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ISSUES REGARDING THE PERUVIAN MATERNAL
AND CHILD HEALTHCARE SYSTEM

A project based upon an independent investigation, submitted
in partial fulfillment of the requirement for the degree of
Bachelor of Arts in Social Work.

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2007

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Peruvian Maternal and
Child Healthcare System

Abstract

This paper highlights the deficiencies of the Peruvian Healthcare system. Despite the treaties and covenants the Peruvian government has signed, it has done little to mitigate the ills of its broken healthcare system. Peru's current healthcare system is characterized by inequality between women, children, the poor and the wealthy. Furthermore, there is a lack of accessibility to maternal and child healthcare services that violates every individual's right to health. The Peruvian government has been unresponsive towards the needs of women, children, and rural culture. Ineffective non-governmental organizations (NGOs) have been incapable of alleviating Peru's broken system. Additionally, Peru has not received adequate economic funds from globalization efforts despite the proven success of new programs, particularly the new cultural adaptations to healthcare services that have been implemented. The research performed in this study discovered a statistically significant negative relationship between the amount of Peruvian gross domestic product (GDP) invested in health and the nation's infant mortality rate, proving the importance of government expenditure investment in the healthcare system. This finding proved that as the amount invested in health increased, the rate of infant mortality decreased. In order to increase the quality of healthcare received by Peruvians, especially women and children, it is necessary that more finances be invested into Peru's healthcare system.

I. Introduction

A. Maternal and child healthcare system/services in Peru

1. Globalization → increase in international awareness of other countries in need
2. Underserved population due to unresponsive Peruvian government
3. Necessity of maternal and child healthcare services
 - a. Definition of prenatal/postnatal services (WHO)
 - b. Primary source for healthy pregnancies/afterbirths
4. Individual's right to health
 - a. Definition of right to health (WHO)
 - b. Right to health protected through human rights treaties
5. Peruvian's right to health
 - a. Government signed various international treaties/covenants to protect their citizens' right to health (AI, n.d.)
 - b. Government done very little to implement such treaties (AI, 2006; A.I, n.d.)
 - i. Due to lack of financial means?
 - ii. Due to shortage of service providers?

B. Extent of problems within the Peruvian maternal and child healthcare system/services

1. Affects of lack of appropriate maternal and child healthcare
 - a. Maternal/child mortality rates among highest in bordering countries (AI, n.d.)
 - i. Maternal mortality rate: 190 per 10,000 live births ("PCP," 2007)
 - ii. One death every 8 hrs. due to complications ("Hacia una Reforma," 2005)
 - b. Major affect on the Peruvian population
2. Profession of social work
 - a. Practice
 - i. Dedicated to achieving social justice for all worldwide (IFSW)
 - ii. Promote development in international practices (CSWE)
 - b. Policy
 - i. Advocating for implementation of already signed treaties
 - ii. Level of investment → among lowest in Latin America → show statistics (AI, n.d.)
 - iii. Must be held to all of the standards it has set for itself in the treaties/covenants
 - c. Research
 - i. International research in social planning and policy development (CSWE, IFSW)
 - ii. Research → proper implementation of signed treaties/covenants → social equality and justice in maternal and child healthcare system/service (CSWE, IFSW)

II. Main Points

- A. Affects of globalization on international awareness/responsiveness
 - 1. Globalization Overview
 - a. Definition
 - b. History of globalization (focus on recent)
 - 2. Globalization → increased interest in international healthcare
 - a. Realization of differences between in healthcare countries (wealthy vs. poor nations)
 - b. Maternal and child healthcare systems/services among countries (wealthy vs. poor nations) → Peru example of poor nation
- B. Peru: General overview of population and services
 - 1. General overview of the country to get reader familiar with Peru
 - a. Economic means in comparison to neighboring countries
 - b. Population size and disparity compared to neighboring countries
 - 2. Peruvian maternal and child populations
 - a. Size of populations
 - b. Adversity they face → healthcare system/services
- C. Maternal and child healthcare general overview
 - 1. Definitions
 - a. Maternal and child healthcare
 - b. Pregnancy care
 - c. Childbirth care
 - d. Postpartum care
 - 2. Importance of maternal and child healthcare
 - a. Maternal healthcare services
 - b. Child healthcare services
- D. Peruvian maternal and child healthcare system/services
 - 1. Overview of current Peruvian child healthcare system/services
 - a. Ministerio de Salud de Perú – Ministry of Health (MINSA)
 - b. Seguro Social de Salud de Perú – Peruvian Social Security System (ESSALUD)
 - c. Seguro Integral de Salud – Integral Health Insurance (SIS): Comprehensive Health Insurance
 - d. Comités Locales de Administración de Salud – Local Committees for Health Administration (CLAS)
 - 2. Treaties/covenants signed by Peruvian government
 - a. General Health Act (Law No. 26842)
 - b. Universal Declaration of Human Rights
 - c. United Nations Committee on Economic, Social, and Cultural Rights
 - d. 1994 Action Programme
 - e. Millennium Development Goals of the United Nations (MDGs)
- E. Issues with the current Peruvian maternal and child healthcare system

1. Lack of implementation of the already signed treaties/covenant by the government
 - a. Peru has signed treaties/covenants (discussed above) but has not stuck with the agreements
 - b. Not protecting the women or children's right to health which is mandated in both international and national pieces of legislation
2. Lack of investment
 - a. One of lowest in Latin America
 - b. Although growth in Peru's economy, decline in amount spent on health per person
 - c. Spends more than twice as much per person on health services for those in prosperous areas than poorer areas = money is not equally allocated
 - d. United Nations concerns in 2006 regarding level of investment
3. Availability/Accessibility of health facilities/services
 - a. Overall limited resources/facilities
 - b. Urban vs. rural healthcare resources/facilities
 - c. Disparity in cesarean section and prenatal care
4. Identity documents and certificates of live birth
 - a. No identity document → hinders access to Comprehensive Health Insurance health services because need identity document to register for these services
 - b. Obstacles for getting an ID
 - i. High cost of National Identity Document, but Ministry of Health says Certificate of Birth is to be free
 - ii. Women and children without IDs
5. Illegal charges for health care
 - a. Some health centers fine for birthing at home
 - b. Even though covered by Comprehensive Health Insurance, some charge for supplies: gloves, transfer to hospital, ultrasound scan, drugs, etc.
 - c. 2003 Pan American Health Organization/Peru's Ministry of Health: 40-30% in 2002 paid for examinations & X-rays, 15% for analyses & drugs
6. Cultural discrimination
 - a. Mistrust of personnel at a health centre & the techniques used during childbirth
 - b. Birthing at the centre vs. birthing at home
7. Lack of adequate health care personnel
 - a. Lack of training of health care personnel (education on health and human rights)
 - b. Poorer areas have less health care personnel

- c. Poorer areas' health care personnel work for less money and longer hours → lesser quality work
- 8. Ineffective non governmental organizations
 - a. Definition of NGO's
 - b. History of NGO's in Peru
 - c. Issues with NGO's
 - i. Most located in urban areas b/c they are more developed (need to be in less developed areas)
 - ii. Assumption that technology can save "third world" countries
 - iii. Struggle to achieve sustainability – help people who can't pay so rely on grants and donations to operate (often short term → hard to achieve sustainability)

III. Opposing Points

- A. Globalization's negative affects on international healthcare systems
 - 1. Financial flow has bypassed low-income countries
 - 2. Lack of financial flow leads to inability to supply adequate healthcare services
- B. Adequate Investment
 - 1. History of Peruvian investment
 - 2. Recent Peruvian investment
 - a. Not due to fiscal priority → tax revenue as a percent of GDP has been low
 - b. Increase in social expenditures: payroll
- C. Availability/Accessibility of health facilities/services
 - 1. Comprehensive Health Insurance – Seguro Integral de Salud (SIS)
 - a. Free access to healthcare for pregnant women and children
 - b. Foundation for protection of health for all individuals
 - 2. Infant mortality rate as an indicator
 - a. Continuously decreasing
 - b. Equivalent to Latin American average
- D. Implementation of signed treaties/covenants
 - 1. Comprehensive Health Insurance → right to health for all individuals by universal free healthcare access
 - 2. User Identification System → assesses ability to pay for treatment, promotes right to health
- E. Working with cultural and racial differences
 - 1. Modifications made between 1999 and 2001
 - a. Promote communication: requires to inform patients why they are carrying out certain examinations → gaining trust
 - b. Family member given placenta after birth
 - c. Kitchen so can prepare household remedies
 - 2. 2003 assessment of program: 90% felt well cared for and would recommend services, 80% confirmed understanding everything that was said because done in native language

3. Technical Standards for Attending Delivery in an Upright Position: adopted August 2005
 - a. Can be accompanied by family member
 - b. Little lighting, comfortable temperature
- F. Adequate health care personnel
 1. USAID general overview and history
 2. USAID partnerships with universities and professional associations → certification and accreditation
- G. Effective non governmental organizations
 1. Exact number of NGOs in Peru is unclear but success is apparent
 2. General accomplishments/list of various NGOs
 3. United Nations Children's Fund (UNICEF)
 - a. History: when and why it was created
 - b. Current: locations and work
 - c. Peru: priorities and accomplishments

IV. Hypothesis

- A. Synthesis of main and opposing points
 1. Inadequate availability/accessibility hinders ability to receive appropriate care
 2. Efforts made to make change in the healthcare system
 3. Healthcare system still inadequate despite adaptations
- B. Expected relationship between level of financial investment in healthcare system and maternal/child mortality rates in Peru (compare decades 1970-2010)
 1. As financial investment increases, mortality rate decreases
 2. As financial investment decreases, mortality rate increases

V. Methodology

- A. Sample: type/how selected/number
 1. The sample is a convenient sample
 2. Sample made up of six pieces of literature
- B. Data Gathering: method/tools/variables
 1. Found through exploration of the internet and printed materials
 2. Independent variable: amount invested in health
 3. Dependent variable: infant mortality rate in Peru
- C. Data Analysis: application of statistical procedures to derive meaning from the data gathering tool
 1. Statistical Package for the Social Sciences (SPSS)
 2. Tested for a correlation between the two variables
 3. Tested for statistical significance of the relationship
- C. Findings: results of statistical procedures
 1. Statistically significant negative relationship → hypothesis was correct.
 2. Pearson Correlation of $-.890$
 3. Statistically significant at a $.017$ level (99% chance it's true)
 4. Coefficient of determination → 79%

VI. Conclusion

- A. Restatement of what the problem is, what was hypothesized, what was found, and a concluding statement
- B. Implications for social work
 - 1. Practice → advocacy for the implementation of covenant and treaties
 - 2. Policy → development and implementation of new legislation
 - a. Mandate implementation of agreements
 - b. Mandate specific percentage of GDP investment in health
 - 3. Research → affects on external validity
 - a. Lack of information across many years
 - b. Lack of information of maternal mortality rates
 - c. Study's uncontrolled factors
 - i. Natural disasters
 - ii. Private expenditure investment in health

Preface

Globalization has increased international awareness of the failings of many healthcare systems, particularly the failings of the Peruvian healthcare system. Peru, located in South America, is largely divided into rural and urban populations. These differences in population reflect the differences in the nation's healthcare system. Maternal and child healthcare services are specifically poor in Peru and consist of such services as pregnancy care, childbirth care, and postpartum care. The current maternal and child healthcare services are offered through a variety of programs including the Ministerio de Salud de Perú – Ministry of Health (MINSA), Seguro de Salud de Perú – Peruvian Social Security System (ESSALUD), Seguro Integral de Salud – Integral Health Insurance (SIS), and Comités Locales de Administración de Salud – Local Committees for Health Administration (CLAS).

Peru has consistently not lived up to its agreed national and international treaties and covenants pertaining to healthcare. Although Peru's economy has been characterized by steady growth in recent years, Peru remains among the lowest of all Latin American countries in its financial investment in health. Additionally, the availability and accessibility of all citizens to healthcare facilities and services is extremely unequal, with the wealthy having much more access than the poor. Availability and accessibility is further diminished with the requirement of identification documents and certificates of live birth that restrict many impoverished Peruvian citizens from accessing services. Further problems include illegal charges for healthcare, cultural discrimination, lack of adequate healthcare personnel, and ineffective non-governmental organizations (NGOs).

Throughout recent years, there have been signs that the healthcare system is attempting to correct its failings. Such signs include a decreasing infant mortality rate, implementing initiatives of signed treaties and covenants, and working more with cultural and ethnic differences. Despite such recent achievements in the Peruvian healthcare system, it has yet to be provided with sufficient governmental and economic support to make the changes that are necessary in bringing the healthcare system to a level in which all individual's right to health are secure and guaranteed.

Introduction

Globalization has brought about an increase in awareness of healthcare services and programs that are provided throughout the world in varying countries (Woodward, Drager, Beaglehole, & Lipson, 2001). Dependent upon the economic means of a country, a range of services and the quality of services provided may vary. Wealthy nations have started to take notice of the needs of people in developing countries and in their governments' unwillingness or inability to provide necessary care and services to their citizens (Birdsall, Rodrik, & Subramanian, 2005). Peru, the poverty stricken nation of South America, is a fine example of a country where a variety of populations are underserved. The availability of maternal and child healthcare services to the general Peruvian population, and especially those living in extreme poverty, has become increasingly infeasible. Despite the treaties that have been signed and the promises that have been made, the lack of accessibility to maternal and child healthcare services, due to an unresponsive government, has developed into a matter that violates every individual's right to health (Amnesty International, 2007; Amnesty International, 2006; Amnesty International, n.d.).

It is crucial that maternal and child healthcare services be present from the time of conception and continue following childbirth and through to the child's adolescence ("WHO Recommended Interventions," 2007). Prenatal to postnatal services include a variety of interventions such as monitoring the progress of pregnancy and the assessment of maternal and fetal well-being, the treatment of abnormalities and complications during pregnancy, childbirth, and post childbirth, and the evaluation of both the mother and child following a premature birthing ("WHO Recommended Interventions," 2007).

These healthcare interventions are a primary source for the development and maintenance of healthy pregnancies and afterbirths ("WHO Recommended Interventions," 2007). Such medical assistance and maternal healthcare offerings are considered to be elements of all individuals' right to health ("WHO: The Right to Health," 2007). The right to health has been preserved and protected in an assortment of national constitutions as well as community and international human rights treaties ("WHO: The Right to Health," 2007). The right to health signifies a government's requirement to generate conditions in which each individual has the capability to be as healthy as possible ("WHO: The Right to Health," 2007).

Peru has taken part in the signing of treaties particular to the protection of an individual's right to health, including such covenants as the 1978 International Covenant of Economic, Social and Cultural Rights and the 1998 Universal Declaration of Human Rights (Amnesty International, n.d.). Despite the fact that Peru has taken steps to assure the right to health for all, it has done very little within its own borders to implement the directives of the signed treaties (Amnesty International, 2006; Amnesty International, n.d.). Whether it is due to the poor financial means of the nation or the possible shortage

of service providers, the Peruvian government has demonstrated a lack of dedication and commitment to the standards it has agreed upon regarding the right to health. This serves to greatly disturb the daily lives of Peruvian women and children (“Encuesta Demográfica,” 2001, as cited in Amnesty International, n.d.).

This vulnerable population’s lack of appropriate and accessible healthcare continues to take a toll on their health and overall lives. The official maternal and child mortality rates in Peru are amongst the highest in its bordering countries (Amnesty International, n.d.). In 2006, the maternal mortality rate was 190 women per 100,000 live births, indicating that a woman dies as a result of pregnancy, confinement and postpartum complications every eight hours (“Hacia una Reforma,” 2005, as cited in Amnesty International, n.d.; “Peru Country Profile,” 2007).

The work to be done in addressing the social policies of Peru includes not only the development of new policies and standards regarding maternal and child healthcare, but also advocating for the implementation of the international and regional covenants that the Peruvian government has agreed to (Amnesty International, 2007). Peru’s level of investment in health is among the lowest in Latin America. In 2003, only 2.1% of gross domestic product was invested into the health care system, a percentage much lower than other countries with similar per capita, including Costa Rica (4.9%) and Colombia (4%). Bolivia, whose per capita income is less than Peru’s, also invested more in health care with its investment of 4.3% (Amnesty International, n.d.). Policy implementation and further research on methods of providing adequate maternal and child healthcare services, such as an increase of investment in health, are essential for the improvement of care in Peru (Amnesty International, n.d.).

The Peruvian government must be held to the standards that it has set for itself in its signing of treaties so that the women and children within its borders will receive the care they have been promised. Through international research and understanding of the need for participation in social planning and policy development, the issues surrounding the necessity of adequate and freely accessible Peruvian healthcare services become obvious. These issues can be implemented and adjusted in a manner to bring about social equality and justice in the healthcare system in protecting every individual's right to health ("CSWE: Council of Global Learning," 2007; "IFSW – Aims of the IFSW," 2005; Amnesty International, n.d.).

Social work is a unique profession that extends across all nations and prides itself in its dedication to achieving social justice for all individuals in hopes of enhancing and improving their quality of life ("IFSW – Introduction," 2005). Social workers are to promote their development and competency in international practices so as to be able to assist inhabitants of all nations, such as the significant population of Peruvian women and children ("CSWE: Council of Global Learning," 2007).

Affects of Globalization on International Awareness

Globalization Overview

Globalization is defined as the increasing integration of economies and societies that takes place between various nations from all around the world (Dollar, 2007). The most recent wave of integration began in the early 1980s as a result of the combination of advances in transport and communications technology ("Globalization," 2007). Due to these advances, large developing countries began to seek foreign investment by opening their borders to international trade (Dollar, 2007). The flow of international trade between

states began to increase exponentially as nations lowered their high import barriers, resulting in widespread economic benefits amongst developing countries (Watkins, 2002). Those who strongly increased their foreign trade experienced a rise in aggregate per capita growth from 3 percent in the 1970s, to 5 percent in the 1990s (Dollar, 2007).

The increasing movement towards integration amongst nations did not prove to have the same positive affect for all. While creating new markets of wealth in higher level developing nations, globalization also began to generate a large amount of disorder and unrest amongst lower level developing and Third World countries (“Globalization,” 2007). In an effort to integrate world markets as a means of equalizing nations, globalization began to form an uneven development amongst nations resulting in the rise of living standards for the wealthy at the expense of the poor (Krugman & Venables, 1995). Despite economic recovery, at the end of the 1990s, an added 15 million people were living below the \$1 a day poverty line as a result of the increase in integration of trade (Watkins, 2002).

Increase in International Awareness of Health Services

The difference in financial gains between higher level developing and lower level developing nations affects not only the population’s level of poverty, but also the level of various services they receive (Dollar, 2007). The unequal benefits of globalization have brought about an increase in international awareness regarding the link between globalization and healthcare services (Woodward, Drager, Beaglehole, & Lipson, 2001). The widening of inequality among nations is now being used as a means of justifying the demand for aid in support of a change in unequal healthcare opportunities in Third World countries (Krugman & Venables, 1995). Nations are beginning to realize that through

integration, they must work to ensure changes in international rules and institutional arrangements. International rules and institutional arrangements must fully reflect the needs of deprived nations so as to utilize the economic benefits of globalization for the betterment of their healthcare systems (Woodward et. al, 2001).

The differences in healthcare systems, and more specifically those involving maternal and child healthcare services, are beginning to make their way to the forefront of international concern in the need for change (Woodward et. al, 2001). Such developing nations as Peru, serve as an excellent example of the inequality of maternal and child healthcare opportunities among the wealthy and poor (“A New Social Contract,” 2006). Peru’s maternal and child healthcare system embodies the challenges and struggles that are faced by developing nations in their attempt to bring about greater accessibility of adequate healthcare for all (“A New Social Contract,” 2006).

Peru: A General Overview of the Nation

Peru is located in the western half of South America on the coast of the Pacific Ocean. Bordered by five other South American countries, Peru is divided into 25 regions and the province of Lima, covering over 1,285,220 km². Approximately 60% of Peru’s land is made up of flat terrain of the Amazon rainforest (“Country Profile: Peru,” 2007). With a population size of 28.4 million individuals, Peru is the fourth most populous country in South America (“Peru Country Profile,” 2007). As of 2005, 72.6% of the Peruvian population resided in urban areas and the remaining 27.4% in rural areas (“Country Profile: Peru,” 2007). Peruvian citizens span from a wide range of diverse backgrounds including Europeans, Africans, Asians, and Amerindians, which are to be considered the indigenous population of Peru (“Peru Country Profile,” 2007).

Peru is regarded as a developing country with a poverty level of approximately 50% and a 2004 medium Human Development Index score. The Human Development Index score is calculated by taking into account a population's life expectancy, literacy, education, and standard of living ("Country Profile: Peru," 2007; Stockholm, 2002). Due to these lack of means and resources of the general population, Peruvian mothers and children are unable to receive the appropriate and necessary healthcare services that they deserve ("Improving Health Care," 1999).

Maternal and Child Healthcare

Definitions

Maternal and child healthcare. Maternal and child healthcare refers to the care and services a woman and child receive during pregnancy, childbirth, and the postpartum period ("WHO Recommended Interventions," 2007).

Maternal and Child Healthcare Service Interventions

Pregnancy care. Pregnancy care takes place throughout the nine months of the woman's pregnancy. Pregnancy care services include the confirmation of pregnancy, the monitoring of progress, assessment of maternal and fetal well-being, detection of problems complicating pregnancy (i.e. anemia, bleeding, multiple pregnancy), tetanus immunization, and syphilis testing ("WHO Recommended Interventions," 2007). Additional care services include treatment of mild to moderate pregnancy complications, pre-referral treatment of severe complications, and the provision of support for women with special needs ("WHO Recommended Interventions," 2007).

Childbirth care. Childbirth care services occur during the period of labor, delivery, and immediate postpartum. These services include such necessary interventions

as diagnosis of labor, detection of problems and complications, delivery and immediate care of newborn, newborn resuscitation, and the monitoring and assessment of maternal and newborn well being following the time of delivery (“WHO Recommended Interventions,” 2007).

Postpartum care. Postpartum maternal and newborn care takes place throughout the six week period following immediate postnatal childbirth. The service interventions that take place during the time following childbirth include such services as promotion, protection, and support for breastfeeding, monitoring and assessment of maternal and child well being, child eye care, child immunizations according to national guidelines, and maternal anemia prevention and control (“WHO Recommended Interventions,” 2007).

Importance of Proper Maternal and Child Healthcare Services

Maternal healthcare services. Each year, an estimated 529,000 women die during pregnancy and childbirth (“Adverting Maternal Death,” 2006). Complications experienced during pregnancy and childbirth is the fourth leading cause of death and disability among women, following HIV/AIDS, malaria, and tuberculosis (“Maternal Health,” 2000; “World Health Report,” 2004). Ninety-nine percent of these women who die during or after childbirth are from developing nations, such as Peru (“World Health Report,” 2004). For every woman who dies as a result of pregnancy or childbirth, approximately 20 more suffer from acquired disabilities, representing at least 10 million women each year (“Maternal Health,” 2000).

Women are in most need of care during delivery and the immediate postpartum period due to the fact that roughly three quarters of maternal deaths occur during this

point in time of childbirth (“Maternal Health,” 2000). Delivery services, especially those of emergency obstetric care, are critical for the well-being of women. Obstructed or prolonged labor is one of the more serious complications that often times causes maternal morbidity and death, thus reinforcing the importance of maternal healthcare services during the birthing process (Reynolds, Wong, & Tucker, 2006).

Child healthcare services. Receiving adequate prenatal care is important for the growth and development of a child while in the womb. Prenatal care has shown to significantly improve the birth weight of a child which is notably related to the overall health and well-being of a newborn (Reynolds et. al, 2006).

The newborn’s first 28 days, which is referred to as the neonatal period, is the most vital time period for receiving proper child healthcare services. It is during this time that the fundamental health and feeding practices of the child begin to establish and in which the child is at highest risk of death (“Overview of CAH,” 2004).

Peruvian Maternal and Child Healthcare System

Overview of Current System

Ministerio de Salud de Perú – Ministry of Health (MINSA). The Ministry of Health (MINSA) is one of the main public healthcare programs in Peru. The MINSA program is financed by tax revenues and co-payments made by users (“Improving Health Care,” 1999). MINSA’s responsibilities include the regulation of the Peruvian health system and the provision of clinical services, including the nation’s immunization program and all vector control activities (“A New Social Contract,” 2006; “Improving Health Care,” 1999).

The majority of the country's primary health care services are provided by MINSA ("A New Social Contract," 2006). The importance of the services provided is largest for the Peruvian population which makes up the bottom 20% of all income levels. This population obtains 70% of their health benefits from MINSA, in comparison to the richest quintile who obtains only 20% of their health benefits from the program ("Improving Health Care," 1999).

More than 80% of the centers, health posts, and Primary Health Clinics (PHC) are part of the MINSA program ("A New Social Contract," 2006). Although MINSA accounts for less than a third of Peruvian hospitals, it accounts for more than two-thirds of the total number of available beds within them, encompassing a large majority of the hospital population ("Improving Health Care," 1999; "A New Social Contract," 2006).

Seguro Social de Salud de Perú – Peruvian Social Security System (ESSALUD). The Peruvian Social Security System (ESSALUD), formally known as IPSS, is another main public healthcare program in Peru. Unlike MINSA, ESSALUD finances and delivers care to formal sector workers and their dependants ("Improving Health Care," 1999). The majority of its beneficiaries are concentrated among the richer 40% of the population, but at the same time the program provides almost a third of outpatient consultations to the population as a whole ("Improving Health Care," 1999). ESSALUD also has a stronger emphasis on secondary and tertiary service, and has a smaller proportion of primary clinics while still having a significant share of hospital beds and physicians ("Improving Health Care," 1999).

Seguro Integral de Salud – Integral Health Insurance (SIS). At the end of the 1990s, the Peruvian government developed a program known as Mother-Child Insurance

(SMI) which extended coverage to underserved mothers and children. In 2001, this program merged with the Schoolchildren Insurance (SEG) to become the new comprehensive health insurance program called Integral Health Insurance (SIS). SIS became a Decentralized Public Body that remains connected to MINSA (“A New Social Contract,” 2006).

The objective of SIS is to protect the health of Peruvians without insurance, while giving priority to vulnerable populations that may be living in extreme poverty. The insurance program works by reimbursing public providers of MINSA for their various costs and plans which they have provided as service to underprivileged individuals (“A New Social Contract,” 2006). The five reimbursement plans provided by SIS are as follows: Plan A represents children 0 to 4, Plan B is for children and adolescents age 5 to 17, Plan C for pregnant women and women in puerperium, Plan D for adults in emergency situations, and lastly, Plan E targeted to adult groups that have been defined by law (“A New Social Contract,” 2006).

Comités Locales de Administración de Salud – Local Committees for Health Administration (CLAS). The Local Committees for Health Administration (CLAS) were developed as nonprofit institutions established by local community members to administer primary-care clinics. The committees receive public funding to produce services which are specified in a three-year contract, agreeing with health authorities on targets and services (“A New Social Contract,” 2006). Financed by the government, CLAS are given the opportunity to manage public facilities to practice population-based local health plans. CLAS operate approximately 10% of all MINSA clinics throughout Peru (“Improving Health Care,” 1999).

Treaties and Covenants of the Peruvian Government

The right to the highest attainable level of physical and mental health of Peruvian individuals has been protected both in international legislation and standards as well as in Peru's national legislation. This legal framework that the Peruvian government has agreed to is to be considered binding to the nation. Peru has also entered into multiple political commitments in international forums in relation to the right to health and, more specifically, in relation to maternal and child health (Amnesty International, n.d). The following include a number of significant treaties, covenants, and national legislation that the Peruvian government has taken part in regarding the protection of every individual's right to health.

General Health Act (Law No. 26842). The General Health Act was enacted by the Peruvian government as a piece of national legislation in July 1997 (Amnesty International, n.d.). In article II of the legislation's introduction, it states that it is the responsibility of the State to regulate, safeguard, and promote the health of all individuals ("Human Rights," 2004). It further specifies in article IV of the introduction, that public health is to be the primary responsibility of the State ("Human Rights," 2004). In 2001, an amendment was made to the General Health Act which extended the right of health to emergency medical and surgical attention during the period of childbirth where the life of the mother or child is at risk ("Peru/Medicine & Health," 2007).

Universal Declaration of Human Rights. The Universal Declaration of Human Rights was originally adopted and proclaimed by the General Assembly of the United Nations on December 10, 1948 and has since continued to be upheld by the UN ("Universal Declaration," 2007). Article 25 of the declaration specifies the protection of

all individuals' right to health. The article reads that every individual has the right to a standard of adequate living for health and for the well-being of the self and of the family. This article also specifies the protection of medical care, especially during times of unemployment, sickness, and disability. In addition, Article 25 further protects an individual's right to health in terms of special care and assistance during the periods of motherhood and childhood ("Universal Declaration," 2007).

United Nations Committee on Economic, Social and Cultural Rights (CESCR).

The United Nations CESCR developed the International Covenant on Economic, Social and Cultural Rights on December 16, 1966 and was put into effect on January 3, 1976 ("International Covenant," 2007). Article 12 of the covenant states that parties of the covenant are to recognize the right of all individual's to enjoy the highest attainable standard of physical and mental health ("International Covenant," 2007). CESCR specifies that the right to health of individuals must include certain legally enforceable components such as health policies and the implementation of health programs which have been developed by the World Health Organization (WHO) ("Substantive Issues Arising," 2000; "Human Rights," 2004).

The Committee has also established that the right to health is to include four major interrelated elements: availability, accessibility, acceptability, and quality of healthcare, facilities, goods, and services (Amnesty International, n.d.). The availability of healthcare refers to the offering of a sufficient quantity of adequate healthcare facilities, programs, and physicians. Accessibility of healthcare signifies the eliminating of barriers, including both physical and economic barriers, which arise as a result of discrimination and lack of provided information. Acceptability indicates facilities and

services that are respectful of medical ethics and cultural appropriateness. Quality of healthcare denotes the requirement of goods and services that are both scientifically and medically appropriate (Asher, 2004).

In addition, the Committee set minimum obligations that are to be met by states to ensure the right to health. These obligations include equitable distribution of all health facilities, the provision of essential drugs to all individuals as defined in the World Health Organization Action Programme on Essential Drugs, and lastly, the adoption and implementation of a national strategy to address the health concerns of the whole population which is to be devised and reviewed periodically (“Substantive Issues Arising,” 2000; Asher, 2004).

1994 Action Programme. In 1994, at the International Conference on Population and Development in Cairo, participating states, including Peru, focused on the need to continue making progress in the reduction of the mortality rates of mothers and children (“Report of the ICPD,” 1994). More specifically, the conference focused on the disparity in mortality rates among developed and developing nations as well as within the nations themselves (Amnesty International, n.d.). The Action Programme that resulted from the conference states that all countries must expand the provision of maternal health services to include prenatal care, maternal nutrition programs, adequate delivery assistance, and emergency obstetric provision (“Report of the ICPD,” 1994).

Millennium Development Goals of the United Nations. The Millennium Development Goals (MDGs) were established in September 2000 at the United Nations Millennium Assembly as a means of synthesizing many of the most important commitments that were made separately at various international conferences and summits

throughout the 1990s (“About the MDGS,” 2007). The MDGs represent a global partnership that has grown as a response to the world’s main development challenges of poverty, maternal health, child mortality, and AIDS (“Millennium Development Goals,” 2007). Two of the eight development goals which are to be reached by 2015 coincide with the issue of maternal and child healthcare; Goal 4 is to reduce by two thirds the mortality rate among children under five, and Goal 5 is to reduce by three quarters the maternal mortality ratio (“Millennium Project,” 2006).

Issues Concerning the Current Peruvian Maternal and Child Healthcare System

Though the Peruvian government has taken part in the development and ratification of both international and state initiatives regarding the protection of maternal and child healthcare for all individuals, the nation continues to struggle with the implementation of such corresponding proceedings (Kaufman & Nelson, 2004). It is important to recognize that a state can violate its obligations not only by what they do, but by what they fail to do as well (Asher, 2004). Peruvian mothers and children continue to be denied their right to health each and every day in both direct and indirect manners (Linares & Pullum, 2007). Despite the steps that have been taken by the Peruvian government, the maternal and child healthcare system is in need of a significant transformation due to its continuance of unequal healthcare provisions which have resulted from the barriers of obtainment that remain (Kaufman & Nelson, 2004).

Lack of Investment in Peruvian Healthcare

Peru’s investment in health is among the lowest in all of Latin America (Amnesty International, 2006). In 2004, public spending on health consisted in 0.7 percent of Peru’s gross domestic product (GDP) in comparison to the continental average of 2.7 percent

("A New Social Contract," 2006). Of the 16 Latin American countries for which there is available comparable data, only Guatemala and Ecuador spent a lesser amount than Peru as a proportion of GDP ("A New Social Contract," 2006).

Despite the steady growth of Peru's economy in recent years, the amount spent on health per person has continued to decline (Amnesty International, 2007).

Underinvestment in health is particularly acute in poor, and predominately rural, areas. The Peruvian government has been found to invest more than twice as much per person on health services in more prosperous regions than in poorer districts (Amnesty International, 2007). This has held true for many years and dates back to the 1980s in which the Lima health region utilized nearly 47 percent of the government's budget for patient-related care, even though the relatively wealthy region made up only 32 percent of the nation's population (Birdsall & Hecht, 1995). The disparity of investment in health among regions continues to this day. Wealthy regions, including Lima and Callao, are allocated approximately 169 nuevos soles (US \$51) per capita, in comparison to regions with lower income levels, including Hauncavelica, Ayacucho and Huánuco, who are allocated less than 80 nuevos soles (US \$24) (Amnesty International, n.d.).

In 2006, The United Nations Committee on the Rights of Children voiced its concerns regarding Peru's level of investment. The Committee became concerned due to the Peruvian government's failure to provide a budget that would meet the economic, social, and cultural rights of children, including their right to health ("Forty First Session," 2006). The Committee recommended that Peru increase its budget allocations so as to guarantee the implementation of these rights, especially for those children who belong to economically disadvantaged groups ("Forty First Session," 2006). The overall

lack of and unequal distribution of governmental investments in the Peruvian healthcare system continues to widen the gap between individuals' ability to maintain their right to health (Kaufman & Nelson, 2004).

Availability and Accessibility of Healthcare Facilities and Services

The availability and accessibility of healthcare facilities and services in Peru are dramatically unequal amongst the population, with the poor having much less access than those who are wealthy (Birdsall & Hecht, 1995). In 2003, the Living Standards Measurement Survey showed that 13.4 million people, making up about half of the Peruvian population, experienced an episode of illness. Of these 13.4 million individuals, only 62 percent received healthcare services. For those who did not receive services, almost two-thirds of them stated that their reasoning for not obtaining healthcare services was due to the fact that they could not afford them ("A New Social Contract," 2006).

Large disparities of access and availability of healthcare facilities and services exist among the rural and urban regions of Peru, especially in services pertaining to the health of women and children (Amnesty International, n.d.). One of the large disparities in provided healthcare services is evident in the rate of cesarean sections performed in rural and urban regions of Peru ("Regional Strategy," 2002). The average rate of cesarean sections in Lima was found to be 26 percent and a 17.5 percent rate in other major cities, compared to less than a 4 percent rate in rural areas ("Encuesta Demografica," 2004). Two-thirds of these individuals from rural regions have to travel more than an hour to obtain such services, compared to the 95 percent of urban region individuals who travel less than half an hour (Birdsall & Hecht, 1995). The inequality between cesarean section rates indicates that due to economic and geographical barriers, women in rural areas who

experience complications during child birth do not have the adequate access to necessary health services as those who live in urban regions (“Regional Strategy,” 2002).

With regard to prenatal care, in 2000, just over 25 percent of women in rural areas did not have access to prenatal care, whereas in cities this figure was only 9 percent (“Encuesta Demografica,” 2000). In 2004, the percentage of women in rural areas who remained without access to prenatal care was still over 25 percent, whereas in urban areas the figure dropped to less than 5 percent (“Encuesta Demografica, 2004). The lack of prenatal care largely affects a woman’s pregnancy and overall well-being of both herself and the child by increasing the risk of infancy death five fold (Linares & Pullum, 2007). Although the inequality in access to healthcare may be among the top concerns of the Peruvian government, it is clear that little has been done to lessen the disparity, indicating a direct violation of the Peruvian government’s participation in the International Covenant on Economic, Social and Cultural Rights (“A New Social Contract,” 2006).

Identification Documents and Certificates of Live Birth

One other factor that limits an individual’s accessibility to healthcare in Peru is the possession of an identification document and the Peruvian Comprehensive Health Insurance scheme. For those who do not have an identification document, the possibility of exercising their right to health and taking part in the Comprehensive Health Insurance scheme is extremely limited due to the fact that in order to register as a user of these services it is necessary to produce an identity document (Amnesty International, n.d.). An estimated three million Peruvian men, women, and children do not have identity documentation. Of these three million, more than a million and a half do not access to these documents (“El Derecho a la Identidad,” 2005).

The large proportion of Peruvian individuals who lack identification documents is due to the obstacles that keep them from obtaining the appropriate documents. One of the major reasons as to why documents have not been obtained by all is due to the high cost of the National Identity Document which many are unable to afford (“El Derecho a la Identidad,” 2005). Other major obstacles in obtaining identification documents exist during the period of childbirth. For those women who do not attend prenatal and postnatal checkups, which makes up approximately 25 percent of women living in rural regions, healthcare facilities impose fines of up to 50 nuevos soles (US \$15) (“El Derecho a la Identidad,” 2005; Amnesty International, n.d.). These women are then denied a Certificate of Live Birth, which is necessary to receive an identification document for a child, until the sum is paid, which for many low-income women is impossible (Amnesty International, n.d.). By keeping women and children from obtaining Identification Documents, the Peruvian government continues to deny them their right to health which is to be protected (“Human Rights,” 2004).

Illegal Charges for Healthcare

Despite the Comprehensive Health Insurance scheme which has been designed to provide free medical care to the low-income population, individuals are still being asked to pay for treatment (Amnesty International, 2006). By law, individuals who are covered by Comprehensive Health Insurance should only have to pay 1 nuevo sol (US \$0.30), which is to be considered as the registration fee for joining the scheme (Amnesty International, 2007). In 2003, more than 30 percent of pregnant women who were affiliated with the Comprehensive Health Insurance scheme were required to pay for analyses and X-rays at various Ministry of Health facilities. Another 15 percent of

women who were part of the scheme paid for examinations and medication (“Análisis y Tendencias,” 2003). Though the Comprehensive Health Insurance scheme is supposed to cover all medical costs and expenditures, healthcare facilities continue to charge scheme participants illegally (Amnesty International, 2007; “Análisis y Tendencias,” 2003).

Cultural Discrimination in Healthcare

Although financial matters play a significant role in receiving healthcare services, the population’s level of trust and comfort with healthcare personnel also has its affects (Amnesty International, 2007). Signs of considerable mistrust in healthcare personnel, as well as the techniques used during childbirth, can account for the reasoning behind why only 21 percent of women in rural regions of Peru gave birth in health centers (“Lineamientos de Política Sectorial,” 2002). Approximately 45 percent of women in 2000 claimed to not have used healthcare services due to the fact that there were no female personnel available at their healthcare facility. These women reported that they would feel embarrassed in exposing their genitals when being examined in a gynecological position by a male physician (“Encuesta Demografica,” 2000). The lack of trust and comfort with healthcare personnel regarding attitudes, beliefs, and customs also account for the 40 percent of Aguarunian and Huambisan women who stated that they had not attended prenatal check-ups during their last pregnancy (Amnesty International, n.d.). Of the 60 percent of women who did attend prenatal check-ups, only 6 percent gave birth in healthcare facilities (Amnesty International, n.d.). Even among the women who were affiliated with the Comprehensive Health Insurance scheme, nearly 90 percent of them had given birth at home, further indicating that motives for not attending a

healthcare facility is not only financial, but also related to the comfort level of a culture as a result of the manner in which services are provided (Amnesty International, n.d.).

Lack of Adequate Healthcare Personnel

The standards of medical education in Peru have been continuously declining with the large-scale and minimally regulated development of new universities of medicine. Many of these newly created universities are located in regions with limited resources that are necessary for the teaching provisions of modern medical education (“Improving Health Care,” 1999).

It is not only the state’s allocation of finances that is unequally distributed throughout the healthcare system, but also the allocation of healthcare personnel (“Compendido Estadístico,” 2003). The disparity between rural and urban regions is significant. Peru’s capital city of Lima has 22 doctors, 11 nurses and 3 obstetricians working within its region for every 10,000 inhabitants. Comparatively, Ayacucho has 5 doctors, 7 nurses, and 4 obstetricians for every 10,000 inhabitants, and Huancavelica has 4 doctors, 3 nurses, and 4 obstetricians for every 10,000 inhabitants (“Compendido Estadístico,” 2003). This difference in numbers clearly represents the inequality of accessibility of healthcare physicians for those who reside in rural areas of Peru (“Compendido Estadístico,” 2003).

The allocated healthcare personnel in rural areas cause issues not only in their limit of number, but also in their limited job security that is due in part to the fact that a large portion of the staff is employed on *Contras por Servicios No Personales*. *Contras por Servicios No Personales* is a form of contract in which personnel do not have any job security or employment rights (Amnesty International, n.d.). These staff members, who

are contracted to service users covered by the Comprehensive Health Insurance scheme, work the same amount of hours as appointed professionals but receive a significantly lower salary and do not receive paid time off for holidays, sick leave, or maternity leave (Amnesty International, n.d.). Due to the lack of job stability in these positions, many healthcare facilities experience a high level of turnover rates in personnel, resulting in a lesser quality of work and an unstable healthcare environment of healthcare personnel (“Improving Health Care,” 1999).

Ineffective Non-Governmental Organizations (NGOs)

Definition. A non-governmental organization (NGO) is any non-profit citizens’ group which has been organized on a local, national, or international level. NGOs perform a wide range of task-oriented services and humanitarian functions as a means of bringing about political change through their advocacy and monitoring of governmental policies (Reilly, 1995).

History of Peruvian NGOs. Non-governmental organizations have had a somewhat short history of development in the nation of Peru, stemming back to their beginnings in the late 1970s. Throughout the late 1970s and 1980s, Peru underwent substantial economic and governmental modifications in which many political representatives and municipal officers were acquired from NGOs (Kaufman & Nelson, 2004; Reilly, 1995). Though many members began to move into the political arena, Peruvian NGOs remained separate and apart from the political parties, instead turning their focus and expertise towards the encouragement and support of grassroots activities (Reilly, 1995).

Current Peruvian NGOs. Today's Peruvian NGOs cover a wide variety of political issues from environmental concerns to the protection of the right to health. The work that NGOs have done throughout the years concerning the right to health has consisted primarily of education and advocacy (Reilly, 1995). Though the NGOs have done a great deal of work in compiling information regarding the issues surrounding individuals' right to health in Peru, little change in the availability and accessibility of adequate healthcare services has resulted (Linares & Pullman, 2007; "A New Social Contract," 2006). Not only has there been little change as a result of the work done by the NGOs, but throughout the years of NGO establishment in Peru, a great deal were focused in urban regions. At one point in time, 67 percent of the NGOs working in Peru were located in Lima (Reilly, 1995). This figure does not even begin to include the percentage of NGOs located in other major cities throughout Peru. It is apparent that the work of the NGOs can be successful in bringing about political change in regards to issues concerning the maternal and child healthcare system, but the NGOs must now refocus on the tasks at hand and devise an improved plan of action to bring about greater changes in the Peruvian healthcare system (Reilly, 1995).

Adequacy in the Current Peruvian Maternal and Child Healthcare System

Globalization's Negative Affects on International Healthcare Systems

Over the last two decades, economic globalization has shown to be the primary driving force behind the overall process of globalization (Woodward et. al, 2001). The financial flow among nations once consisted mostly of aid and commercial loans to governments but has slowly transformed into the private sector in which it is dominated by investments in productive capabilities by intercontinental corporations and by the

buying of shares by institutional investors (Woodward, 1998). This transformation of financial flow however, has largely bypassed low-income countries, such as Peru, who remain critically dependent on such aid flow (“Global Development Finance,” 2001).

The lack of economic benefits of globalization extending to all countries proves to greatly affect a nation’s healthcare sector. The link between the success of a national economy and the healthcare sector requires economic growth to be sustainable and deliberately directed towards the poor, which for many low-income countries depends on the financial aid they receive through the economic process of globalization (Woodward et al., 2001). The economic resources generated from globalization have yet to become more favorably distributed to developing nations as a means of strengthening their healthcare systems so as to be able to provide widespread access to cost-effective health interventions (Woodward et al., 2001). Without the financial aid supplied through globalization, developing nations continue to suffer, more than others, in their ability to supply adequate healthcare services (“Trade in Health Services,” 2002).

Adequate Investment by Peruvian Government

History of Peruvian investment. During the 1980s, Peru’s economy was deeply disturbed by inflation and weighed down by debt obligations (Thorp, 1996). The financial state of the Peruvian economy greatly affected the health sector. Health spending was low and unevenly distributed among geographical regions as well as across various sectors of the healthcare system (Kaufman & Nelson, 2004). Observed over an extended period, Peru spent the greatest amount on healthcare in the 1970s and early 1980s. Due to the economic crisis of the 1980s, healthcare budgets decreased drastically, hitting its lowest point of investment in 1990 and 1991 (“A New Social Contract,” 2006; Kaufman &

Nelson, 2004). Even after the beginning of its recuperation in healthcare spending in 1992, the Peruvian government was still unable to match its previous levels of investment. In 1994, the per capita spending on health by the central government was 7 soles, compared to 19.4 soles in 1970, and 21 soles in 1980 (“El Desafío de Cambio,” 1996).

Recent Peruvian investment. In comparison to fellow Latin American countries, Peru’s basic investment in the healthcare sector proves to be less than others (Amnesty International, 2006). Despite its inferior investments in relation to its neighboring nations, Peru’s level of health expenditures is not due to the government’s fiscal priority, but more in part due to tax revenues as a percent of GDP being low. This low level of tax revenue restricts the Peruvian government’s ability to invest an equivalent amount of health expenditures with respect to other Latin American nations, forcing the government to invest a level that is appropriate for its means (“A New Social Contract,” 2006).

Following a small reduction in social spending in 2000, social expenditures began to moderately increase from 5.1 to 5.5 percent of GDP in 2004 (“A New Social Contract,” 2006). With the increase in social expenditures came an increase in payroll investments for those working in the healthcare sector. From 1999 to 2005 the payroll investment increased from 36 percent to 54 percent, due in some measure to the increase in hiring of individuals as well as to the increase in wages and benefits for healthcare workers (“A New Social Contract,” 2006). By increasing the investment in payroll and benefits of healthcare service providers, the Peruvian government is able to provide a greater number of healthcare professionals to the general population (Amnesty International, n.d.).

Adequate Availability and Accessibility of Healthcare Facilities and Services

Seguro Integral de Salud – Integral Health Insurance (SIS). In 2002, the Peruvian government introduced the Comprehensive Health Insurance scheme Seguro Integral de Salud (SIS) as a means of providing a number of healthcare plans, including free access to health for children less than five years of age as well as for pregnant women and new mothers who live in poverty (Amnesty International, 2007). Despite recent concerns regarding various illegal medical charges towards members of the SIS plan enacted by a number of healthcare facilities, the Peruvian government has developed a foundation for the protection of health for all individuals without insurance (Análisis y Tendencias,” 2003; “A New Social Contract,” 2006).

As of 2004, Seguro Integral de Salud covered 33.4 percent of the Peruvian population which consisted of approximately 9 million individuals, with a perspective target of covering 13 million Peruvians. Almost 70 percent of the resources of SIS in 2004 were directed specifically towards Plan A and Plan C, representing those of age 0 to 4 and women who are pregnant or in puerperium. Between 2000 and 2004, SIS proved to achieve wide coverage in maternal care in that attention for deliveries in healthcare facilities increased from 57.9 percent to 70.4 percent, and professional attention for deliveries increased from 57.5 percent to 71.1 percent (“A New Social Contract,” 2006).

Infant mortality rate as an indicator. The continuously decreasing infant mortality rate in Peru serves as a further indicator of the increasing availability and accessibility of healthcare facilities and services. Throughout the last decade, the decline in Peruvian infant mortality has been comparatively higher than that which has been experienced in other Latin America nations (“A New Social Contract,” 2006). From 1991 to 2005, Peru

experienced a decrease from 64 to 23 infant mortalities per 1,000 live births (UNICEF, 2007; “A New Social Contract,” 2006). With a rate of 23 deaths per 1,000 live births, Peru has been able to reach the Latin American average rate of infant mortality.

Additionally, comparing the period of 1995-2000 with 2000-2005, Peru experienced an infant mortality reduction of 32.6 percent, 12 percent more than Latin America’s reduction average of 20.6 percent. These significant decreases further signify the increasing services that are available to the Peruvian population (“A New Social Contract,” 2006).

Implementation of Signed Treaties and Covenants

Throughout the development and ratification of both international and state initiatives regarding the protection of maternal and child healthcare, the Peruvian government has made great strides in its implementation of the corresponding treaties and covenants. Most significantly, Peru’s development and implementation of its Comprehensive Health Insurance scheme (Seguro Integral de Salud – SIS) as well as its User Identification System (Sistema de Identificación de Usuarios – SIU), have allowed the government to work towards its protection of all individuals’ right to health (Amnesty International, n.d.; Bacheller, Cavanaugh, Stewart, & Zinner, 2005). Seguro Integral de Salud (SIS) ensures access to basic health services for those living in poverty and consists of five different insurance plans which cover various groups of individuals including mothers and children (Análisis y Tendencias,” 2003). The five insurance plans are broken down into the following: Plan A, representing children 0 to 4 years of age, Plan B for children and adolescents age 5 to 17, Plan C, for women who are pregnant or in

puerperium, Plan D, for adults in emergency situations, and Plan E, representing specific adult groups which have been defined by law (“A New Social Contract,” 2006).

Peru’s User Identification System (SIU) is utilized to assess and determine each individual’s ability to afford various treatments provided by the Comprehensive Health Insurance scheme. An individual’s purchase power is determined through the use of the Socio-economic Evaluation Sheet (Ficha de Evaluación Socioeconómica – FESE) which takes into account a person’s financial capabilities. Depending on the individual’s purchasing power, they are expected to pay all, part of, or none of the cost of the medical care which they have received (Bacheller et. al, 2005). Through the development and success of such programs as the Comprehensive Health Insurance scheme and the User Identification System, the Peruvian government has demonstrated the means of their ability to provide a right to health for all individuals.

Working with Cultural and Racial Differences

In examining the way in which healthcare services had been provided, the Peruvian government realized that many were done so in a manner that reflected a lack of understanding and compassion towards Peruvian natives and their cultural beliefs. Over the past decade, many changes have been implemented in corresponding prenatal and delivery services as a means of providing medical interventions in a more culturally competent manner (Amnesty International, n.d.).

Modifications: 1999-2001. Through the years of 1999 to 2001, a culturally-adapted project was put into affect so as to provide more appropriate sexual and reproductive health services (“Modelo de Atención,” 2003). The aim of the project was to promote communication between health professionals and the community as a means of

increasing the development of trust amongst the two groups. The project included measures that adapted prenatal checkups and delivery services in which they were able to become more culturally sensitive (“Modelo de Atención,” 2003). These specifications included creating a private environment with the use of curtains so as to provide an atmosphere that excludes those who are not involved in the birthing process. The room is also to be provided with a bed and a sturdy rope, allowing the woman to hold herself up as a means of giving birth in an upright position. The protocol for care also stipulates that spouses, and/or family members would be able to attend all prenatal checkups as well as the delivery (“Modelo de Atención,” 2003). The facility in which the delivery takes place is also to provide a kitchen area where the husband or other family members are able to prepare household remedies which are to be used during and after delivery. Following delivery procedures, it is also mandated that the placenta is to be given to the family member present so that it may be buried in its proper traditional manner (“Modelo de Atención,” 2003). The code of behavior further specifies that the individual attending the birth, whether it is a clinician or another type of healthcare professional, should speak Quechua and preferably be female so as to make the birthing process more understandable and relaxed for the mother and her family (“Modelo de Atención,” 2003).

Outcomes of 1999-2001 modifications. The culturally sensitive modifications that were developed regarding prenatal and delivery services proved to have positive affects in regards to the comfort level of those who were provided with such interventions. In 2003, 90 percent of users who were interviewed stated that they felt well cared for and would recommend such services to family and friends (“Modelo de Atención,” 2003). These women also confirmed that due to their comfort level, in the future they

themselves would have their next child delivered at the healthcare facility. In regards to their understanding of the procedures as well as anything else that may have been explained by the healthcare professional, 80 percent confirmed that their comprehension of the overall delivery process was due to the fact that the procedure was conducted in Quechua (“Modelo de Atención,” 2003).

Ministry of Health technical standard. In August 2005, the Ministry of Health developed a technical standard that further mandated appropriate standards for a culturally sensitive delivery process. The Technical Standard for Vertical Delivery Assistance with Intercultural Adaptation not only specified the importance of allowing a woman to give birth in an upright position, but additionally stated that the delivery environment is to consist of low level lighting, no light colors, and a comfortable temperature (Ministerio de Salud, 2005). One of the most significant details of the standard is the established responsibility of the healthcare professional to inform the women of the reasoning as to why they are carrying out particular examinations throughout the time of pregnancy and delivery so as to allow for freedom of expression and action from the women in accordance with their cultural customs (Ministerio de Salud, 2005).

Adequate Healthcare Personnel

United States Agency for International Development (USAID). USAID is an independent federal government agency of the United States that originated in 1961 to assist struggling foreign nations (USAID, 2007). USAID’s multipronged work in the Peruvian healthcare system has recently began to focus in on working towards a certification system for healthcare professionals as well as a system of accreditation for

academic institutions that train and education healthcare personnel (USAID, 2005). In working with the Ministry of Health in 2005, USAID's strategy for improving the skills of healthcare personnel through its support of the accreditation of professional training institutions and certification of healthcare professionals advanced more rapidly than expected. Out of Peru's 80 universities, 50 had been brought into the new accreditation methodology (USAID, 2005). With the increase in accredited educational programs came an increase in both the number of births attended by a healthcare professional and in the number of patient visits. From 2002 to 2005, the total number of births attended increased from 514 to 572, and the number of patient visits increased from 166,078 to 226,091. The work of USAID has brought about a drastic change in the educating and training of healthcare personnel in Peru. This change has since allowed for a greater number of adequate healthcare professionals to be available to the Peruvian population which has lead to overall improved service in the healthcare sector (USAID, 2005).

Effective Non-Governmental Organizations (NGOs)

Although the exact number of non-governmental organizations involved in the maternal and child healthcare sector of Peru is unclear, the amount of progress and success they have had throughout the years is not. NGOs have been considerably responsible for the growth in healthcare facilities and services which have resulted from their hard work and dedication towards providing adequate healthcare for all (UNICEF, 2007). Various significant NGOs working in Peru include Oxfam, Provida Perú, CARE, Direct Relief International, and UNICEF.

United Nations Children's Fund (UNICEF). UNICEF was created on December 11, 1946 by the United Nations General Assembly to provide emergency food and

healthcare to children who had been devastated by World War II. Now present in 191 countries around the world, UNICEF continues to reach out to the needs of children all around the world (“About UNICEF,” 2007).

UNICEF’s work in Peru has continued to focus on its main priorities of contributing to the development of fair and comprehensive public policies that encourage and maintain the rights of women and children, while at the same time recognizing the respect for diversity (UNICEF, 2007). UNICEF works closely with the Peruvian government in its monitoring of the government’s implementation of its national plan of action so as to be sure that changes are brought about in support of women and children. Progress has been seen in UNICEF’s work with the indigenous population in its promotion of intercultural dialogue in the areas of their protection of health (UNICEF, 2007). With its work in bringing about a transformation in the attitudes of healthcare personnel, UNICEF has been able to introduce cultural adaptations in prenatal and delivery healthcare services. In working towards minimizing the maternal mortality rate to 80 per 100,000 live births, UNICEF has developed the Safe Motherhood Programme in the departments of Cajamarca, Cusco and Apurímaca so as to serve as a model of appropriate healthcare interventions for the Peruvian government (UNICEF, 2007).

Hypothesis

The maternal and child healthcare system in Peru proves to be among the least proficient of healthcare systems in comparison to those of similar nations. The inadequate availability and accessibility of healthcare facilities and services continue to hinder the ability of Peruvian women and children to receive appropriate care. Throughout the years, adaptations to matters concerning both maternal and child healthcare legislation

and services have been made as an attempt to improve and strengthen the healthcare system. Despite the efforts made by the Peruvian government, far too many women and children continue to die each year as a result of inadequate healthcare services. The continuance of an ineffective maternal and child healthcare system after the implementation of modifications has occurred may be attributed to the level of financial investment in the healthcare system by the Peruvian government.

Therefore, one would expect to see a relationship between the level of financial investment in the maternal and child healthcare system and the infant mortality rate in Peru. In comparing the differences in years between 1980 and 2004, it is expected that the relationship between the two variables will be one of a negative relationship. This negative relationship is to be represented by an outcome in which as the amount of money invested into the healthcare system increases, the mortality rate of infants will decrease. This predicted outcome exemplifies the impact of the level of financial investment in the healthcare system on infant mortality rates.

Methodology

Sample

The study consisted of a convenient sample comprised of six sources of statistical information. Each source was either found through internet investigation and was obtained from reliable governmental and health organization websites, or was found in printed material by international organizations. The sample selected was done so by the convenience of the information upon researching the given variables. The sources provided the necessary statistical information regarding Peruvian infant mortality rates as well as degree of Peruvian health sector financing and expenditure. The selected sample

includes the Peruvian Demographic and Family Health Surveys of 1986, 1991-1992, 1996, and 2004-2005, the EconStats' Global Economic Data, and The World Bank's *A New Social Contract*.

Table 1.1: Infant Mortality Rate and Amount of GDP Invested in Health with Corresponding Years

	1980	1985	1990	1995	2000	2004
Infant Mortality Rate in Peru (per 1,000 Live Births)	89	82	58	46	40	23
Amount of Gross Domestic Product (GDP) Invested in Health (US\$\$: in Millions)	206	171	139	642	796.5	1152

(Demographic and Health Survey 1986, 1991-1992, 1996, 2004-2005; EconStats 2007; A New Social Contract 2006)

Data Gathering

The method of data gathering that was utilized for the study consisted of an extensive exploration of the internet, printed materials, and their corresponding resources. The internet and printed material investigations were composed of a search for appropriate statistical information concerning the variables of the study. The study was made up of two specific variables: 1) Peruvian infant mortality rate and 2) the dollar amount of Peruvian health sector expenditure and financing. The Peruvian health sector expenditure was based on the dollar amount the Peruvian government invested in the healthcare sector from its gross domestic product (GDP), measured in US dollars. The Peruvian infant mortality rate serves as the study's dependent variable while the Peruvian health sector expenditure serves as the independent variable. Both the independent and dependent variables are from the specified years of 1980, 1985, 1990, 1995, 2000, and 2004. The information selected was based upon the availability and accessibility of the information in addition to the information being available in the English language.

Data Analysis

The collected data was analyzed by means of statistical testing through the utilization of the computer program Statistical Package for the Social Sciences (SPSS). SPSS was used to determine the Pearson Correlation between the independent and dependent variables. The values of the independent variable, infant mortality rate, were compared to the values of the dependent variable, health sector expenditure, as a means of determining their correlation in the specified years. The SPSS program was also used in determining the statistical significance of the correlative relationship between the independent and dependent variables.

Findings

Through the use of the statistical comparison procedures of SPSS, the study was able to produce results of statistical significance in the relationship between the independent and dependent variables. The findings of the statistical procedure showed a statistically significant negative relationship between the dollar amount of health sector expenditure and the infant mortality rate in Peru. As the amount of health sector expenditure increased, the infant mortality rate decreased. Despite the fact that throughout the years of 1980, 1985, and 1990 both the amount invested and the infant mortality rate decreased, the substantial increase in amount invested and the decrease in infant mortality rate in 1995, 2000, and 2004 were able to counterbalance the sample as a whole and produced a significant negative relationship between the independent and dependent variables.

The statistical findings showed a Pearson Correlation of $-.890$, representing a negative relationship between the two variables. The negative relationship also proved to be statistically significant at a $.017$ level, representing a 99% chance of the findings to be

true. Furthermore, the coefficient of determination, determined by squaring the value of R (Pearson Correlation), showed that 79.21% of the variability in the infant mortality rate can be explained by the fact that it is related to the amount invested in the healthcare sector. These statistically significant findings prove the hypothesis of a negative relationship between the independent and dependent variables to be true.

Table 2.1: Statistical Package for the Social Sciences (SPSS) Correlation Table

Correlations			
		Infant MortalityRate	Amount Invested Health
InfantMortalityRate	Pearson Correlation	1	-.890*
	Sig. (2-tailed)		.017
	N	6	6
AmountInvestedHealth	Pearson Correlation	-.890*	1
	Sig. (2-tailed)	.017	
	N	6	6

*. Correlation is significant at the 0.05 level (2-tailed).

Conclusion

The necessity of quality maternal and child healthcare is crucial to a nation's overall state of health. Through its development and ratification of national and international health related treaties, the Peruvian government has pledged to secure the right to health for all individuals but has yet to deliver such promises. The disparities in healthcare services and facilities among rural and urban populations continue to plague the women and children of Peru. As hypothesized, a significantly negative relationship exists between the two variables of the amount of money invested by the government in the healthcare sector from the Peruvian gross domestic product (GDP) and the rate of infant mortality. It has been shown that through 1980 to 2004, as the amount of money invested in the healthcare sector increased, the rate of infant mortality decreased. This

finding further emphasizes the importance of the investment of Peruvian government expenditure in its healthcare system. It is imperative that the Peruvian government be held to their established commitments of both financial and practice based services in providing a healthcare system in which women and children of all geographic and socioeconomic populations will be able to reap the benefits of their right to health.

Implications for the Social Work Field

The implications of practice and policy in the field of social work in regards to the Peruvian maternal and child healthcare system lie in the advocacy and development of healthcare related legislation. In social work practice, the main focus remains in advocating for the implementation of the national and international covenants that the Peruvian government has agreed to in securing its citizens their right to health. It is necessary that the Peruvian government be held to the standards to which they have agreed to provide and through the continuous advocacy of workers this change is possible. As for the policy implications of social work, the development and implementation of newly constructed legislation in respect to the condition of Peru's maternal and child healthcare system. Such possible legislation may include mandates of the Peruvian government to uphold its responsibility in its signed covenants regarding the right to health for all individuals. Other mandates may require the government to invest a specified percentage of its GDP into the healthcare sector due to the seen relationship between the amount invested and infant mortality rates.

The basis of the work to be done in the social work field in regards to research most importantly deals with the availability of material in regards to international healthcare related statistical information. The external validity of the study's performed

research was greatly affected by the lack of available information. After extensive research of both the internet and printed materials, only a relatively small sample of information was able to be obtained. The majority of the information that is available does not cover a wide range of years, but only those of recent history. For instance, the only available statistical information pertaining to the Peruvian maternal mortality rate covered from the year 2000 to the most recently documented year of 2007. This small sample consisting only of recent years was therefore not able to be used in the study as a means of demonstrating its relationship with the amount invested in health. Other factors that contributed to the external validity of the study included factors that were not controlled for in the study. Such factors include national disasters and the investment of private expenditures in health. Uncontrolled factors such as these may play a role in the relationship between the amount invested in health and the nation's mortality rates due to the variance in available expenditure as a result of these factors. The lack of available information and the study's uncontrolled factors are both influential reasoning of the importance of the continuance in research relative to international maternal and child healthcare in the field of social work.

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