**Peru**

**Country profile**

For Demographic and Health Surveys, the years refer to when the Surveys were conducted. Estimates from the Surveys refer to three or five years before the Surveys.

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### Peru and the world

**1. Maternal mortality ratio: global, regional and country data, 2005**

A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related to the pregnancy or its management but not from accidental or incidental causes. The maternal mortality ratio is the number of maternal deaths per 100,000 live births per year. The ratio in Peru is 240 per 100,000 live births, which is higher than the average of 130 per 100,000 live births in Latin America and the Caribbean but lower than the global average of 400 per 100,000 live births.

**2. Lifetime risk of maternal death (1 in N), 2005**

The lifetime risk of maternal death is the estimated risk of an individual woman dying from pregnancy or childbirth during her adult lifetime based on maternal mortality and the fertility rate in the country. The lifetime risk of dying from pregnancy-related causes in Peru is 1 in 140, which is lower than the average of 1 in 290 in Latin America and the Caribbean and lower than the global figure of 1 in 92.

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### Demographic and health data

**3. Total population (in thousands)**

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peru</td>
<td>27,589</td>
<td>27,589</td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>127,589</td>
<td>127,589</td>
</tr>
<tr>
<td>World</td>
<td>6,071,000</td>
<td>6,071,000</td>
</tr>
</tbody>
</table>


A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related to the pregnancy or its management but not from accidental or incidental causes. The most frequent causes of maternal deaths in Latin America and the Caribbean (for 1997–2002) were haemorrhage (uncontrolled bleeding), hypertensive disorders (high blood pressure) and obstructed labour. There are no country-specific data for Peru.

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**5. Total fertility**

The total fertility is the average number of children that would be born to a woman over her lifetime. The total fertility rate can be separated into the births that were planned (wanted total fertility rate) and those that were unintended (unwanted total fertility rate). In Peru, a survey conducted in 2000 indicated a total fertility rate of 2.8 per woman. This rate gradually declined during the period of the surveys in 1986, 1992, 1996 and 2000.

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**Sources:**

6. Births by urban versus rural location

Among the women interviewed in a survey conducted in 2000, about 54% of births occurred in urban areas.1

The total number of births (in thousands): 583 (2005)2

<table>
<thead>
<tr>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>54%</td>
<td>46%</td>
</tr>
</tbody>
</table>

7b. Perinatal mortality rate

Perinatal mortality refers to deaths of fetuses in the womb and of newborn babies early after delivery. It includes (1) the death of a fetus in the womb after 22 weeks of gestation and during childbirth and (2) the death of a live-born child within the first seven days of life. The perinatal mortality rate reflects the availability and quality of both maternal and newborn health care. In Peru, perinatal mortality varies by subregion, from 13 per 1000 pregnancies in Ica to 45 per 1000 pregnancies in Cusco.

8. Adolescent pregnancy rate by age for girls 15–19 years old

Adolescent pregnancy is pregnancy in an adolescent girl (girls 10–19 years old). The adolescent pregnancy rate indicates the proportion of adolescent girls who become pregnant among all girls in the same age group in a given year. Surveys conducted in 1986, 1992, 1996, 2000 and 2004–2005 found that the proportion ranged between 1% and 4% for all the surveys, and the trends varied across all age groups.

9. Adolescent pregnancy rate by urban versus rural location

In Peru, a survey conducted in 2004–2005 indicated that about 2% of women 15–19 years old were pregnant with their first child. The proportion was higher in rural than in urban areas.

10. Adolescent pregnancy by subregion

Adolescent pregnancy rates vary between different parts of Peru. According to surveys conducted in 2000 and 2004–2005, Selva and Loreto had the highest rates. Adolescent pregnancy rates can vary for many reasons including cultural norms, socioeconomic deprivation, and education, access to sexual health information and contraceptive services and supplies.
11. Unmet need for family planning, 2004–2006 8%
The unmet need for family planning is the proportion of all women who are at risk of pregnancy and who want to space or limit their childbearing but are not using contraceptives.


12. Family planning: modern contraceptive use by age group
Modern contraceptive methods include oral and injectable hormones, intrauterine devices, diaphragms, hormonal implants, female and male sterilization, spermicides and condoms. According to surveys conducted in 1986, 1992, 1996, 2000 and 2004–2005, the use of modern contraceptives has been increasing in all age groups. Women 45–49 years old had the greatest increase.


13. Contraceptive use by urban versus rural location
In Peru, surveys conducted in 1986, 1992, 1996, 2000 and 2004–2005 showed that contraceptive use was consistently higher in urban than in rural areas. The 2004–2005 survey shows that 99% of women who were currently married in Peru were using a contraceptive method. This represented a gradual increase in prevalence over all these surveys, in both rural and urban areas.


14a. Contraceptive use by subregion
The prevalence of contraceptive use varies in different subregions of Peru. Surveys conducted in 1986, 1992, 1996, 2000 and 2004–2005 showed an upward trend in all subregions, although some at a higher rate than others.


14b. Contraceptive use by subregion
The prevalence of contraceptive use varies in different subregions of Peru. Surveys conducted in 1986, 1992, 1996, 2000 and 2004–2005 showed an upward trend in all subregions, although some at a higher rate than others.


15. Antenatal care
Antenatal care visits (ANC) include all visits made by pregnant women for reasons relating to pregnancy. According to a survey conducted in 2000, about 82% of women received ANC for their latest pregnancy that ended in a live birth. Of the pregnancies that ended in live births, about 67% were given ANC by a skilled provider at least once.

16. Utilization of skilled birth attendants

A skilled birth attendant is an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period and in the identification, management and referral of complications among women and newborns. All women should have access to skilled care during pregnancy and at delivery to ensure that complications are detected and managed. According to a survey conducted in 2004–2005 about 70% of childbirths were assisted by a skilled birth attendant: 89% in urban areas and 43% in rural areas.

<table>
<thead>
<tr>
<th>Wealth Quintile</th>
<th>% of Births Assisted by Skilled Birth Attendant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest</td>
<td>29.0</td>
</tr>
<tr>
<td>Poorer</td>
<td>68.5</td>
</tr>
<tr>
<td>Middle</td>
<td>95.3</td>
</tr>
<tr>
<td>Richer</td>
<td>99.6</td>
</tr>
<tr>
<td>Richest</td>
<td>99.8</td>
</tr>
</tbody>
</table>


17. Utilization of skilled birth attendants by wealth quintile

Whether a woman delivers with the assistance of a skilled attendant is highly influenced by how rich she is. In a survey conducted in 2004–2005, almost 100% of women in the highest wealth quintile had a skilled attendant present at birth versus only 28% of women in the lowest wealth quintile, representing almost a four-fold difference.

18a. Utilization of skilled birth attendants by subregion

The percentage of women giving birth with the assistance of a skilled attendant varies by subregional location within Peru. According to a survey conducted in 2006, reported to be higher in the central subregion, and lower in the Northern subregion. The highest proportion was seen in Central subregion (59%) compared to 20% in the Western subregion.

<table>
<thead>
<tr>
<th>Subregion</th>
<th>% of Births Assisted by Skilled Birth Attendant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>70%</td>
</tr>
<tr>
<td>Northern</td>
<td>20%</td>
</tr>
<tr>
<td>Western</td>
<td>20%</td>
</tr>
</tbody>
</table>


18b. Utilization of skilled birth attendants by subregion

The percentage of women giving birth with the assistance of a skilled attendant varies by subregional location within Uganda. According to a survey conducted in 2006, reported to be higher in the central subregion, and lower in the Northern subregion. The highest proportion was seen in Central subregion (59%) compared to 20% in the Western subregion.

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<td>20%</td>
</tr>
<tr>
<td>Western</td>
<td>20%</td>
</tr>
</tbody>
</table>


19. Place of delivery

Delivery in a health facility can reduce maternal and neonatal death and morbidity. A survey conducted in 2004–2005 indicated that about 70% of pregnant women in Peru gave birth in a health facility. About 28% of births were at home, with the associated risks.

<table>
<thead>
<tr>
<th>Place of Delivery</th>
<th>% of Births Assisted by Skilled Birth Attendant</th>
</tr>
</thead>
<tbody>
<tr>
<td>In facility</td>
<td>70%</td>
</tr>
<tr>
<td>At home</td>
<td>28%</td>
</tr>
</tbody>
</table>

20. Caesarean section rates by urban versus rural location

Caesarean section is a surgical procedure in which incisions are made through a woman’s abdomen and womb to deliver her baby. It is performed whenever abnormal conditions complicate vaginal delivery, threatening the life and health of the mother and/or the baby. According to a survey conducted in 2004–2005, about 16% of births were delivered by caesarean section in Peru: about 6% in rural areas and 23% in urban areas.

![Graph showing caesarean section rates by urban versus rural location]


21a. Caesarean section by subregion

Caesarean section rates also vary between subregions in Peru. According to a survey conducted in 2000/01, the caesarean section rates varied from approximately 1% in Western subregion to approximately 5% in central subregion.

![Graph showing caesarean section rates by subregion]


21b. Caesarean section by subregion

Caesarean section rates also vary between subregions in Peru. According to a survey conducted in 2000/01, the caesarean section rates varied from approximately 1% in Western subregion to approximately 5% in central subregion.

![Graph showing caesarean section rates by subregion]


22. Low birth weight

Babies weighing less than 2500 g at birth are considered to have low birth weight. According to a survey conducted in 2000, of the babies who were weighed at birth, about 6% were reported to weigh less than 2500 g (2.5 kg). Low-birth-weight babies often face severe short- and long-term health consequences and tend to have higher mortality and morbidity.

![Graph showing low birth weight by year]


23. Anaemia in pregnancy

Anaemia refers to abnormally low levels of haemoglobin (iron-containing oxygen proteins) in the blood. The percentage of pregnant women with low haemoglobin levels (less than 110 g/l) was about 39% according to a survey conducted in 2000. Severe anaemia is an important contributing factor to maternal deaths due to haemorrhage during childbirth.

![Graph showing anaemia levels in pregnancy]


24. Prevention of mother-to-child transmission of HIV

The percentage of pregnant women living with HIV and receiving antiretroviral drugs (ARVs) to prevent the transmission of HIV to their child (PMTCT) increased from 10% in 2004 to 34% in 2006.

![Graph showing PMTCT rates by year]

25. Equity – gap in coverage of four major interventions by wealth quintile

This graph illustrates the gap in coverage of four key interventions (family planning, maternal and newborn care, immunization and treatment of childhood illness) by wealth. The coverage gap reflects the difference between the goal of universal coverage of everyone in these four intervention areas and actual coverage. Where the gap is larger, it means there is less adequate coverage. The opposite indicates better coverage. The graph indicates that, in the surveys conducted in 1992, 1996, 2000 and 2004, the coverage gap is highest for the poorest and is lowest for the richer members of society (wealthiest quintile). Overall, the gap in the survey conducted in 2004 (19%) was lower (that is, improved coverage) compared with the 1992 survey (35%). Achieving equity requires improving coverage levels in the poorest quintiles.


26. Reproductive health
Maternal health


27. Financial flow
(per capita expenditure on health, in US dollars) 2007


28. Human resources

The work of at least 23 health workers (doctors, nurses or midwives) per 10 000 population is estimated to be necessary to support the delivery of the basic interventions required to achieve the Millennium Development Goals related to health. Globally, 57 countries have been identified with critical shortages below this minimum. These countries have a severe crisis in human resources for health. Of these 57 countries, 36 are in sub-Saharan Africa. Peru, with about 19 health workers (as defined above) per 10 000 population, is one of the countries facing this crisis daily, with mothers and children lacking access to proper maternal and child care, HIV/TB and malaria care, and sexual and reproductive health information and services, including skilled birth attendants.

The shortage is exacerbated by staff losses due to migration (in search of a better life) of skilled staff to high-income countries, leaving behind already impoverished health services and systems.

Increasing the human resources around the world and establishing a balance between the services needed and the personnel available, and their distribution, are key elements of a well-functioning health system and critical requirements for achieving Millennium Development Goals.

29. Ratification of treaties and support of international consensus

<table>
<thead>
<tr>
<th>Treaty and Agreement</th>
<th>Ratification Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
<td>Yes</td>
</tr>
<tr>
<td>Convention on the Rights of the Child</td>
<td>Yes</td>
</tr>
<tr>
<td>International Covenant on Economic, Social and Cultural Rights</td>
<td>Yes</td>
</tr>
<tr>
<td>International Conference on Population and Development</td>
<td>Yes</td>
</tr>
<tr>
<td>Fourth World Conference on Women</td>
<td>Yes</td>
</tr>
</tbody>
</table>


30. Other determinants of health: water, sanitation, communication and road networks

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value (Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed-line and mobile phone subscribers (per 100 population)</td>
<td>40 (2006)</td>
</tr>
<tr>
<td>Internet users (per 100 population)</td>
<td>23.6 (2006)</td>
</tr>
<tr>
<td>Roads paved (% of total roads)</td>
<td>13 (2000)</td>
</tr>
<tr>
<td>Improved water source (% of population with access)</td>
<td>84 (2006)</td>
</tr>
<tr>
<td>Improved sanitation facilities (% of urban population with access)</td>
<td>85 (2006)</td>
</tr>
</tbody>
</table>