PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: AB2852

Project Name	PE- (APL2) Health Reform Program
Region	LATIN AMERICA AND CARIBBEAN
Sector	Health (80%);Non-compulsory health finance (20%)
Project ID	P095563
Borrower(s)	GOVERNMENT OF PERU
Implementing Agency	Ministry of Health Peru
	Ministry of Health Peru
Environment Category	[ ] A [X] B [ ] C [ ] FI [ ] TBD (to be determined)
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1. Country and Sector Background

Peru is a heterogeneous country with a population of more than 27 million. It went from being an eminently rural country in 1950, when only 33% of the population lived in urban areas, to a predominantly urban country. By 2004, 72% of its population lived in cities[1]. However, rural population in absolute terms is currently greater than 8.3 million. There are marked differences in poverty levels among the country's regions. In 1994, 12.2% of the urban population compared to 62.9% of the rural population was extremely poor. By 2004 these figures had changed to 9% for urban areas, and to 56% for rural areas[2]

The country is facing the global financial crisis with strong macroeconomic indicators and sound macroeconomic policies in place, although the crisis has changed Peru's medium term growth prospects. Economic growth has remained high and broad in the past six years, and has been accompanied by public sector surpluses, relatively low inflation, high levels of international reserves, and a manageable external current account. However, it is expected that the global financial crisis (particularly the ongoing credit growth moderation, falling commodity prices and the recessionary risks of developed economies) will affect Peru's growth prospects, slowing down the economic activity for 2009-11, but still with robust rates of growth. In order to face these challenges, the government of Peru has decided to secure access to contingent lines of credit to strengthen its preparedness in the event that the external environment worsens substantially.

Peru has experienced aggregate improvements in some health outcome indicators during the last decade. The decrease in the national infant mortality rate (IMR) has been one of the most important achievements, and is currently below the LACR average of 24.2 deaths per 1,000 live births (as of 2006)[3]. Peru is on track to achieve its Millennium Development Goal (MDG) target for this indicator. However, IMR inequalities persist; while the aggregate rate has declined, the improvement has not been uniform among

[1] ENAHO 2004
[2] ENAHO 2000, 2004
[3] HNP data base World Bank, 2006, and WHO basic indicators 2007

socioeconomic groups or Regions. In 2006, the IMR varied from 5 per 1,000 (in the richest quintile) to 45 per 1,000 (in the poorest quintile). Moreover, the *relative share* of perinatal[4] and early neonatal mortality[5] as a cause of infant deaths has increased. The leading causes of death among children under 1 year old are related to low coverage of birthing care in health facilities, lack of immediate professional attention for the newborn, and maternal malnutrition (there is a 25.4% prevalence of anemia among women between 15 and 49 years of age) [6, 7].

Malnutrition continues to constitute a major public health problem in Peru. One-quarter of Peruvian children younger than five suffer from chronic malnutrition, while 50% of children under five and 69% of children under two suffer from anemia (ENDES, 2001). Moreover, the pace of progress has been uneven, and, in the case of chronic malnutrition, it has been slowing down. Malnutrition is almost four times higher among children living in rural areas (39%) as it is in children living in urban areas (10%). In 2004 chronic malnutrition reached 44% among the extreme poor and 28% among the poor against only 5% among the non-poor (INEI, 2006). In addition, breastfeeding practices have decreased in the past five years. Exclusive breastfeeding until the 6th month of age (which is considered optimal) has decreased from 79% to 76% among infants from 0 to 1 month of age, and from 67% to 60% among infants from 2 to 3 months of age[8].

Maternal mortality continues to be a serious problem in Peru. The maternal mortality rate (MMR) is 164 deaths per 1,000 live births, almost double the regional LAC average. According to the Ministry of Health (MINSA), Peru has the fourth highest MMR in LACR, after Bolivia, Paraguay[9] and Haiti. There is also pronounced disparity in the MMR across the country, suggesting unequal access. The MMR for Lima was 52 in 2000, while the MMR for Huancavelica and Puno the same year were 302 and 361, respectively.

Birth delivery attended by skilled professionals is unequal among Regions. Regions with lower economic growth, high levels of poverty, and high percentages of rural population are especially affected. For example, in Huancavelica only 21% of births are professionally attended, and in Puno 27.8%. In addition, the risk of dying due to complications in pregnancy, delivery, or puerperium[10] is more than ten times higher in poor Regions such as Ayacucho and Puno (36 deaths and 36 deaths per 1,000 women in reproductive years, respectively) than in more affluent Regions such as Lima and Ica (3 deaths per 1,000 women in reproductive years, each).

Gaps also persist in access to health services between the poor and the non-poor, and between rural and urban areas due to economic conditions. Financial obstacles still represent a significant barrier to access. In the poorest quintile, 34% of individuals reported they had no access to health care for lack of money, while in the richest quintile only six percent did.[11] Moreover, 40% of the poorest population accounted for only 32% of the number of days of hospitalization in MINSA hospitals, while the richest 40% used 45% of total hospitalization days.[12]

A key challenge to address these disparities in access is increasing accountability within a very

[4] Period between 22 weeks of gestation, 500 grams of weight and the first 7 days after birth. CIE - 10
[5] Period between birth and the first 7 days of life, CIE-10
[6] Endes 2000 – 2001 Peru
[7] Sistema de naciones Unidas en el Peru. Hacia el cumplimiento de los objetivos de desarrollo del Milenio en el Perú. Informe 2004.
[8] Comparison of the 2000 Demographic and Family Health Survey (DHS-ENDES) with the 2004-06 DHS-ENDES.
[9] MMR of Paraguay is 190 per 100.000 lb (2004).
[10] The period between childbirth and the return of the uterus to its normal size.
[11] ENAHO 2006
[12] ENAHO 2006

fragmented health care system. The Peruvian health care system is still highly segmented. It comprises two subsectors (public and private) and various subsystems that historically have worked independently and lacked coordination. As a result, the current system fails to offer health insurance protection to the whole population (62% of Peruvians lack health insurance)[13]. One promising step toward coordination inside the sector occurred in 2006 with the unified purchase of medicines by MINSA, the Social Security System (ESSALUD) and the rest of the Military hospitals.

In the face of these challenges, MINSA has established policies and strategies aimed at obtaining demonstrable results in maternal and child health morbidity and mortality. MINSA has defined access to institutional births with good quality services as a key operational standard for the primary health system, recognizing that this indicator is a key tracer of the quality of primary and secondary medical care. In this context, MINSA has set an aggressive target to improve coverage of institutional births in the poorest Regions.

One of the most important innovations designed to address the lack of a harmonized supply of health care services, and to deal with inequalities in access due to income limitations, was the Seguro Integral de Salud (SIS). SIS was created in 2001 and reimburses MINSA public providers for the variable costs within specified health plans. SIS gives priority to the vulnerable population living in poverty or extreme poverty. SIS has made important contributions to sector development, such as improvements in the use of resources, reduction of economic barriers to access, and production of transparent information for sector-based insurance management.

Currently, while SIS is the main financing instrument to address supply-side weaknesses, it accounts for 14 percent of the health sector budget and has low coverage, which shinder achievement of targets for institutional births. SIS covers over 16% of the population, while ESSALUD covers 18% and private entities cover 4%[14]. Although most of the beneficiaries of SIS come from the two poorest quintiles and from rural areas, the majority of the population within these quintiles is still not covered by any health insurance. Increased effort is needed to extend SIS coverage in key Regions, including poor, dispersed, and indigenous populations. In particular, it is intended that SIS will raise coverage of a full insurance package for women of childbearing age in the poorest Regions of Peru by around 75 percent between 2008 and 2010, as well as setting an operational standard for the supply of medicines in primary and secondary health posts that provide birth delivery services. In this way, SIS aims not only to guarantee funding for health care costs for the poor, but also to promote the notion of a guarantee of the right to maternal and child health services.

2. Objectives

Framed within the long-term objectives of the Health Reform Program, the project objectives are to:

(i) improve family health care practices for women (during pregnancy, delivery and breast-feeding) and children under three years old in the nine poorest provinces
(ii) strengthen health service network capacities to solve obstetric, neonatal and infant emergencies, and provide comprehensive health services to women (during pregnancy, delivery and breast-feeding) and children under age three in the nine poorest provinces
(iii) 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.

[13] ENAHO 2006
[14] ENAHO 2006

The nine Regions of focus in the Project are: Amazonas, Huánuco, Huancavelica, Ayacucho, Apurímac, Cusco, Cajamarca, Ucayali and Puno.

Success in achieving the above objectives in the targeted 9 Regions will be assessed using the following key indicators:

(1) Increase the proportion of institutional deliveries[15] in rural areas of the nine selected Regions from 44% (2005) to 78% (2013).

(2) Reduce the prevalence of anemia among pregnant women in the nine Regions from 41.5% (2005) to 35% (2013).

(3) Increase the proportion of pregnant women of the nine Regions with at least 1 prenatal control during the first trimester of pregnancy from 20% (2005) to 45% (2013).

(4) Reduce the hospital mortality rate among neonates in the nine selected Regions from 9.5% (2005), to 5% (2013)[16].

(5) Reduce the prevalence of anemia among children under age 3 in the nine Regions from 69.5% to 60%.

(6) Increase from 40% to 50% the share of children in the nine selected Regions who are exclusively breastfed until 6 months of age.

3. Rationale for Bank Involvement

The World Bank has been active in health in Peru in recent years, maintaining a constant dialogue with authorities and supporting reform efforts through analytical and lending operations. The proposed project would complement other past health sector investment projects in Peru financed by the World Bank and other donors that have supported the Government of Peru's (GoP) efforts to implement institutional reforms, increase health care coverage, strengthen primary care and vaccination programs, lower rates of infant and maternal mortality, and improve maternal and child nutritional status. The Bank's involvement in the health sector dates back a number of years and has focused mainly on maternal and child health issues. From 1994-2000, the Government implemented the Basic Health and Nutrition Project, which supported MINSA operations to strengthen maternal and child services in three regions of Peru. In 1998, the Bank carried out analytical work which showed that maternal and child health issues were still a priority, and called for institutional reforms to address these issues.

The proposed project is the second phase of an Adaptable Program Loan (APL) which supports health reform in Peru. The overall objectives for the APL Program are to: (a) improve maternal and child health; and, (b) help reduce morbidity and death among the poor due to communicable diseases and inadequate environmental conditions. The first phase project was an investment loan, Health Reform Support Project I (Programa de Apoyo a la Reforma del Sector Salud I - PARSALUD I), part of a cluster of Bank-supported activities designed to improve basic health indicators in Peru.

This cluster included influential AAA (RECURSO), which made recommendations for health policy reforms needed to obtain better results in health. These recommendations were implemented through a series of four policy-based loans (Programmatic Social Reform Loans, or PSRLs) and an investment loan

[15] As defined by SIS: deliveries attended in a health establishment
[16] Neonates Lethality rate is the mortality among neonates that arrived alive to the hospital

(PARSALUD I). The latter, financed jointly with the Inter-American Development Bank (IADB), had as its main objective the reduction of perinatal and infant mortality through empowering the poor to strengthen the demand side while improving the quality of the supply side of health programs and services. It had three achievements. First, it targeted Regions with the highest incidence of IMR, and MMR, and the lowest access to effective and quality services.[17] Second, it addressed inequalities in access by expanding health insurance coverage under the SIS. Third, the GoP began to address geographic inequalities by proposing the decentralization of the governance structure of the health sector to the Regions. The proposed second phase of this project will contribute to sustain these GoP's achievements under PARSALUD I. It is relevant to note that because of protracted implementation of phase one of the APL, phase two is being proposed for the timeframe originally foreseen for the third phase. This PAD takes into account the project document evaluation indicators elaborated by MINSA and submitted to the Investment Evaluation Unit of the same Ministry, as well as to the Ministry of Economy and Finance in compliance with the National Public Investment System – SNIP– (Sistema Nacional de Inversión Pública).

More recently, the National government has asked the World Bank to continue to support MINSA and sub-national governments to improve the efficiency and quality of publicly-financed services, focusing on coverage of maternal and child health care in a decentralized context. The World Bank is uniquely positioned to contribute expertise on issues related to designing regional health care networks, adapting sector governance to better address maternal and perinatal health care, resource management, and performance improvements. These reforms are oriented toward stimulating system rationalization and accountability, in part through the reconfiguration of service delivery into a new maternal and neonatal health care delivery model.

The Bank's contributions in system reform and decentralization are crucial. Both the national and subnational governments seek the Bank support for consolidating the reforms and decentralization of the health system. The World Bank is uniquely positioned to contribute expertise on issues related to designing regional health care networks, adapting sector governance to better address maternal and perinatal health care, resource management, and performance improvements. While the PARSALUD II Project would represent a small portion of national (recurrent) financing, there is considerable demand from the national government for Bank support to the policy reforms as well for its fiduciary contributions to ensure an expedite and efficient execution of the supply investments supported by this project. Moreover, the Project would represent additional funding for regional governments which will be channeled to investments and interventions that are not covered by current budgetary allocations. The ongoing decentralization process has brought a new focus in the sector and requires strong support in order to ensure continued improvement in key health indicators.

This proposed second phase of the APL builds on activities being undertaken by other donors. As was the case for PARSALUD I, this second phase would also be jointly financed and supervised by IADB. The Bank team anticipates coordinating activities with other donors, including the European Community, UNICEF, and USAID, especially on intercultural issues, monitoring, and capacity building of regional health authorities.

4. Description

This proposed second phase APL would have four components and total project costs of US$162.4 million. This project has been jointly prepared with the IADB. The GoP has requested that the Bank and IADB finance up to US$15 million each, with the remainder to be covered by other fiscal resources. The

[17] Amazonas II (Bagua), Ayacucho, Huancavelica, Apurimac I (Abancay) and Apurimac II (Andahuaylas), Cuzco, Puno and Huanuco

project will be implemented in the same Regions as under the APL I (Amazonas, Huánuco, Huancavelica, Ayacucho, Apurímac, Cusco and Puno) plus two additional Regions: Cajamarca and Ucayali. These Regions were prioritized because IMR and MMR still remain well above the national average, and thus need further intervention. Disbursement for this project will be based on standard mechanisms for investment projects as requested by the GoP and the categories under which funding will cover components were prepared by the borrower.

When PARSALUD's I main focus was to support SIS in the expansion of the MOH's maternal and child health services and programs in the selected Regions, the main focus of PARSALUD II is to support SIS to improve the quality of provision of those services and programs, as well as to improve the organization of a new health delivery model in a decentralized context in the same regions. In addition, reducing the gap of results in mothers and children from rural populations requires PARSALUD II support to SIS in improving health promotion interventions and develop campaigns of changing behaviors in dispersed populations, as well as improving cultural sensitivity of health services to indigenous population in the targeted areas, increasing demand and guaranteeing the access of rural population to all levels of the health care chain.

Component 1. Improving health practices at the household level for women and children under age three in rural areas of the nine targeted Regions (US$6.0 million). This component will finance three lines of actions:

Subcomponent 1.1. The design, implementation, and monitoring of a Behavioral Change Communication and Education Program (BCCEP). The BCCEP aims to promote healthy practices at the household level, including increase demand for health services, with a focus on mothers during pre- and post-natal periods and children under three, taking into consideration the cultural context of rural and indigenous populations.

The activities to be financed include: (i) studies to identify current practices, beliefs and attitudes, including the use of health services; (ii) 9 tailored BCCEP strategies (by region); (iii) development, validation, and production of culturally sensitive printed and audio-visual materials (radio spots, soap operas, videos, etc.); (iv) equipment for basic training and dissemination (PCs, data display devices, TVs, DVD); (v) training of MINSA, DIRESAs staff, as well as staff, networks, micro-networks, and community agents for the local implementation of the BCCEP; (vi) a training program for local authorities, community leaders, social and civil society organization; (vii) learning workshops and study tours; (viii) technical assistance to health staff and community members on the implementation of the BCCEP; (ix) monitoring and evaluation of the BCCEP; (x) evidence-based studies for health promotion in maternal and neonatal health care. In addition, a competitive fund of approximately US$1 million (to be financed under the IADB loan), would be established to finance local initiatives to improve healthy communities.

Subcomponent 1.2. Promotion of SIS enrollment rights and identity rights among eligible target population. This sub-component aims to support the GoP in enrolling eligible women and their children for SIS benefits. The lack of national identification documents is a serious obstacle to accessing social programs: the problem is especially serious in indigenous rural areas. In the country, almost 10% of adult population is undocumented, and women who lack a Documento Nacional de Identidad (DNI) may lose access to health insurance (SIS), as well as to other social protection and development opportunities. Therefore, the Project will promote SIS enrollments, and DNI requests.

Specifically, the project would finance: (i) the design and implementation of a campaign promoting SIS rights and identity rights. This campaign would facilitate the work to be carried out by civil servants in charge of the delivering of the DNI; (ii) the design, production and dissemination of materials promoting

SIS rights and identity rights for all nine Regions; and (iii) training of health staff and local authorities on the promotion of SIS rights and identity rights.

Component 2. Increasing the capacity to provide better maternal and child health services for the poor (US $142.3 million). This component would strengthen the health delivery model through improving the capacity of health service networks to attend obstetric and neonatal emergencies, to improve the integration between pre-natal and post-natal care, and health care for children under three. The component would support:

Subcomponent 2.1. Improvement in the quality of services in health facilities. This would include: (i) minor constructions, rehabilitation, and equipment investments, including supervision vehicles, for the networks in the Regions supported by the Project, related to the improvement of the 8 essential obstetric care functions, and one neonatal service[18]; (ii) technical assistance and training for health personnel; (iii) inclusion of an intercultural focus in service provision; and (iv) a fund to support innovative proposals to finance local initiatives for health services provision (to be financed by the IADB)..

Subcomponent 2.2. Raising the efficiency and effectiveness of networks. The main purpose of this subcomponent is to improve the new health delivery model to be implemented under the project. The table below explains the differences between the old and new health model for mother and child care.

This would include: (i) strengthening management systems at network level; (ii) improving the referral and counter-referral system, (iii) supporting the implementation of health care chains for maternal and neonatal service referrals, (iv) clinical governance studies, and (v) regulation of the health networks and maternal health care chains.

Component 3. Strengthening government capacities to offer more equitable and efficient health system in a decentralized environment (US$5.2 million). This component would work towards the strengthening of MINSA, and the decentralization of the health system through:

Subcomponent 3.1. Regulatory framework in support of service quality. The PARSALUD results-based model entails innovations that require regulatory reforms in order to ensure that they are incorporated into the institution and are sustainable. Technical assistance including training will be provided to support the integrated health delivery model and the development of support systems. These include the development of the regulatory framework and implementation plan for: (i) the accreditation and certification system, currently proposed by the law but not regulated, (ii) infrastructure maintenance systems, (iii) a reference laboratory system, (iv) hemotherapy (v) hospital financing, (vi) pharmaceutical purchasing and logistics system, and (vii) a health communication and promotion system.

Subcomponent 3.2. Strengthening of SIS. The Project would support SIS to develop the public insurance system. This would entail technical assistance for: (i) the development of the regulatory framework, improvement of the SIS information system, aimed at better monitoring enrollment, coverage and access in the Regions initially included in the project, (ii) quality assurance mechanisms, and technical assistance for the implementation of the SISFOH targeting system to ensure adequate targeting of health insurance financing in urban areas.

Subcomponent 3.3. Systems development to enhance the monitoring capacity of MINSA. This set of activities would support the improved implementation of existing systems, namely SIS (see above), and SIGA, all of which can produce monitoring data and thus introduce greater accountability into the system. This is particularly important for the MINSA decentralization process, whereby the sector is moving

[18] WHO, essential obstetric health care functions, and one neonatal health care, 2003.

towards a greater regulatory role and the Regions will be taking on greater responsibility for implementation.

Subcomponent 3.4. Support to decentralization. The Project would support the continued implementation of Management Agreements (MA) developed under APLI, as instruments for supervision and accountability between the central regulatory level and the Regions, which are responsible for service provision. To this end, new MAs will be signed, and the Project would provide direct technical assistance and training to MINSA and regional staff. In addition, the Project will support the design of an incentive/penalty system that will ensure that the MAs are effective instruments. Finally, Subsidiary Agreements will be signed between MINSA and Parsalud II with the region of Cusco and the region of Cajamarca, respectively, to detail the terms and conditions in which the above-mentioned regions shall repay the Borrower the portion of the Loan allocated to them under the Project as set forth in the Operational manual.

Component 4. Project Coordination, and Monitoring & Evaluation (US$ 8.9 million). This component would finance activities related to the administration of the project, such as: (i) The financing of external concurrent auditors, (ii) monitoring and evaluation activities, including impact evaluation of specific detailed project activities, and (iii) project management and procurement team within MINSA.

The PCU PARSALUD will operate as a PCU under an operations manual agreed with the Bank.

5. Implementation

The Project will be managed by a PCU that will report to the Vice Minister of Health. The PCU will have the same responsibilities as it did in PARSALUD I, which includes fiduciary issues (i.e. financial management and procurement) and activities planning. The PCU will plan and implement Project activities in coordination with relevant Ministry Regions, which have already been identified as responsible for specific Project components or clusters of activities.

A Project Steering Committee (PSC) will be created to approve yearly operational plans, annual reports, and any significant change in the design, as required. The Steering Committee responsibilities are described in the Operations Manual. The composition of this committee has not been established but the following structure has been proposed (to be confirmed during appraisal): the Steering Committee would be headed by the Vice Minister (who would be delegated by the Minister). The other members would be: one representative of each of the Ministry's General Directorates and the OPDs, one representative of each of the 9 Regions, the Coordinator of PARSALUD, one representative of MEF, and one representative of the health networks.

The project will be managed in accordance with an Operations Manual that will provide guidelines on all operational issues including overall functions, financial management arrangements, procurement arrangements, structure of the PCU, and linkages with MOH, Regions and the Banks.

6. Sustainability

The project has been evaluated and approved by the GoP using standard measures of sustainability. The major concern is the affordability of recurrent costs, so this project includes three elements to promote its sustainability: (i) the inclusion in the evaluation of the recurrent cost to be funded either by regional budgets or through SIS; (ii) the commitment of regional governments to provide enough personnel and maintain facilities to keep the local health networks working on reducing maternal and child mortality; and, (iii) the inclusion of regional and national goals into the Management Agreements scheme, which

can be achieved by monitoring the population at the national and local levels. This evaluation was cleared by the Peruvian Ministers' Council, which receives requests from the Ministry of Economy and Finance.

With respect to financial sustainability, there are two means by which funds are committed to the social sectors. The first mechanism was an initiative from the World Bank and the Government of Peru based on the Programmatic Social Reform Loans. In that context six functional prioritized programs (PSPs) were defined that were budget-protected in their non-salary component. Within those programs, the health sector budget grew in a sustained manner mostly in the activities related to the recuperative interventions. In addition to the PSPs, the second mechanism is based on the Financial Equilibrium of the Public Sector Budget for Fiscal Year 2006 (Law No. 28653) which pledges to the prioritized programs at least 30 percent of any additional budget coming from taxes collection.

7. Lessons Learned from Past Operations in the Country/Sector

World Bank experience in project implementation in Peru provides a number of lessons that have contributed to the design of this proposed project. In particular, those learned from the implementation of the APL I.

An evidence-based results approach strengthens the project by protecting it from external pressures. The APLI had significant difficulties in implementation during the first two years. These difficulties had a number of causes, but they were particularly influenced by the lack of a clear implementation strategy that would ensure results. Once the project team decided to focus on results and established the necessary inputs (supported by evidence-based research), the project started to flow and outcomes were achieved. The evidence-based results framework has been the main instrument for project design in this proposed second phase of the project.

In addition, there is a clear need for political support from the Minister and his/her management team. Results-oriented management is not common practice in Peru. As such, any such practice of this type in the health sector requires significant support. This was clear during the implementation of the first phase of the APL, where ministerial influence made a decisive difference in implementation. The results-oriented framework has been promoted throughout the Ministry during the first phase but, as with all cultural changes, the process has been slow.

Finally, institutionalization of projects is very difficult in the health sector and needs to be followed-up closely by the Bank. The original design for the first phase of the project called for a PCU that would mainly manage administrative processes while technical aspects would be designed and implemented by the Ministry's technical areas and by the Regional Directorates. Although this design has been successful in other sectors in Peru, this was not the case for the first phase of the APL. As a result, the Ministry hired a technical team that led the design and implementation of activities in consultation with the Ministry. While this was an improvement from the previous project (which operated in a bubble within the Ministry), greater involvement of the Ministry and of regional staff are necessary to ensure sustainability. It is expected that the new institutional arrangements will lead to greater ownership within the Ministry.

Based on the experience during implementation of APL I it was agreed that the Bank could further support the borrower by (i) providing know-how and technical support to the MINSA regarding development of policies, plans, and investments related to implementation of the SIS in poorest Peru's Regions; (ii) developing a robust stewardship framework for a new health delivery model implementation in the maternal and neonatal health care; (iii) improving jointly with IADB the quality of program supervision of the total project amount, and not only the portion corresponding to the loan; (iv)

mandating an impact evaluation; and (v) incorporating a health promotion-based approach for indigenous populations.

On the other hand, regarding malnutrition, the "RECURSO" AAA studies showed that malnutrition in Peru is due to lack of mothers' awareness, lack of accountability from providers, and lack of incentives by everybody. These recommendations were provided for health policy reforms needed to obtain better results in health, and as a potential road map to be followed in order to improve key outcomes. This proposed second phase APL addresses these issues.

8. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP 4.01)	[x]	[ ]
Natural Habitats (OP/BP 4.04)	[ ]	[x]
Pest Management (OP 4.09)	[ ]	[x]
Cultural Property (OPN 11.03, being revised as OP 4.11)	[ ]	[x]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[x]
Indigenous Peoples (OP/BP 4.10)	[x]	[ ]
Forests (OP/BP 4.36)	[ ]	[x]
Safety of Dams (OP/BP 4.37)	[ ]	[x]
Projects in Disputed Areas (OP/BP 7.60)*	[ ]	[x]
Projects on International Waterways (OP/BP 7.50)	[ ]	[x]

9. List of Factual Technical Documents

1. Ministerio de Economía y Finanzas. Proyecto de Inversión Pública. Perfil de la Segunda Fase del Programa de Apoyo a la Reforma del Sector Salud - PARSALUD II.
2. Ministerio de Salud. Segunda Fase al Programa de Apoyo a la Reforma del Sector Salud – PARSALUD II – Estudio de Factibilidad, July 2007
3. Banco Mundial. Diagnóstico Socio-Cultural de Pueblos y Comunidades Indígenas del Área de Intervención del PARSALUD II. May 2006
4. Banco Mundial. Plan para los Pueblos Indígenas. June 2006
5. Banco Mundial. Informe de Evaluación Ambiental
6. Informe de Evaluación Ambienta. Perfil de PARSALUD II Fase. Febrero 2005
7. Aide Mémoire – Final Preparation Mission – PERU – PARSALUD II – March 11-14, 2008
8. Aide Memoire – Special Preparation Mission – PERU – PARSALUD II – November 12-15, 2007
9. Aide Mémoire – Technical Visit – PERU – PARSALUD II – December 11-14, 2007
10. Aide Memoire – Preparation Mission – PERU – PARSALUD II – September 3-6, 2007
11. Aide Memoire – Pre-Evaluation Mission – PERU – PARSALUD II – June 22–28, 2006
12. Aide Memoire – Preparation Mission - PERU - Health Sector Reform II (PARSALUD II) - From March 9th to 15th, 2006.
13. Aide Memoire Preparation Mission - PERU - Health Sector Reform II (PARSALUD II) - From November 14th to 23rd, 2005.
14. Aide Memoire – Pre Identification (Exploratory) Mission IBRD-IADB - PERU - Health Sector Reform II (PARSALUD II) September 6-14, 2005
15. Implementation Completion and Results Report (ICR) – PARSALUD I – March 2007

* *By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas*

16. Ugarte Ubilluz, O. Aseguramiento Universal en Salud en el Peru. Ministerio de Salud. Nov 2008
17. Velásquez, Anibal; Seclén Y, Poquioma E, Cachay C, Espinoza R. Munayco C. La Carga de Enfermedad y Lesiones en el Perú. Mortalidad, Incidencias, prevalencias, duración de la enfermedad, discapacidad y años de vida saludables perdidos. Febrero 2008
18. MINSA. Plan Esencial de Aseguramiento en Salud (PEAS). Tomo II Costos Totales de los esquemas de manejo integral de las condiciones asegurables para el I nivel de atención. Abril 2008.
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