Success Factors for Women’s and Children’s Health

PERU
The present publication on “Success factors for women’s and children’s health: Peru” is the result of an extensive consultation process that included representatives from state agencies, civil society, NGOs, scientific societies, cooperating bilateral and UN agencies.

Success Factors for Women’s and Children’s Health is a three-year multidisciplinary, multi-country series of studies coordinated by PMNCH, WHO, World Bank and the Alliance for Health Policy and Systems Research, working closely with Ministries of Health, academic institutions and other partners. The objective is to understand how some countries accelerated progress to reduce preventable maternal and child deaths. For more details see the Success Factors for Women’s and Children’s health website available at http://www.who.int/pmnch/successfactors/en/

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1. Executive Summary

Peru has made significant progress in improving the health and nutrition of women and children and is one of ten countries with a high maternal and child mortality burden that in 2012 were on the fast-track to achieve Millennium Development Goals (MDG) 4 (to reduce child mortality) and 5A (to reduce maternal mortality). The country has also achieved a significant reduction in chronic undernutrition (MDG 1). This document summarises the range of national and international, health sector and multi-sector initiatives implemented during the period 1990-2013 which resulted in this progress.

This period saw the consolidation of Peru’s democratic system and the launch of a process to gradually decentralise public administration. Regarding economics, a sustained fiscal policy has been reflected in positive macroeconomic indicators and a gradual increase in GDP. In this context, an institutional framework has been gradually established which has enabled the adoption of state policies benefiting the most vulnerable groups, permitting a continuous reduction in poverty and extreme poverty as well as improvements in women’s and children’s health and nutrition.

Health sector initiatives and investments

The reform of the health sector in the 1990s and the policies and programmes developed to eliminate barriers to accessible and quality healthcare which prioritise women and children have been important factors in Peru’s progress in the achievement of its goals. Similarly, health insurance schemes and strategies to provide culturally-appropriate care for childbirth and to retain human resources working in less accessible areas have contributed to improved access to services for these groups.
Investments and initiatives outside the health sector

Involvement of and collaboration among other sectors has also been essential. Improvements in access to education, especially for women, have had a positive impact on maternal health and child nutrition. Strategies designed to improve focus, cultural appropriateness, adoption of mechanisms for intersectoral collaboration at the highest levels of power and the use of scientific evidence for decision-making have also been implemented in programmes aimed at supporting rural and vulnerable populations. This has resulted in an increase in the number of women accessing health care services for antenatal care and institutional deliveries.

Challenges and future priorities

Although Peru continues to make progress in compliance with its development goals, there are still some challenges remaining which should be addressed in order to safeguard achievements made and accelerate the rate of progress. These challenges include:

1. Socioeconomic and geographic inequality;
2. Newborn health;
3. Improving the quality of health services;
4. Providing comprehensive sexual and reproductive health services; and
5. Reducing the gap in human resources for health.
2. Introduction

Peru is one of 10 low- and middle-income countries (which also include Bangladesh, Cambodia, China, Egypt, Ethiopia, the Lao People’s Democratic Republic, Nepal, Rwanda and Viet Nam) with a high maternal and child mortality burden that in 2012 were on the fast-track to achieve MDGs 4 (to reduce child mortality) and 5a (to reduce maternal mortality). This progress reflects a process which has combined political, economic and social measures to generate a climate of relative economic stability and social peace. Between 1990 and 2013, the period covered by this report, GDP per capita gradually increased, poverty and extreme poverty reduced and the health of the country’s women and children improved.

This objective of this report and accompanying review process was to identify factors both within and outside the health sector which have enabled Peru to make significant progress towards achieving MDGs 1, 4 and 5 – focusing on how improvements were made, and emphasizing policy and programme management best practices and how these were optimised and tailored to Peru’s unique context. The report has been produced with information available in official statistics, technical reports from Peru and United Nations agencies and the support of key actors invited by PAHO/WHO to a multistakeholder review meeting in March 2014.

Representatives from the Ministries of Health, Education, Development and Social Inclusion, Women and Vulnerable Groups, and Economics and Finance, and representatives from the Congress of the Republic of Peru, the Ombudsman’s Office, civil society, academia, scientific societies and international partners jointly analysed the policies and programmes implemented in Peru which aim at improving women’s and children’s health and nutrition. For this reason, this report does not attempt to make causal inferences linking these policies and programmes to improvements in maternal and child health and nutrition. It instead describes the strategies that Peru has implemented as part of efforts to maximise performance in key areas of health, nutrition and development.

The first section analyses the political, social, economic and demographic context which frames the period 1990-2013 and which has been a decisive factor in the progress observed. This section highlights the democratic consolidation process and development of the institutional system, as well as the mixed results of the application of the development model adopted by Peru in the 1990s. The second section describes the key trends in maternal and child mortality in the period 1990-2013.

The third section describes the health sector policies which have enabled improvements in women’s and children’s access to health and quality care. Regarding the health sector, references are made to investments and measures adopted to broaden coverage of social protection, especially for the most vulnerable groups, results-based financing and the coverage and quality of services offered. Policies adopted by the education sector, the department for women and vulnerable groups and the department for development and social inclusion are also presented.

The fourth section presents an analysis of the current situation and identifies the challenges to be approached in the short term to ensure that achievements are sustainable and the progress made in recent years is accelerated. Lastly, we propose steps to be taken to galvanise progress and significantly improve the current situation for Peruvian women’s and children’s health, ensuring equity and the full exercise of their rights.

**Economy**

In early 1990, the Peruvian economy experienced the most severe inflation crisis in its history against a backdrop of terrorist violence which targeted public and private production means. To overcome this, the new government implemented adjustment measures which stabilised the economy. In 1993 the new Political State Constitution established a new institutional framework which laid the foundations for a social market economy which currently guides Peru's economic policy.

From that point onwards, Peru's productive capacity gradually began to recover (see Figure 1). Accelerations in growth were primarily the product of modernization in the mining industry and increases in the global price of minerals in the following decade, in a context of trade liberalisation. Positive advances were also observed in employment growth and reductions in poverty. Between 2004 and 2012, the poverty rate reduced from 58.7% to 25.8% as a result of economic growth and social policies associated with greater fiscal solvency. A growth in employment of approximately 2.5 million workers was recorded during this period and the unemployment rate reduced to a national average of 3.7% in 2012.
Despite this progress, Peru is yet to address the fact that the informal sector plays a fundamental role in the economy, providing a significant number of jobs and generating a considerable proportion of GDP. In the 2007-2010 period, the informal sector constituted 59.4% of total employment (agriculture and non-agriculture), with inherent implications for the exercise of labour rights and social protection, especially for women, who have gradually joined the labour market in recent decades.

**Political**

Several aspects of public life were brought into question as Peru entered the 1990s: the political class and the deconstruction of the social organization which resulted from the economic crisis, terrorist violence, the evidence of excesses committed by the state in the name of countering terrorism and the high corruption levels of public officials.

The capture of the main terrorist leader in 1992 was an important milestone in Peru’s pacification process, but it was also the year in which parliament closed and a constituent assembly was formed. The assembly passed the Political Constitution of 1993 which is still in force today. The democratic government was reinstated nine years later in 2001 and has been consolidated since then.

Enactment of the legal framework began in 2002, through which powers, roles and resources were gradually transferred to the 25 regional governments into which the country was politically divided under the state decentralization process. Between 2005 and 2012, the budget managed by the regional governments rose by 143%. Similarly, the budget managed by local governments rose by 183% between 2007 and 2012.

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**Figure 1: GDP growth, 1980-2013**

![GDP growth graph](http://www.bcrp.gob.pe/estadisticas/cuadros-anuales-historicos.html)
The implementation of this process has been varied and while some regions have shown significant progress regarding social and production development. Other regions, however, are in the midst of a crisis resulting from corruption and shortcomings in management since the transfer of powers was not accompanied by the skills and supervision required for quality results according to regional and local realities.

This period was characterised by the creation of an institutional framework which enabled the development of social policy with the active involvement of civil society and support from international partners. The National Agreement (AN) was signed in 2002 and established a set of state policies. The AN was created on the basis of dialogue and consensus among the state and representatives from political and civil society organizations to mark out Peru’s path towards sustainable development and to confirm its democratic governability.10

The signing of the National Agreement was a significant milestone for the country's institutional development. The AN's second goal of equity and social justice covers the policies for universal access to health services and social security, the promotion of food security and nutrition and strengthening the family, protection and promotion of childhood, adolescence and youth. Working groups resulting from the AN were formed in March 2004, establishing the political, social and economic commitment to childhood which required immediate action to prevent all harm and ensure the natural development of childhood.

The Political Parties' Agreement on Health was created in 2005 with the support of international partners and promotes specialist dialogue among technical officers from political groups for the purpose of improving abilities to analyse and increase dialogue among parties.
Social
The social fabric which had been torn apart by the political violence of the 1980s was gradually restored in a climate of political stability and economic growth. Peru is now a country with less poverty and extreme poverty than at the beginning of the 1990s (see Figure 2), although broad economic and social gaps remain among richer and poorer groups.

Structural reform in the 1990s involved a greater allocation of fiscal resources to health, education and the creation of programmes aiming at optimizing expenditure, including Basic Health for All and Basic Education for All in the respective sectors. For the health sector, the era was characterized by projects financed by external partners, such as Basic Nutrition and Health (World Bank), Project 2000 (USAID) and the Project to Strengthen Basic Health Services (Inter-American Development Bank).

These circumstances allowed the construction of Ministry of Health-run health institutions to resume, and between 1992 and 1996 the number of institutions nearly doubled from 3817 to 5933. Local Health Administration Committees (CLAS), a new form of service management, were introduced at the same time with the help of community involvement.

During the 2000s, fiscal expenditure on health remained relatively stable. Peru is still on the list of countries which spend the least on health in relation to GDP, despite being the fifth largest economy in the region.

In order to minimize the negative effects that the structural adjustment programme of the 1990s had on people living in poverty, social programmes were implemented which principally intended to provide food assistance to the most affected groups. This focus moved towards the implementation of programmes aimed at reducing poverty and extreme poverty, and more recently to a focus on inclusion as an indispensable requirement for development.
This led to modernization of social policy management, which is currently carried out through ministries created for this purpose.

The first efforts can be traced back to 1991, with the launch of the Social Compensation and Development Fund (FONCODES). The Fund was created as a decentralised, autonomous body to serve population groups living in extreme poverty through the development of projects related to social support, infrastructure and production developments.16 One year later, the National Food Assistance Programme (PRONAA) was created to provide support to people living in marginalised rural and urban areas.

With the transition to democracy, the “Foundations of the strategy to overcome poverty and provide economic opportunities for people living in poverty” was formulated by the Office of the President of the Council of Ministers through the Interministerial Committee for Social Issues. This plan established principles for managing social policy,17 emphasizing the need for comprehensive strategies to tackle poverty and social participation and to strengthen capabilities, especially in the regions.

The Ministry for Women and Social Development was created in 2002 to replace the Ministry for Women and Human Development. This body is responsible for designing, proposing and executing social and human development policy, and promoting gender equity and equal opportunities for women, children, older persons, groups in poverty and extreme poverty and groups who are discriminated against and excluded in society. This was an expression of the political commitment mentioned above.12, 18

This process also included local governments which were allocated resources to reduce chronic child undernutrition and provide public services through the Incentive Plan for Improvements in Municipal Management and Modernization which forms part of the budget-based results policy.
Demographics

Between 1990 and 2013, Peru's population grew from 22,639,443 to 30,475,144. The urbanisation process which began in previous decades gradually progressed and the percentage of the population living in urban areas surpassed the percentage living in rural areas. 75.7% of the population currently lives in urban areas.

The population is mainly concentrated in the departments located in Peru's coastal cities. Comparing population by regions, Lima has a population density of 274.2 inhabitants per km², followed by Lambayeque and Piura, while at the other extreme, jungle regions such as Madre de Dios, Loreto and Ucayali have a population density of less than 5.0 inhabitants per km².

During 2013, the population increased at an average growth level of 1.1%, compared to that observed in 2000 (1.5%) in 1990 (2.1%). Between 1990, 2000 and 2013, the global fertility rate reduced from 3.8 to 2.9 and 2.4 births per woman respectively. Consequently, between 1990 and 2013 the proportion of children under 5 reduced from 13.7% to 9.5% of the total population.

Peru is a young country which is currently going through a period of demographic dividend, a situation in which people of working age make up the greatest percentage of the population, with fewer children and older adults. The population aged between 15 and 60 consequently has relatively fewer dependents younger than 15 and older than 60 who need to be cared for. This relationship is expressed through the dependency ratio, which reduced from 80% in 1981 to 60% in 2007, and which is forecasted to reach around 50% between 2025 and 2030.

As a result of these trends, in 2014 adolescents and young people (aged 15 to 29) already made up 27% of the population and the majority of them have better levels of education and connectivity than their peers had in the past.

Other examples of Peru's demographic trends show that the country will continue to have a majority young adult population who will require education and employment services and who will start raising their own families. This must not be an afterthought to the population's aging process. In fact, adults aged over 60 constitute the population group which has increased fastest, and this will have a greater impact on the demand for care, both in the home and in the social protection and health systems.

This situation is linked to increasing survival and has led to changes in the morbidity and mortality profiles, generating new challenges for social and health services. In fact, in the last 20 years, mortality (and presumably morbidity prior to mortality) for reasons related to the aging process has doubled. Therefore, as the population aged over 60 grows in absolute and relative terms, from 2.9 million (9.4% of the population) in 2014 to 8.74 million (21.8% of the population) by 2050, elements such as changes in the epidemiological profile, access to health services to address the role played by diseases linked to the aging process, non-contributory pension programmes and care systems will remain greatly relevant to public policy design.

By 2013, Peru had achieved the targets relating to MDG 1 and 4 and had made significant advances towards achieving MDG 5A. The prevalence of chronic child undernutrition fell from 37.3% to 17.5% between 1990 and 2013, surpassing the goal of 18.7% set for 2015. See Figure 3.

However, this average conceals the considerable differences prevalent in the country’s interior, where very different situations currently co-exist. Child undernutrition rates in areas such as the Moquegua region, Lima and Ica are 4.1%, 5.1% and 7.7% respectively, while rates in regions like Huancavelica, Cajamarca and Apurímac are 42.4%, 35.6% and 29.0% respectively.

Regarding MDG 4, in 2009 Peru achieved the target set for 2015 to reduce under 5 child mortality to a rate of 26 deaths per 1000 live births. In this case, a significant reduction was observed during the analysis period. The mortality rate recorded in 1991-1992 was 78 deaths per 1000 live births, and the rate recorded in 2012-2013 was 21 deaths per 1000 live births. The same occurred for infant mortality: the target set for 2015 of 18 deaths per 1000 live births was surpassed in 2010 and by 2013 the rate was 16 deaths per 1000 live births. See Figure 4.

Maternal mortality in Peru has also gradually reduced from the 1990s. Although the target set for 2015 (66.3 deaths per 100 000 live births) has not yet been achieved, significant progress has been made in this area. In 1996, 265 deaths were recorded per 100 000 live births, which reduced to 185 in 2000 and 93 in 2011. During this period, the number of births attended by healthcare professionals in a health institution and coverage of antenatal care increased significantly.
5. Health Sector Initiatives and Investments

Institutional arrangements

Since the 1980s, Peru has been a signatory to international instruments, aimed at promoting development in women’s and children’s health as a principal strategy. The country has therefore assumed the commitments enshrined in the 1987 Safe Motherhood Initiative, the 1990 World Summit for Children, the 1994 International Conference on Population and Development, the Fourth World Conference on Women in 1995, the Millennium Declaration in 2000 and the 2002 United Nations General Assembly Special Session on Children.

The management model in force in the 1990s was characterised by vertical programmes, the injection of essential resources from the public purse and international technical cooperation to benefit maternal and child health. The National Programme for Family Planning 1996-2000 promoted the use of modern methods of family planning, although it was called into question for its methods of implementation, considered to violate human rights.\(^\text{23}\)

From 2001-2003, there was an explicit opposition to sexual and reproductive health which materialised through the withdrawal of resources from the Family Planning programme. By the end of this period, the vertical programmes had been dissolved and the comprehensive healthcare model had been adopted. Health strategies were formulated in 2004, but preparation was inadequate and not enough funding was provided to guarantee that the anticipated results would be achieved. However, in 2006, health priorities were identified for the period 2006-2015, with neonatal health recognised as the top priority.

Institutional arrangements for addressing chronic undernutrition developed in a different way. The successful experiences of projects led by NGOs such as CARE, PRISMA and Caritas, as well as the Good Start project\(^\text{24}\) (see inset) implemented by UNICEF in 1999 with USAID funding, generated evidence which helped to clear the path towards institutional development which was later accomplished in the framework of the National Agreement signed in 2002.
In 2004, the Office of the President of the Council of Ministers, the Ministry of Health and the Pan-American Health Organization promoted the initiative to improve mothers’ and children’s health in critical areas in Peru. It had three basic objectives:

1) reduce child undernutrition in children under the age of 2 in the first and second poverty quintiles;
2) reduce anaemia levels in the mother and child population in the first and second poverty quintiles;
3) reduce maternal and perinatal mortality in the first and second poverty quintiles, prioritizing rural, mountain and jungle areas.

The Initiative against Child Undernutrition (IDI) was created in 2006 as a result of these initiatives. Initially formed by the organizations ADRA, CARE, Caritas, Prisma, USAID and WFP, it currently brings together 15 institutions and bodies from civil society, international partners and United Nations agencies. One of the first actions of the IDI was to foster political commitment to the fight against undernutrition in the framework of the 2007 election process under the slogan “5, 5 in 5” (referring to the commitment to reduce chronic undernutrition of children under 5 by 5% in five years of government). The government created the CRECER programme in 2007, which is managed by the Interministerial Committee for Social Issues, part of the Office of the President of the Council of Ministers.

GOOD START PROGRAMME

The Good Start programme launched in 1999 in three regions in the Peruvian Andes (Cusco, Cajamarca and Apurimac) and one region in the Amazonian forest (Loreto) as a collaboration between the Peruvian government, USAID and UNICEF. The programme aimed to prevent stunting in children under 3 and provide healthcare for pregnant and breastfeeding women through community-based interventions such as antenatal care, promoting intake of adequate food during pregnancy and breastfeeding, exclusive maternal breastfeeding and improving complementary feeding from six months, monitoring iron and vitamin A deficiency, early stimulation and promoting personal and family hygiene practices and iodised salt consumption.

The programme team was led by local governments working in local communities, health workers and local nongovernmental organizations. The programme placed an emphasis on strengthening the skills and abilities of women working in local governance and healthcare promotion in rural areas. In 2004, the program reached approximately 75,000 children under 3 and 35,000 pregnant and breastfeeding women in 223 rural communities.

The evaluation conducted between 2000 and 2004 demonstrated that the prevalence of low height for age among children under 3 in communities supported by the programme reduced from 54.1% to 36.9%, while anaemia rates reduced from 76.0% to 52.3%.

The evidence generated from this and similar projects laid the foundations for CRECER, the national strategy against chronic child undernutrition launched in 2007, which continues through the current administration’s “Inclusion for Growth” strategy.
Financing and social protection

The health system reforms introduced in the 1990s made way for the introduction of resource allocation and public investment schemes which allowed for improved accessibility and quality of services offered to the population. Total expenditure on health continued to increase in the following decade (see Figure 5) until it reached 554.5 US dollars per capita in 2012.25

The adoption of insurance-based social protection schemes through the creation of school health insurance (SEG) in 1997, mother and child insurance (SMI) in 1998 and the fusion of the two into Comprehensive Health Insurance (SIS) in 2001 extended health coverage to a significant proportion of the population. SEG and SIM were the main sources of health insurance for the Peruvian population in 2000.26 See Figure 6.

SIS was formulated to protect the health of people living in poverty and extreme poverty with no health insurance. In practice, the requirement to have identification documentation to register for the insurance and the introduction of the single beneficiary identification form (FESE) to gain a socio-economic assessment of the household proved to be a barrier to access for the most vulnerable sectors of the population. However, the situation is currently reversing thanks to the adoption of policies to improve access to identification documents and focusing on geographical areas which prevent some population groups from meeting these requirements.

Over the years, the services included in the Essential Health Insurance Plan (PEAS) benefits package, which is financed by the SIS, have experienced increasing demand, coverage and use. Between 2000 and 2012, the proportion of institutional deliveries increased from 24% to 58% in rural areas and from 58% to 85% in urban areas,27 and the proportion of births attended by a health professional has also increased. In Peru, as in other countries in the region, this increase in institutional care for deliveries has been linked to a significant reduction in the maternal mortality rate.

In addition, the injection of resources to modernise the healthcare system through public investment projects, such as the Health Sector Reform Support Programme (PARSALUD), has contributed to improved infrastructure and quality in the services offered, resulting in an increase in institutional deliveries in the areas prioritised by the programme (see Health Sector Spotlight).

Results-based budgeting (RBB) was introduced in 2007 as a different way to allocate, approve, execute, supervise and evaluate the public budget. It links the allocation of resources to measurable products and results which are valued by the population.29, 30
Health sector spotlight

HEALTH SECTOR REFORM SUPPORT PROGRAMME - PARSALUD I

This programme launched in 2000, was financed by the Peruvian government and repayable loans from the Inter-American Development Bank (IDB) and the World Bank (WB). The programme was initially designed as a strategy to reinforce services in general and was redesigned in 2003 to focus on maternal and neonatal health. The programme was organised into four components:

1. Strengthening demand, particularly by developing Comprehensive Health Insurance, to promote greater use of mother and child health services in order to reduce barriers limiting access, especially economic barriers;
2. Improving health services offered by the eight priority Health Directorates to improve problem-solving capacities (improvements in infrastructure and equipment, as well as training human resources in management and support skills) in each region’s obstetrics and neonatal networks;
3. Modernizing the Ministry of Health to help it to implement processes to improve its capacity to regulate the public health system; and
4. Programme administration.

The programme was based on scientific evidence and emphasised increasing coverage of institutional deliveries in priority departments through the creation and reinforcement of 74 health institutions with basic obstetrics and neonatal functions (FONB). The health institutions were to be located no more than two hours from populated rural centres.

In quantitative terms, the programme directly provided care to around 167,000 pregnant women and 134,000 neonates and indirectly provided care to 630,000 women of fertile age and 1,200,000 children between one and four years of age. Institutional deliveries in rural areas in the seven regions prioritised by the Programme also increased from 24% (2000) to 44% (2005).28

The logical model for PARSALUD II was designed to reduce chronic child undernutrition on the basis of experience from PARSALUD I. PARSALUD II was launched in 2009 in the nine poorest regions of Peru.
The first budgetary programmes to be created were for mother and child care: the Joint Nutritional Programme (PAN) and the Maternal Neonatal Health Programme (SMN). The design of PAN’s budgetary structure took into account lessons learned and the logical causal framework of PARSALUD I and II. Since their creation, both programmes have received an increased budgetary allocation. The budget allocated to SMN increased from 404 to 1068 million nuevo soles between 2008 and 2011 and PAN’s budget rose from 702 to 1388 million nuevo soles in the same period.

Continuing efforts to improve abilities, allowances, distribution, retention and human resources have strengthened services, and although this is still a challenge at the national level, it is being considered in the current reform process. In the meantime, some regions such as Apurímac and Ayacucho have adopted policies to reduce gaps in available human resources, which has had a direct impact on maternal and neonatal mortality in the last decade.

**Policies, plans and standards**

Sexual and reproductive health policy at the end of the 1980s focused on family planning measures. The National Population Policy was approved for the first time in 1985. A 1995 decree was passed making contraceptive methods free of charge, and voluntary surgical contraception (VSC) was included in the National Programme for Reproductive Health and Family Planning 1996-2000.

In the period between 1990 and 2011, the total fertility rate reduced from 4 to 2.6 births per woman, while the use of modern family planning methods among married women doubled between 1986 and 2000 (from 23% to 50%). However, since then this indicator has stagnated. By 2012, the usage rate of modern methods was 51.8%, which could be a consequence of the objection to VSC and the abovementioned conservative policies regarding sexual and reproductive health between 2001 and 2003.

In the same decade, projects to improve the quality of maternal and child care were launched with the support of international partners, including Project 2000, financed by USAID, and the Training Programme for Women’s and Children’s Health (PCMI). PCMI intended to generate changes in organizational culture and stimulate analysis of the service in practice through teamwork and the identification of problems. The Perinatal Information System (SIP) was implemented in 2000 with the help of the regional experience of the Latin American Centre for Perinatology, Women’s Health and Reproductive Health (CLAP/SMR), part of PAHO/WHO. SIP collects maternal and perinatal information in order to make timely decisions in accordance with the sector’s policies.

This period also saw the launch of specialist care strategies for adolescents in order to cater to their specific needs and expectations. Although important progress has been made in this area, strategies to improve access to health services still need to be developed, such as ensuring the provision of family planning methods for younger adolescents.
FEMME PROGRAMME

The Foundations to Enhance Management of Maternal Emergencies programme (FEMME) was launched between 2000 and 2007 in Ayacucho, a southern region of Peru, to address the high maternal mortality rate, the unmet need for obstetric healthcare, inefficiency of health services and insufficient management systems. The programme aimed to promote a rights-based approach to health and strengthen the functional capacity of institutions.

The key components of the FEMME initiative were: the development of protocols and guidelines to provide adequate, evidence-based and culturally appropriate emergency obstetric and newborn care (EmONC), training and skills-building for health professionals, strengthening of community participation with the formation of a Multisectoral Committee for the Reduction of Maternal Mortality, improved data collection and information systems, minor improvements in infrastructure, and criteria-based audits to improve quality of care.

Evaluation of the programme revealed that during its implementation, FEMME managed to reduce barriers faced by pregnant women and reinforced facilities to improve emergency obstetric and newborn care. Emergency care increased by 54% between 2000 and 2004 and there was an 80% reduction in the fatality rate. The Ministry of Health reported a 45.5% increase in the number of obstetric complications treated and a 49% reduction in maternal mortality.

FEMME received significant regional and national political support, and guidelines and protocols were incorporated into the study plans of midwifery and nursing training courses in Ayacucho. Parts of the programme were also implemented nationally, and the Ministry of Health introduced FEMME protocols and clinical guidelines into the national framework.
In order to address cultural barriers to giving birth in a health facility, the state adopted the technical standard for vertical delivery in 2005.35 “Waiting houses” have been implemented throughout the country as a strategy to reduce geographical barriers which prevent women from accessing a health institution in a timely manner. Between 2000 and 2006, the number of waiting houses increased from 99 to 337 overall in high Andean areas.36 Despite this progress, this strategy is yet to be adapted to the needs of people living in jungle areas.

In recent years, participatory interventions have been implemented to close cultural gaps between health providers and the high Andean population and increase coverage of institutional deliveries (see inset). The Ministry for Health formulated the National Strategic Plan for the Reduction of Maternal and Perinatal Mortality 2009-2015 on the basis of this experience with support from international partners. This plan promotes intersectoral actions and the active participation of the different social actors committed to maternal and child health.29

A RIGHTS-BASED, CULTURALLY RELEVANT MODEL FOR COMPREHENSIVE MATERNAL AND PERINATAL HEALTH CARE

The model was implemented in two micro-networks in Churcampa province, Huancavelica, with support from Medicus Mundi Navarra and financing from AECID. It focused on implementing education, health and communications strategies.

The model sought to strengthen health and education skills for the school-age population, the community and health workers. Services were strengthened in order to provide care aiming at promoting safe and healthy motherhood and adequate perinatal survival in accordance with service users’ beliefs and expectations, and health personnel were trained to manage obstetric and perinatal strategies in a culturally-appropriate manner.

The communications component was designed to empower the community through the development of skills relating to health rights and responsibilities and to open spaces for the community to participate in health management through involvement in budgets and political advocacy for safe and healthy motherhood with leaders, authorities and public officials. A joint intervention proposal was developed and adopted by these actors and supported by Medicus Mundi Navarra.

Among the main achievements of the project are a reduction in pregnancies, a reduction in adolescent pregnancies, an increase in the percentage of pregnant women who have had six antenatal health monitoring sessions and an increase in institutional deliveries to a rate above the national average. Furthermore, by the fourth year of the project there were no reported cases of maternal mortality.
Significant progress has been made in recent decades regarding the population’s access to primary education. According to data from the National Household Survey (ENAHO), the literacy rate of the population aged between 15 and 24 in Peru is high: nearly all young people of both genders in this age range are literate (98.7%). However, young people living in rural areas are not yet reaching the level of their peers living in urban areas and women are still at a disadvantage in relation to men.37

At 99.5%, the Lima Metropolitan Area has the highest proportion of literate young people. 98% of the youth population of the rest of the country is literate, and more than 97% of young people in coastal, mountain and jungle regions are literate.37

Net rates of registration in primary education increased by 4.6%: from 91.5% in 2002 to 96% in 2012, according to data from the National Household Survey. Percentages relating to access are high and nearly universal in Lima as well as in the rest of the country. Progress in rural areas has been more significant: in the same period, the net rate for rural areas increased from 89.7% in 2002 to 96% in 2012 (6.3%). The rate increased by 3.5% in urban areas, where it was already high and marginal increases become more complex approaching the target.

Finally, an increasingly large proportion of six-year-old boys and girls entered the first year of primary education and finished their sixth year at the age of eleven, which is evidence that they did not repeat the year or fall behind. Considerable progress has been made in the last decade and the percentage of students finishing primary school at the age of eleven has increased from 38.5% in 2000 to 69.4% in 2012. General progress has also been made in rural areas and in all natural regions, albeit to a different degree. This may be largely attributed to the Learning Achievements Budget Programme launched in 2007, which aims to increase quality and equity in basic and primary education throughout the country.

Measures adopted by successive governments have produced noticeable improvements in universal access to primary education and literacy, although results regarding access to basic education in primary and secondary education in rural and jungle areas are less visible. This was also the case with regard to the quality of education.38
Policies to alleviate poverty and promote social inclusion

As mentioned in previous sections, Peru has progressively and gradually constructed an institutional system to manage social policy and implement programmes to alleviate poverty. This system has shifted its focus from food assistance in a context of economic adjustments at the beginning of the 1990s to one of poverty reduction and social inclusion in more recent years.

Since their creation, the government ministries for women and human development, social development, vulnerable groups, development and social inclusion have promoted policies on the recognition of the fundamental rights of women, children and vulnerable groups. They have also increasingly become involved in the management of social programmes.

Through the National Plan for Equal Opportunities for Men and Women 2000-2005, the Ministry for Women and Social Development spearheaded a series of regulations and programmes aimed at strengthening economic entrepreneurship among women and their inclusion in the labour market without discrimination. It also gave impetus to regulations to eradicate the exploitation of child labour and forced labour of boys and girls and managed the social programme WAWA WASI to provide comprehensive care to children aged between 0 and 4 as a strategy to support working mothers.

During the first years of the 2000s, advances were made in regulation regarding the recovery of labour rights, such as the right to breastfeed and to antenatal and postnatal leave. These had been cut during the 1990s as they were considered to be labour costs which went against labour flexibility policies. Similarly, a law was passed to protect pregnant women engaging in labour activities which put their health and/or the normal development of the embryo or fetus at risk. This law enshrined the woman’s right to work in accordance with her state of health without her labour rights being affected.

Programmes aiming at alleviating poverty for the new generation were implemented in this context. This includes JUNTOS, a conditional cash transfer programme launched in 2005 which brings together initiatives to improve direct access to health and education services for women and small children.
CRECER NATIONAL STRATEGY

CRECER was a national intervention strategy which brought together national, regional and local public entities, private entities, international partners and civil society to tackle poverty and social exclusion. The programme was created through a supreme decree in July 2007. Management of the strategy was led by the Office of the President of the Council of Ministers through the Technical Secretariat of the Interministerial Committee for Social Issues, working in direct collaboration with civil society, United Nations agencies, international NGOs and the community of donors who played a fundamental role in reinforcing the regulatory framework and strategy management and in developing skills in regions and districts.

CRECER combined actions in the areas of health, education, water and sanitation, households and agricultural policy to create a comprehensive strategy to reduce chronic undernutrition and anaemia. This resulted in a reduction in chronic child undernutrition indicators, which was directly linked to public investment and regional government involvement. Between 2007 and 2011, Piura and Ayacucho achieved reductions of 9% and 7% respectively.

The programme distributes cash initiatives to families on the condition that the health and nutrition of their children under 5 are monitored, to families whose children and adolescents aged between 6 and 14 years are registered at and attend school, and to pregnant women and breastfeeding mothers who access antenatal and postnatal monitoring services.

A 2009 World Bank assessment found that the JUNTOS programme had a positive impact on poverty, income and consumption levels, as well as on the use of health services and investment in more nutritional food products. Regarding education, it has contributed to improvements in the indicators of registration and attendance at preschool. This has been achieved without any undesired results relating to misuse of money (alcohol consumption), the fertility rate or reduction in adult labour participation.

The CRECER programme was launched in 2007 by the government to prioritise social policy and proposed a multisectoral approach based on a multi-causal analysis of poverty (See inset).

The Ministry for Development and Social Inclusion is currently responsible for managing all social programmes under the umbrella of the “Inclusion for Growth” strategy adopted in 2013. This strategy establishes the guidelines to be adopted by all sectors involved in the achievement of goals which are organised into five strategic axes and described in the scope of the life-cycle:

- Child nutrition (0 to 3 years): Reduce chronic child undernutrition through initiatives which focus on pregnant mothers and on children in this age range.
- Early child development (0 to 5 years): Boost physical, cognitive, motor, emotional and social development in the early years of childhood.
• Comprehensive development in childhood and adolescence (6 to 17 years): Increase every boy, girl and adolescent’s skills through personal, educational and occupational development.

• Economic inclusion (18 to 64 years): Improve opportunities and capacities for households to increase their own incomes.

• Protection of older adults (65 years and older): Protect and improve older adults’ well-being, ensuring their access to a pension and quality in a range of services.

The National System for Development and Social Inclusion (SINADIS) is a formal space for joint, intersectoral and intergovernmental management for the purposes of implementing the National Strategy for Development and Social Inclusion - “Inclusion for Growth”.

In 2014 the Ministry for Development and Social Inclusion began to implement strategies to improve the comprehensive services offered through the Performance Stimulation Fund (FED), which is based on the successful experience of EUROPAN (see inset). It is worth noting that since its creation, the Ministry for Development and Social Inclusion has made cost-effective interventions in the implementation of its health initiatives.

The Ministry for Women and Vulnerable Groups formulated the fifth edition of the National Action Plan for Childhood and Adolescence (PNAIA) which covers the period 2012 to 2021. The Plan brings together efforts from public and private institutions, civil society organizations and international partners for the benefit of girls, boys and adolescents to ensure that state policy respects their rights to health, education and respect within the family and community.
Role of international partners

In line with guidelines arising from the Paris Declaration, Peru is working with multilateral and bilateral agencies, donors and national and international NGOs engaging in high levels of cooperation and coordination in order to strengthen public policy in Peru.

Efforts made by the Initiative against Child Undernutrition (IDI) to tackle chronic child undernutrition and the later creation of the CRECER strategy are prime examples of the role played by international partners in alliance with civil society. IDI is currently a strategic ally for the government in the supervision and accountability of child undernutrition. Other collectives such as the Driving Group for Maternal and Neonatal Health and the Neonatal Health Collective have followed IDI’s lead as relevant bodies for political advocacy in women’s and children’s health and ensuring the sustainability of progress made.

The Driving Group for Maternal and Neonatal Health in Peru is formed by the Round Table for the Fight against Poverty, PAHO/WHO, UNICEF, UNFPA, Pathfinder, PRISMA, CARE and USAID which collaborate to achieve the targets of Millennium Development Goals 4 and 5 in Peru. In 2007, on the driving group’s initiative, the Congress of the Republic signed a document demonstrating their commitment to the “National Alliance for a Safe and Healthy Motherhood in Peru”, which was ratified the following year. Among other actions, it also promoted the development of workshops to formulate the “Regional Multisectoral Plans to Reduce Maternal and Neonatal Mortality” in different regions of the country.

The Peru Neonatal Health Collective began as a group of dedicated professionals working together on neonatal and child health issues in Peru. PAHO, CARE Peru and the Ministry of Health later joined the collective, followed by UNICEF. Notable among its major achievements are the adoption of the Technical Health Standard and cost-effective initiatives to reduce neonatal mortality, which were approved in 2008 by the Ministry of Health and the approval in 2009 of the national subsystem for epidemiological perinatal and neonatal surveillance.

In 2009, the group became a national alliance named the Peru Neonatal Health Collective, which is principally funded by CARE Peru. At that time, the collective was formed of UNICEF, PAHO, CARE, Prisma, Plan International, Kusi Warma, different Ministry of Health departments, civil society groups, different professional groups and their associations (paediatricians, nurses and midwives, among others) and experts, neonatologists and other physicians.

The Childhood, Food Security and Nutrition Joint Programme was launched in 2008. It was financed by the Spanish government through the Millennium Development Goals Fund, led by PAHO/WHO and brought together five United Nations agencies (FAO, UNODC, PAHO/WHO, WFP and UNICEF) to support the implementation of CRECER nationally, regionally and in 65 priority districts in the Apurimac, Ayacucho, Huancavelica and Loreto regions which presented the highest levels of vulnerability, poverty and chronic undernutrition in Peru at the time.
The Joint Programme intended to strengthen:

a. technical and analytical skills and management at different levels of government;
b. the implementation of initiatives grounded in evidence-based data in order to improve child nutrition;
c. the promotion of production practices to guarantee food security; and
d. the promotion of family practices for child and maternal care.

Between April 2008 and February 2009, the nongovernmental organizations ADRA, CARE, CARITAS and PRISMA also implemented the CRECER National Strategy Support Programme in 12 regions of the country with the support of the United States Agency for International Development (USAID). This programme enabled authorities and local actors to engage in political advocacy, information dissemination and communication and technical assistance, and allowed them to strengthen management capacities and promote secondments to encourage regional and municipal management personnel to exchange and learn from successful experiences.

Another essential support mechanism from international partners has been the EURO-PAN budgetary support covenant signed between the Peruvian government and the European Commission at the end of 2009 in order to contribute towards efforts to reduce chronic child undernutrition in the poorest regions of the country.

National nongovernmental organizations also played an active role, such as the “SEMBRANDO” programme implemented by the Institute for Work and Family. This programme was aimed at families in rural communities living in areas higher than 2500 m above sea level and in conditions of extreme poverty and aimed to provide training, promote appropriate technology and encourage social participation to promote health care for women and children, adequate nutrition and improvements in production practices and in the household. A prime example of its proposal was promotion of the use of “improved stoves” which prevent smoke emitted during cooking being released inside the cooking area.

EURO-PAN BUDGETARY SUPPORT COVENANT

The EURO-PAN Budgetary Support Covenant was signed in 2009 between the Peruvian Ministry of Economy and Finance and the European Commission and allocated €59.75 million to contribute towards Peru’s efforts to reduce chronic child undernutrition through the Joint Nutritional Strategic Programme (PAN).

EURO-PAN measured the performance of PAN in the 54 poorest districts in Apurímac, Ayacucho and Huancavelica since the chronic undernutrition figures in these regions were much higher than the national average (34.3%, 36.8% and 52.2% respectively in comparison with 19% nationally). The Covenant was implemented over three years through periodic payments according to the level of compliance with commitments and targets set for regional governments. These targets were based on the coverage of immunization, supervision of children’s growth and development (CRED) and the provision of iron and vitamin A supplements for children and iron sulphate for pregnant women.

Between 2010 and 2012, with the additional budgetary support generated by EURO-PAN, the proportion of fully-vaccinated children in the districts selected increased by nearly 24%, achieving the annual targets at an average rate of 105%. In addition, in this period the percentage of children insured under SIS with full CRED for their age multiplied by five, surpassing annual targets by 23%. Lastly, the percentage of pregnant mothers insured under SIS receiving iron supplements remained stable at 94.3%, achieving 99% of annual targets.\textsuperscript{45}
8. Governance and Leadership

Citizen cooperation, participation and vigilance

The People’s Ombudsman was created in the 1990 political constitution to defend fundamental rights and to ensure that the state administration complies with their duties and efficiently provides public services throughout national territory. Since then, it has been an indispensable institution in Peru because of its independence and the technical level of its reports.

The Round Table for the Fight against Poverty (MCLCP) was created in 2001 through a supreme decree passed by the Ministry for Women and Human Development. The group provides a space for state and civil society institutions to collaborate on the adoption of agreements and to coordinate actions to efficiently fight against poverty in each region, department, province and district in Peru. The group is an active space which has become legally recognised over time.

The objectives of the MCLCP at all levels are:

a. to base social policy on human development with a focus on equity and gender;

b. to achieve greater efficiency in the implementation of programmes for the fight against poverty;

c. to centrally involve citizens in the design, decision-making and monitoring of state social policy and

The MCLCP has played an essential role in prioritizing and raising awareness of early childhood. The group proposed 11 priority actions in support of childhood which were submitted for inclusion in the National Agreement in 2005 and are prime examples of their influence in national public policy.

ForoSalud, the Civil Society Health Forum, was launched in 2001 and is another space which brings together civil society under the banner of health. It promotes debate, diagnosis and the dissemination of information gained through studies and experience. It also supports the formulation of proposals and collective construction of agreements and dialogue on health issues in Peru and globally, based on the broadest pluralism and independence through social association. It involves citizens in health surveillance and public monitoring of the work done by health and government actors.

The current situation

Despite the progress made by Peru, health inequities still remain. The latest surveys show that the reduction of chronic child undernutrition is decelerating and the indicators of anaemia and child and neonatal mortality are reversing.

According to the 2013 Demographics and Family Health Survey, chronic child undernutrition has reduced nationally, but at a slower pace than in previous years, and it has increased in six regions of the country. Prevalence has reduced in the last three years, falling from 19.5% in 2011 to 18.1% in 2012 and 17.5% in 2013. At the same time, anaemia in children under 5 has increased from 30.7% in 2011 to 32.9% in 2012 and 34.0% in 2013, at the expense of the urban population among which it increased by 2.5% (from 28.6% in 2012 to 31.1% in 2013).

According to the same survey, infant mortality (death of children under 1) has increased from a national average of 16 deaths per 1000 live births in 2011 to 17 deaths per 1000 live births in 2012 and 19 deaths per 1000 live births in 2013, demonstrating a steady increase for the third consecutive year. Neonatal mortality (death during the first month of life) has also increased, rising from 9 deaths per 1000 live births in 2012 to 12 deaths per 1000 live births in 2013.

This adds to the health inequity in Peru, in which children with the greatest probability of being undernourished or dying are those born into poor households, born in mountain, jungle and rural areas and whose mothers have not had access to formal education. Such factors also influence women’s access to health services.
While the under 5 mortality rate for children living in urban areas is 19 deaths per 1000 live births, this rises to 24 deaths per 1000 live births in rural areas. Among those who survive, chronic child undernutrition affects a greater proportion of children who live in rural areas (25.3%) in comparison with those who live in urban areas (7.1%). In cases where the mother has not had access to education, the percentage of children affected is 37.2%, while the rate among children whose mothers have accessed higher education is 3.1%. Children living in mountain regions (23.2%) and jungle regions (17.8%) are most affected in comparison to those who live in Lima (2.2%).

On average, access to antenatal monitoring for pregnant women is nearly universal (95.9%). However, there is still a gap among urban and rural mothers (98.9% and 88.9% respectively) and a 12.5% gap among those who have not had access to education and those who have accessed higher education. The majority of women (89.1%) were attended by qualified personnel during childbirth, but there were gaps observed among urban women (97.3%) and rural women (71.3%), with women in jungle regions recording a lower percentage (73.0%), as well as those who had no access to education (58.3%) in comparison to those who had accessed higher education (99.0%).

In addition, although the majority of deliveries were attended in a health institution (88.6%), this occurred less frequently for women living in jungle areas (75.4%) and in rural areas (69.8%) than for their peers living in coastal and urban areas.

Women and children living in jungle regions therefore recorded the most concerning social indicators. Inequities were also observed in the interior among groups living in urban areas and those living in rural communities, as well as among mestizo populations living in rural communities located along Amazon rivers and in indigenous communities. Indigenous groups recorded the poorest social indicators out of all population groups in Peru.

The Peruvian Amazon represents 62.0% of national territory and in 2007 a population of 332,975 inhabitants lived in native communities in the area. The vast geographical distribution, scarcity of public services and large cultural gaps mean that public programmes have a limited effect within these communities and minimal impact on health, nutrition, education and living conditions in these communities. In the Amazonas region, the rate of coverage of institutional deliveries among indigenous women in Condorcanqui, a province of majority Awajún and Wampi peoples, was 13.8% in 2012.

The results of the 2012 Demographics and Family Health Survey demonstrated that 13.2% of all adolescents aged between 15 and 19 years had been pregnant at some point in their lives. Close to 11% (10.8%) of adolescents were already mothers and 2.4% were pregnant for the first time. The percentage of adolescents living in rural areas who were already mothers or who were pregnant for the first time was double that of adolescents living in urban areas. In the last 16 years, the average percentage of adolescent mothers has remained around 13% nationally, 10% in urban areas and 21% in rural areas.
Departments in jungle areas present higher percentages of adolescents who are already mothers or who are pregnant for the first time. The Amazonas Department leads the ranking with 30.5%, followed by Ucayali with 27.3%, Loreto with 25.3% and Madre de Dios with 23.1%. Similarly, more than half (57.3%) of adolescent mothers are within the first and second wealth quintile. The adolescent motherhood rate in the highest quintile is 7.8%.49

The state’s response to this situation has been insufficient. Health financing has not significantly increased as a percentage of GDP and the percentage of public health expenditure has fallen significantly. The positive effect that SIS has had on access to institutional deliveries and care from health professionals has mainly increased demand from wealthier segments of the population.52 Similarly, there are still noneconomic barriers which limit access for women who speak indigenous languages, who live in rural areas and/or whose husbands control health decision-making in the household.

Although 98.7% of the population were literate by 2011, there is still a general illiteracy problem despite Peru being declared officially “free from illiteracy” in June 2011. INEI figures from the same year, which include the whole population aged 15 or older, demonstrate that Peru’s illiteracy rate is 7.1%, which is rather higher for women (10.5%) than for men (3.8%). Similarly, illiteracy in rural areas (17.4%), especially among women (26.8%) and the indigenous population (20.1%), still needs to be addressed.

New challenges

The picture described so far is proof that there are still questions to be answered in one part of the country. These issues must be addressed in order to avoid stagnation, or even regress, and to boost progress in achieving equity in women’s and children’s health with respect to Peru’s inherent social, cultural and geographic diversity.

Representatives of the institutions consulted have therefore identified the urgent need to address the following challenges:

1. The persistence of social, economic and geographic inequality, despite significant economic progress. There are still shortcomings in infrastructure and access to education, health and basic services such as water and sanitation. Although Peru has observed general improvements regarding health, there are severe regional discrepancies which negatively affect indigenous populations.

2. Increase in newborn mortality. Although MDG 4 has been achieved, the current trend must be reversed to effectively reduce neonatal mortality (death during the first month of life). Although progress has been made in the use of scientific evidence to support the implementation of cost-effective measures, this should be reinforced to achieve greater impact.

3. Gaps in infrastructure and social and cultural gaps which affect access to and quality of health services. The number of people with access to health services has increased significantly, however, quality health services and delivery methods have not yet been adapted to users’ needs relating to their social and cultural norms, nor to the sparse population distribution present in large parts of the country. This aspect is fundamental for the achievement of MDG 5.

4. Limitations in the provision of comprehensive sexual and reproductive health services. Family planning programmes must be strengthened to ensure women’s full exercise of their sexual and reproductive rights and to achieve greater progress in reducing the global fertility rate. Efforts are required to implement the recently-adopted therapeutic abortion protocol53 as well as guaranteeing access to sexual and reproductive health services to adolescents aged over 14, which implies that Article 4 of the Health Act should be amended.
5. Gaps in human resources for health. Peru is one of 100 countries facing a severe crisis in human resources for health.\textsuperscript{54} The concentration of health workers in urban areas, inequalities in distribution and the high rotation of professionals in rural areas have had a negative impact on the continuity and quality of services and user confidence, resulting in a low usage of services. There is an urgent need to develop investment packages and acceptable and sustainable incentives to overcome these challenges. In addition, progress is needed to develop strategies to increase training for health workers, validate specialist qualifications through ability and experience, attract and retain personnel in neglected areas.

Next steps
Peru has made significant progress in reducing maternal and child mortality and chronic undernutrition through several efforts made by the state with the involvement of civil society organizations and international partners. The current social, political, economic and demographic context provides a suitable platform to respond to challenges and drive progress towards achievement of future MDGs proposed by the Sustainable Development Goals.

The Health Reform process launched in 2013 is a fantastic opportunity to improve health conditions and access to services with a special emphasis on vulnerable groups. Future action should therefore prioritise:

- \textbf{Strengthening of sectoral governance} and regional management capacities, boosting joint intersectoral and intergovernmental mechanisms to focus on reducing existing inequities.
• Institutionalization and strengthening of mechanisms which ensure accountability and citizen involvement in monitoring, especially in the regions, given that governing bodies administer resources and are obliged to provide timely, efficient and relevant services required by the population.

• Promotion of increases in the public health budget and more efficiency in expenditure. State expenditure on social programmes and the health sector is still below the regional average. Expenditure from the public purse is a significant proportion (38% in 2011) of health financing, which has a greater impact on low income groups. To ensure that expenditure is efficient, resource programming should be adapted to meet local needs and subnational management capacities should be strengthened.

• Incorporation of a focus on rights and interculturalism through the sectoral reform process and in the formulation and implementation of policies and programmes aimed at improving health for the whole population, but particularly for women and children, indigenous peoples and vulnerable groups. The new design should be flexible enough to allow public services to be delivered in a way that meets people’s needs, as these can vary according to a person’s economic, social, cultural and geographic situation, so that service users are recognised as citizens with the full exercise of their rights enshrined in the state’s political constitution.

• Strengthening of the Sexual and Reproductive Health Strategy to effectively support regional governments in their efforts to increase family planning coverage, improve the quality of antenatal monitoring and coverage of institutional deliveries in rural areas and reduce adolescent pregnancy by implementing the Multisectoral Adolescent Pregnancy Prevention Plan adopted in October 2013.

• Generation of disaggregated information to identify pockets of inequity in a timely manner, especially within more socially-excluded groups such as Amazonian indigenous communities. This will require collaborative work from all actors involved. Information systems must be harmonised to enable monitoring and accountability at all levels of political decision-making.

• Development of policy on human resources for health. Policies should be sustainable in the medium-term and long-term and place special importance on the allocation of professionals and technicians in order to reinforce the primary healthcare strategy and to connect institutions training these human resources with Peru’s health needs.
Conclusions

Peru is a high-performing country which has achieved significant progress in improving maternal and child health. This report presents a summary of the policies, programmes and strategies adopted by different public institutions, civil society and partners which aim at promoting progress in Peru towards the achievement of MDG 1, 4 and 5 throughout the last two decades.

The consolidation of democracy and the continued increase in GDP have generated a climate conducive to the development of an institutional structure which promotes sectoral and intersectoral policies for the benefit of women’s and children’s health, supported by results-based financing and backed by scientific evidence.

Sectoral policies aiming at improving social protection and health have improved accessibility to health services and coverage of antenatal services, institutional deliveries, immunization and other factors. However, progress has been inconsistent and there are still disparities in health among rural and urban, poorer and wealthier populations, among those with greater or lesser access to education, and among indigenous peoples and non-indigenous peoples.

Despite the progress made, the evidence suggests that MDG 5 (to reduce maternal mortality) will not be achieved in the established time frame, and therefore Peru must take further action to increase insurance coverage and improve the quality of sexual and reproductive health services and the management of emergency obstetric care.

This is also the case for the health of the youngest children (neonates). Peru must focus its attention on this population group to increase the probability that their birth will be registered, and measures should be adopted to ensure their survival and the conditions necessary for their comprehensive nutrition and development.

The implementation of a sectoral reform process, the experience gained from national and regional intersectoral collaboration, an approach based on health determinants, the full involvement of civil society organizations and the government’s firm commitment to budgetary increases for social areas all encourage optimism in the face of the challenges ahead.
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