directors in most regions continued to exercise responsibility for		80 percent childhood immunization worldwide is reached (35)

YEAR	Country Events	Peru Health Events	World Bank Events	World Events and Projects by other Agencies
	around 14 percent in 1985; real wages had declined by 60 percent since 1985; and the country was under hyperinflation. Prices had increased by a factor of 27 million over the previous three decades. (CAS) Economic stabilization and adjustment program begins in August. The government creates an emergency social assistance program to provide direct food and health assistance to the poor. (CAS)	managing health services and facilities; In response to adjustment, prices of imported medicines increase and voluntary civil service lay-offs attract staff to MoH By 1990 number of health centers increased by 60% and health posts doubled between 1980 and 1990 but ¼ of al centers were inoperative in 1990 due to lack of equipment; ¼ of all physicians located in Lima		
1991	"Fujishock"- Dramatic reforms to stabilize economy and eliminate hyperinflation Policy reform to promote competitiveness, deregulate, simplify tax regime, liberalize trade, reduce size of public sector, control public sector wages (March) The emergency social assistance program is replaced by FONCODES (Aug).	Cholera outbreak- most serious in Americas in century The last indigenous case of polo occurs in Northern Peru Majority of MoH workers on strike for four months during the cholera outbreak Second National Population Programme formulated.	Bank approves Peru's application for lending to a country with protracted arrears- Peru agreed with Bank and IMF on external financing plan, adopted IMF stabilization program and Bank-supported adjustment program and continued debt service payments to Bank (July) Primary Health Care Project is closed having disbursed only 17 percent of the loan approved	
1992	Fujimori's autogolpe Inflation moderated to just below 60%; consolidated public sector fiscal deficit declined from 6.5 of	Peru DHS results published	First Bank Mission on Basic Health and Nutrition Project (April)	Mexican financial crisis sends shockwaves through Latin America. Americas are certified polo-free

YEAR	Country Events	Peru Health Events	World Bank Events	World Events and Projects by other Agencies
	GDP in 1990 to 3% in 1992, improved trade and FDI El Nino phenomenon causes a severe drought			
1993	First 4 months of 1993, there is a 3.2% growth in GDP; But ½ population is poor and 1/5 is extremely poor	1993 poverty alleviation program financed social investment fund, PROCODES and new health sector project, Proyecto Salud Basico para Todos (PSBT)- Basic Health for All (ICR)	BHNP appraisal mission (Jan) Arrears with the Bank and IMF cleared (March) BHNP Negotiations (Nov) FONCODES I approved (US$100 million IBRD loan; US$498 million estimated total project cost). It is the first IBRD-assisted social fund project. (Dec) *Peru: Poverty Assessment and Social Policies and Programs for the Poor* published	USAID, Project 2000 IDB. Strengthening Health Sector Program (Programa Fortalecimiento del Sector Salud)
1994		*CLAS (Comités Locales de Administración de Salud)* initiated (2PAD, p. 8)	BHNP Planned date of Effectiveness (Feb) CAS (Vol I) published Peru- Public Expenditure Review published	
1995	Fujimori reelected for second term	INEI begins to implement quarterly household survey (2PAD, p 45)	BHNP project reorganization; operational plan for 1995 focuses on integrated health care and quality of care BHNP's TB component expanded to communicable disease component to include malaria (ICR)	

YEAR	Country Events	Peru Health Events	World Bank Events	World Events and Projects by other Agencies
1996		Peru DHS results published	Reorganization and scaling-up of complexity of BHNP; new 3-year strategic plan; developed and changes organizational and budget structure of project, including changes to components (ICR) Amendment on October 11 changes BHNP budget categories (ICR 10); Livia Benavides begins as "contraparte directa del proyecto" in Lima (*A)	
1997		Seguro Escolar Gratuito (SEG) created to provide free health services and medicines for children who attend public schools; Two laws approved to establish general principles of sector reform- Ley Geneal de Salud and Ley de Modernizacion de la Seguridad Social and Government establishes UCM and the COMSSS (Comisión Monitora de la Seguridad Social en Salud) Reorganization of ESSALUD through incorporation of Private Healthcare Providers (EPS) to manage part of its basic plan; in addition a superintendent for EPS was created to supervise the private companies under the EPS scheme (p. 654 *Opportunity for a Different Peru*)	BHNP TOR for mass implementation of new integrated health model (ICR, p. 4) CAS 1997- 2001 published	El Nino produces extreme weather conditions

YEAR	Country Events	Peru Health Events	World Bank Events	World Events and Projects by other Agencies
1998	*Ley Marco de Decentralización* eliminates MINPRE—but then was reestablished by Congress a few weeks later (2PAD p. 50) El Nino phenomenon affects health outcomes, particularly in Piura where malaria increased and maternal deaths were related due to road blockages. (ICR p. 9)	System of rural *rondas* established for Extramural Health Care (ELITES) (p. 654 *Opportunity for a Different Peru*) MOH pilots Seguro Materno Infantil (SMI) in Tacna and Mayobamba (2PAD p. 8). Unidad para la Modernización del Sector Salud is created to start work with the donor agencies; it is presided over by Jaime Johnson Change in the MOH director (DGSP) resulting in improved BHNP project coordination (ICR 10)	Major contract for implementation of health practices component signed (Jan) (ICR); BHNP supervision mission in February assessed possibility of closing project due to barriers to institutional coordination with project on part of Borrower (ICR 10); BHNP bidding lasts through mid-1998 due to delays in Bank's approval of TOR and mid-bidding changes based on MOH request to develop certain products for health reform; MOH wanted to include Villa El Salvador (South Lima) in project area; project activities in Chota reoriented towards community participation in service delivery (p. 4) Final project reorganization in late 1998 and project is in line with MOH functional programming structure Final transfer for BHNP to MOH	
1999		Dirección General de Salud de las Personas (DGSP) drafts plan to streamline 8 national programs related to MCH and environmental health and creates the SMI in MOH and expands SMI implementation to seven health departments (2PAD, p. 7)	BHNP baseline data collected in early 1999 (ICR p. 6) BHNP Community-level health promotion component working with CHW initiated under contracts with local NGOs but is reduced in scope	

YEAR	Country Events	Peru Health Events	World Bank Events	World Events and Projects by other Agencies
		Fujimori announces that responsibility for primary health care service delivery will be transferred to municipalities over the next four years (2PAD, p. 8)	(compared to SAR); BHNP contract of health practices component dissolved due to unsatisfactory contractor performance (ICR p. 7) World Bank Country Study: *Peru, Improving Health Care for the Poor* published *Poverty and Social Developments in Peru 1994- 1997* published PARSALUD Pre-appraisal mission (July) PARSALUD project appraised (2ICR p. 21)	
2000	Fujimori wins election but then the bribe scandal involving Montesinos occurs. In November, Paniagua is elected by the Congress as interim care-taker.	Starting in 2000 MOH budget will incorporate all of the DISA annual budgets (2PAD p. 7) Peru DHS results published	BHNP Ex-post data collected at end of 2000 (ICR p. 6) PARSALUD negotiated and approved by Board (US$80 million IBRD credit; US$239.3 total project costs; 12/31/03 expected closing date) (Nov- Dec)	
2001	Fujimori resigns President Toledo is elected	The Government decided to combine SMI and SEG to form SIS (Law 27767) (Parodi SIS evaluation, p 8)	BHNP ICR released (6/26/01) PARSALUD loan agreement signed by GOP (April) Programmatic Social Reform Loan Project I approved (June) and closes (September) disbursing US$100 million	

YEAR	Country Events	Peru Health Events	World Bank Events	World Events and Projects by other Agencies
			PARSALUD launched during supervision mission (Nov) (2ICR, p. 22) CAS Progress Report published	
2002	*Sistema Nacional de Inversión Pública* emerges within Ministry of Economy to approve civil works- affected acquisition of project-related goods. (2ICR, p. 11)	Peru's Minister of Health issued an apology for the forced sterilization of indigenous women during the presidency of Alberto Fujimori. Regional and local health plans institutionalized (2ICR, p. 18) SIS replaces SMI (2ICR p. 19)	Programmatic Social Reform Loan Project II approved (September) and closes (December) disbursing US$100 million OED Country Assistance Evaluation published CAS 2002- 2006 published Peru Public Expenditure Review published	
2003			PARSALUD Mid-term review (Sept) PARSALUD Closing date extended PARSALUD restructured- new action plan developed for 2004-5 and some new targets established (2ICR p. 6) PRSL III approved (November) and closes (December) disbursing US$150 million	Global Fund project. Strengthening Prevention and Control of HIV and Tuberculosis in Peru. US$50 million.
2004		Status of doctors contracted under CLAS changed to appointed (December) (p. 656 Opportunity for a Different Peru) Peru begins continuous DHS survey	PRSL IV approved and closes (December) disbursing US$100 million CAS Joint Progress Review	

YEAR	Country Events	Peru Health Events	World Bank Events	World Events and Projects by other Agencies
		(2004- 2008)		
2005			PARSALUD Closing date extended to Dec. 15th (2ICR p. 8)	
2006	President Alan Garcia is elected for a second term.		New Country Partnership Strategy; RECURSO Peru I: *A New Social Contract for Peru* published Bank preparing PARSALUD II CAS/ Country Partnership Strategy 2007- 2011 Policy Note: *An Opportunity for a Different Peru* published	Belgian grant for US$6 million to SIS

Annex H: Borrower's Comments

PERÚ | Ministerio de Salud | Oficina General de Planeamiento y Presupuesto

Decenio de las Personas con *Discapacidad en el Perú*
"Año de la Unión Nacional Frente a la Crisis Externa"

OFICIO N° 1435 - 2009- OGPP-OCI/MINSA

Lima, 26 JUN. 2009

MINISTERIO DE SALUD
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Señora
MONIKA HUPPI
Jefe
División de Evaluación de Programas Sectoriales
Grupo de Evaluación Independiente
The World Bank
Presente.-

Asunto : Proyecto Salud y Nutrición Básica (Préstamo N° 3701) y Programa de Apoyo a la Reforma del Sector Salud (Préstamo N° 4527) Informe de Evaluación de los resultados de los proyectos

Ref. : The World Bank Carta S/N del 04.06.09; Exp. 09-046903-001

De mi consideración:

Me dirijo a usted, a fin de saludarla muy cordialmente y a la vez remitir adjunto, el Informe N° 023-OCI-OGPP/MINSA, en relación al Informe de Evaluación de los resultados de los proyectos: Salud y Nutrición Básica (Préstamo N° 3701) y Programa de Apoyo a la Reforma del Sector Salud (PARSALUD - Préstamo N° 4527), de acuerdo a lo solicitado a través del documento de la referencia.

Hago propicia la oportunidad para reiterar a usted, los sentimientos de mi especial consideración.

Atentamente,

MINISTERIO DE SALUD · OFICINA GENERAL DE PLANEAMIENTO Y PRESUPUESTO

Econ. AUGUSTO M. PORTOCARRERO GRADOS
Director General
Oficina General de Planeamiento y Presupuesto
MINISTERIO DE SALUD

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Decenio de las Personas con Discapacidad en el Perú
"Año de la Unión Nacional Frente a la Crisis Externa"

INFORME N° 023 - 2009- OCI- OGPP- MINSA CARGO -09

A : **Econ. AUGUSTO PORTOCARRERO GRADOS**
Director General
Dirección General de Presupuesto y Planificación

ASUNTO : Remisión de Opinión sobre "Informe de Evaluación de los Resultados de los Proyectos: Salud y Nutrición Básica-PSNB (Préstamo N° 3701) y Programa de Apoyo a la Reforma del Sector Salud –PARSALUD (Préstamo N° 4527)

REF. : Carta The World Bank del 04.06.09; Exp. 09-046903-001

FECHA : Lima, 24 de junio de 2009

Me dirijo a usted, a fin de remitir adjunto la opinión sobre el Informe de Evaluación de los Resultados de los Proyectos: Salud y Nutrición Básica-PSNB (Préstamo N° 3701) y Programa de Apoyo a la Reforma del Sector Salud –PARSALUD (Préstamo N° 4527), remitido por The World Bank.

1. **Antecedentes:**

   Documento técnico denominado "Informe de Evaluación de los Resultados de los proyectos: Salud y Nutrición Básica-PSNB (Préstamo N° 3701) y Programa de Apoyo a la Reforma del Sector Salud -PARSALUD. (Préstamo N° 4527). Elaborado por el Grupo de Evaluación Independiente (IEGWB), unidad dependiente del Directorio Ejecutivo del Banco Mundial en el año 2008

   El documento consta de 98 páginas; está dividido en tres partes fundamentales, una primera parte corresponde al proyecto PSNB, una segunda parte al proyecto PARSALUD I fase y una tercera sección correspondiente a anexos.

2. **Fortalezas del documento**

   2.1 Destaca el minucioso y bien documentado análisis del contexto político social, que se presentaba en el país en la década de los 90 y durante la primera mitad de la década de los 2000.

   2.2 Da cuenta sobre que los objetivos planteados en los proyectos se caracterizaban por su claridad, sencillez y concreción. Muestra cómo se incorpora en el PSNB el componente de saneamiento ambiental y estrategias como AEIPI que se mantiene hasta la actualidad. En PARSALUD destaca la estrategia del CLAS.

2.3 Invita a los directivos y funcionarios en general, del MINSA, al auto-cuestionamiento sobre aspectos relacionados directamente con el actuar político y técnico: **i)** la variabilidad de las políticas sociales entre ellas la política de salud en función de los intereses de los gobiernos de turno, constituyen limitantes para la buena marcha de los proyectos, puesto que estos son paralizados o presionados a cambiar sus objetivos, ámbitos etc. **ii)** el cambio frecuente de directivos de puestos clave y la desactivación de unidades orgánicas trae como consecuencia el deterioro de aspectos técnicos en el MINSA. **iii)** escasa capacidad por parte del MINSA para emplear instrumentos o herramientas para el seguimiento y evaluación de los proyectos de PARSALUD I. **iv)** ausencia de renovación de tecnologías y el desaprovechamiento por parte del MINSA, de nuevas metodologías que fueron trabajadas por los proyectos. **v)** el acopio y manejo de información de calidad sigue constituyendo una debilidad técnica del MINSA

3. Debilidades del documento:

3.1 El informe de evaluación del IEGWB solo da cuenta de componentes en ambos proyectos con sus principales actividades, no figuran indicadores ni supuestos. El proyecto PARSALUD I ha presentado hasta tres matrices de Marco Lógico con fines y propósitos variados, que no permitieron focalizar adecuadamente la orientación futura de logro de resultados. Asimismo, no se concretó la elaboración de las Líneas de Base propuestas para ambos proyectos. Estas dos carencias hacen inviable un buen seguimiento y evaluación.

3.2 La ausencia de Línea de Base y un Marco Lógico con deficiencias, han llevado a concluir en algunos componentes, que con la intervención del los proyectos o sin ella se hayan obtenido resultados positivos.

3.3 Da cuenta que el proyecto PSNB y la primera fase de PARSALUD, no incorporan indicadores de cobertura, que en en este tipo de proyectos por endeudamiento, se hacen necesarios para garantizar que la ayuda llegue a amplios sectores de beneficiarios.

3.4 Las actividades incumplidas por el proyecto son atribuidas exclusivamente a problemas del MINSA. No evalúa a las ONG que intervinieron en la ejecución de actividades o por lo menos el documento no lo menciona.

3.5 No presenta los instrumentos utilizados para la evaluación, al punto que podría considerarse más bien una sistematización de experiencias.

3.6 No se evidencia en el texto que el proyecto haya intentado asesorar al MINSA en ciertas decisiones clave; p.e. la desactivación de los CLAS.

3.7 No hace mención a la existencia de un Plan de Contingencia, dada la experiencia del Banco Mundial y su asesoramiento en el diseño de proyectos en países con alta inestabilidad política y económica, un plan contingencial debería haberse contemplado, pues en los sucesivos rediseños que se realizaron al proyecto PARSALUD, se limitaron a una disminución de objetivos y ámbitos.

3.8 El informe de evaluación menciona eficiencia sustancial en el gasto, para el proyecto PARSALUD, sin embargo, el GOP asume el costo total del Seguro Materno Infantil, reduce los montos de los préstamos tanto del Banco Mundial como del BID, sin haberse modificado el costo total del proyecto (préstamo).

4. Conclusiones y Recomendaciones

La incorporación del Presupuesto por Resultados es una decisión trascendente para el manejo transparente de los recursos y garantiza a los proyectos una mayor eficiencia en el uso de los préstamos. Sin embargo, es necesario que se complemente con una Gestión por Resultados que articule acciones y estrategias para la consecución de una mayor eficacia, equidad e impacto.

Se hace necesario fortalecer áreas clave para la gestión de proyectos con énfasis en los procesos de seguimiento y evaluación. El fortalecimiento debe comprender la incorporación de nuevas metodologías así como de herramientas informáticas de tecnología actual para la mejor gestión de la información.

Al respecto, adjunto se anexa el proyecto de oficio de respuesta dirigido a la Jefa de la División de Evaluación de Programas Sectoriales del The World Bank.

Lo que hago de su conocimiento para fines pertinentes.

Atentamente,

Dr. JOSE ALBERTO CASTRO QUIROZ
Director Ejecutivo
Oficina de Cooperación Internacional
Oficina General de Planeamiento y Presupuesto
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