Structural Adjustment Programs and the Trickle-Down Effect: A Case Study of the Fujimori Period in Peru, Using Reproductive Health as an Indicator for Levels of Poverty

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Abstract

The purpose of this analysis is to investigate whether the Organisation for Economic Co-operation and Development/United Nations/World Bank (OECD/UN/WB) poverty reduction objectives are compatible with the neo-liberal development model, using Peru as a case study. Three OECD/UN reproductive health indicators were selected to assess poverty: female literacy, infant mortality and maternal mortality. Fertility rates were also analyzed to explore the impact that neo-Malthusian policies have wielded.

Shortly after his ascendance to power in 1990, President Fujimori undertook health finance reforms to promote cost-effectiveness and efficiency under political guidance from international financial institutions (IFIs). Internationally, Peru was portrayed as a neo-liberal success story. However, maternal mortality rates throw into contention claims that economic growth has a trickle-down effect. From the fertility rates, it can be deduced that the advent of structural adjustment has led to a resurgence of a neo-Malthusianism approach, putting family planning on the front burner, to the detriment of reproductive health.

Introduction

The main objective of this study is to assess the hypothesis that growth in gross domestic product (GDP), generated in the framework of neo-liberal structural adjustment programs (SAPs), leads to a "trickle down" effect, benefiting the poorest sectors of society. According to the trickle-down theory, there is no need for active and progressive redistribution measures, as wealth will redistribute itself.

The study has the twofold objective of exploring the liberalization of the Peruvian economy during the Fujimori period and the concomitant structural adjustment policies that curb social-sector spending, particularly affecting reproductive healthcare in Peru. It will subsequently point

out how neo-Malthusian and neo-liberal discourses, although distinct ideological influences, are intricately intertwined in this context.

It will be argued that the neo-liberal model of development imposed by international financial institutions on less-developed countries, with its health finance reforms aiming principally at improving cost-effectiveness and efficiency of healthcare spending, is not compatible with the OECD/WB/UN goals of improving reproductive health by 2015, as outlined in *Shaping the 21st Century* (OECD 1999).[1] The neo-liberal principles that sought to promote economic growth in the long run have not led to a trickle-down[2] effect. This result is highlighted by consistently poor reproductive health in women in economically disadvantaged areas of the country, with mortality rates increasing in these regions. Furthermore, it will be argued that this neo-liberal model of development, with its strong focus on neo-Malthusian population control policies that favour family planning programs over reproductive health, is detrimental to women's reproductive health.

The reproductive health status of a country is a good indicator of how gender has been affected by health sector reforms. In this study, reproductive health has been selected as a good gauge of women's position in society, while reflecting changes to the socio-economic situation of a country. Another reason for choosing reproductive health as an indicator for poverty is that the neo-liberal model of development used as a basis for structural adjustment also encompasses a strong focus on neo-Malthusian population control policies, emphasizing population control through family planning.

The following indicators – maternal and infant mortality rates and female literacy rates – are assessed in this study. With respect to these indicators, the 2015 goal aimed at achieving a two-thirds reduction in infant mortality rates and a three-quarters reduction in maternal mortality rates (OECD 1999). Also, disparity in literacy rates between men and women was to be reduced by increasing female literacy rates. In this study, it will be shown how the rise in maternal mortality rates throws into contention claims that economic growth leads to a trickle-down effect.

A fourth indicator assessed in the study, fertility rates, not specified in the OECD/UN/WB initiative, has been included to illustrate how neo-Malthusian population control policies have affected fertility rates.

In assessing the main hypotheses of the study, Latin America was chosen because most countries in the region have undergone a series of harsh SAPs due to their indebtedness, following the failure of the import substitution development[3] model. Within this region, Peru was selected because its complex socio-economic reality constitutes an optimal case study. Peru is among the countries in Latin America with extremely high disparities in regional income levels, disparities that can be translated to a divide on ethnic grounds, affecting particularly the indigenous non–Spanish-speaking population.

This article outlines the linkage of Peru's economy to the global market economy within the context of SAPs launched by President Fujimori following his election in 1990, the implementation of SAPs in Latin America, the growing salience of the World Bank in the health sector; the "populationist" versus "developmentalist" debate in population control and a socio-economic overview of Peru with highlighted regional and ethnic disparities. The four key indicators mentioned above are also analyzed.

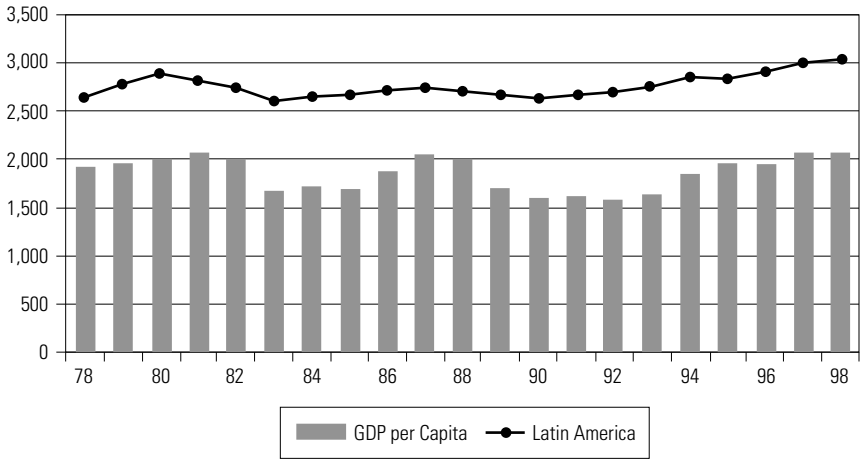
The Linkage of Peru to the Global Market: The Advent of Structural Adjustment under President Fujimori

Alberto Fujimori came to power at an extremely difficult and complex moment in Peru's history. In 1985, the Social-Democrat president, Alan García, had refused to dedicate more than 10% of Peruvian export revenues to foreign debt repayment on the grounds that further increasing repayments would impede economic development. In response, Peru was "excommunicated" from the international economic community and denied any new loans by the International Monetary Fund (IMF) and the WB. Consequently, Peru fell into dire economic straits. Total GDP fell by 8% in 1988 and by another 11.9% in 1989. Hyperinflation soared from 1722% in 1988 to 2775% in 1989 and 7650% in 1990 (Rochabrún 1996).

The ideological charge toward neo-liberalism was provoked by the IFIs' disapproval of former President Alan Garcia's economic policy, which was incapable of containing inflation or dealing with his moratorium debts. Fujimori returned Peru to good credit standing by restarting debt payments. The success of his economic shock program cemented the ideological shift in society, more generally, toward market-oriented solutions to economic and social problems.

President Fujimori's extreme austerity package or, as it is referred to in Peru, *paquetazo* (big package), consisted essentially of "shocks" aimed at reducing inflation by drastically cutting public expenditure, thus increasing the State's revenue (Guillermoprieto 1990). Reforms carried out by President Fujimori's government changed all central aspects of economic management in Peru by applying policies that formed part of the so-called Washington Consensus. Since 1992, Peru had negotiated a series of Extended Facility Programs with the IMF. The main tenet of these programs was the strict application of free-market policies to cure hyperinflation and spur economic growth. The objectives were to promote outward-oriented growth, expand the role of the private sector as the driving force of growth, remove barriers to international capital flows and diminish the economic role of the State (Rojas 1997). The programs, of 3 years' duration, aimed at consolidating the gains made in each successive program.

Figure 1. Peruvian GDP per Capita (1990)



IADB (1999). Graph reproduced with the permission of the Inter-American Development Bank.

The SAPs carried out in Peru in the 1990s did accomplish some significant results. The most notable successes were the reduction of the general fiscal imbalance and the decrease in inflation. The government managed to reduce the rate of inflation drastically, from 10.2 % in 1990 to 7.65% in 1995 (International Planned Parenthood Federation n.d.). Total annual GDP levels rose steadily throughout that period. As shown in Figure 1, Peruvian GDP per Capita (1990) by the Inter-American Bank of Development (IADB 1999) the per capita GDP in Peru rose from $1600 in 1990 to $2100 in 1998. These high growth rates have been lauded internationally as an indicator of Peru's economic recovery. Whereas Latin American economies had been stagnating during these years, Peru was touted as a model success story in the international financial community. However, although President Fujimori's economic program has been very successful in controlling inflation, it has not been able to translate short-term economic gains into progress in development. The impact of structural adjustment on the social inequalities that abound in Peru is assessed later.

Implementation of Structural Adjustment in Latin America

Throughout the 1980s, a large number of less-developed countries (LDCs), particularly in Latin America, underwent SAPs due to entanglement with an excessive debt burden, declining revenues from primary commodities and overall stagnation. Programs aimed to address protracted balance of payment problems, which had resulted in high rates of inflation and a dire economic situation. The primary objective of structural adjustment is reorienting the economies of LDCs to market-centred ones, following three components or principles liberalization (L), privatization (P) and globalization (G). These components are collectively referred to as the "LPG" model (Webb and Shariff 1992) and are overseen by the WB and the IMF. A main tenet of the model of neo-liberal development advocated by OECD countries is that, with active integration into the global market, LDCs would in due course experience economic growth. In many respects, the IMF–Mexico rescue package became a standard model applied to countries facing similar balance of payment problems, with little consideration or adjustment to the specific socio-economic/cultural situation of the country.

As a remedy, several Latin American countries, including Brazil, Mexico and Chile, were prescribed the standard structural adjustment treatment during the 1980s. Peru did not begin until the 1990s. The SAPs, subsequently implemented, reflected a strong endorsement of liberal development assumptions. Their main aims were to restore balance to the government's domestic and international accounts and, thereby, put development on a sustainable footing by devaluing the currency, liberalizing prices, reducing trade barriers, eliminating subsidies and limiting public sector employment and expenditure. The IMF stepped into the breach to prevent the debt crisis, and financial packages were offered with the stipulation that the debtor nation sign a binding agreement to modify its macroeconomic policies.

Structural adjustment has been particularly intense in the economies of Latin America, where the average annual growth plummeted to 5.5% in the 1970s (UN Commission on the Status of Women 1995). In Latin America, as part of the transition to the new development model based on the free play of market forces and liberalization of foreign trade, the State was reformed and its role in social policy redefined. In the 1990s, Latin America countries achieved greater macroeconomic stability and returned to the path of growth, correcting the severe imbalances in macroeconomic fundamentals that had arisen during the 1980s, a period widely referred to as "the lost decade." In the region, GDP grew at an average annual rate of 3.5% between 1990 and 1997 (Economic Commission on Latin America and the Caribbean [ECLAC] 1998). For proponents of market-oriented globalization, this was a succinct illustration of the triumph of the market over the nation-state. For critics of globalization, however, the victory of the market also meant the end of the State as the protector of the economically weak against the economically strong. In Latin America, economic growth did not alleviate high rates of poverty and disparity in income distribution. It became apparent that not all sectors of the population would benefit, either directly or indirectly through a trickle-down effect. This poverty afflicted particularly harshly indigenous populations living in rural areas in Bolivia, Guatemala and Peru.

The 1987 UNICEF report *Adjustment with a Human Face* (WHO n.d.) gave rise to programs with a more moderate stance that adhere to SAPs and their tenets, while extolling the need to provide safety nets for the poor, foster a participatory approach in the decision-making, and create pro-poor policies that can facilitate structural adjustment. An example of a more moderate concept is ECLAC's "productive transformation with equity," from 1991. The objectives of the ECLAC proposal are to produce, within the neo-liberal pattern, an efficient, durable and international competitive economy, and to establish democratic structures and equity at the same time.

While neo-liberalists give priority to deregulation and liberalization of markets and advocate a passive role for the State, the ECLAC proposes a selective action by the State, such as compensatory programs to combat extreme poverty, retaining the view that growth can be attained with equity (Ramos 1995). It was within this pro-poor economic growth framework that President Alejandro Toledo, elected in 2001, pledged to fulfil an ambitious campaign to lift Peru's impoverished masses

from a historical cycle of social inequity and inadequate education and healthcare. The following section shows the evolving and more salient role of the WB and IMF in health and population.

Health Reforms

The inefficiencies of Latin American health systems had been known for many decades. Despite pronounced inequality, however, sustained high levels of public investment in social programs had ensured that a relatively large group was eligible for healthcare provided by the government. The inefficiencies were only accentuated by the economic crisis of the 1980s, culminating in the IMF and WB taking advantage of the crisis and pressing for health reforms as a condition for borrowing. The IMF required structural adjustments to reduce the huge public debt that governments had contracted in previous years. Because a large part of public expenditure was allocated to social services, the IMF and WB required the government to reduce those services. It was at that juncture that the WB began to play a prominent role in international health policy. By the end of the 1980s, the WB had become the major international health lender and started to assist countries to prepare health reforms based on neo-liberal economic principles.

One objective of the reforms was to free central government funds to pay for the huge public debt. In 1993, the WB devoted the *World Development Report* to the health sector, highlighting the ideological shift toward neo-liberalism and its focus on efficiency, not only in economic but also in social reform areas (Ewig 2002). In this document, in addition to reinforcing privatization strategies, the WB included the need to improve equity and efficiency in allocations through guaranteeing universal access to a basic package of services determined according to what each country could afford and based on cost-effectiveness principles. Governments would remain responsible for no more than a basic health package, components of which could vary, depending on a country's level of development.

In the following section, it will be shown how the neo-Malthusian approach links population growth to poverty and how IFIs influence health and population through the conditions of their loans.

Neo-Malthusian Population Control in the Context of Neo-Liberal Structural Adjustment Programs

Controversies surrounding population and development are not new. However, Malthusian premises of population control have never been so fundamentally challenged, and by such diverse actors, as during the 1970s. Ever since 1789, when the Reverend Thomas Malthus first published calculations to demonstrate the impact of population growth on food production, his theories have been regularly revived and reformulated.

The mid-1970s were a period of considerable rethinking in international development policy. The belief in economic growth as a panacea for development problems had been largely discredited. This led to a fresh approach to issues on population control, especially in southern countries, and gained ascendancy over the neo-Malthusian model. Proponents of this view recognized that population growth was linked firmly to development and that a rise in average income levels did not, in itself, suffice. Instead, improvements in general health and education, especially women's education, were viewed as essential to reducing infant and child mortality rates, thus laying the basis for a lower "demand" for children and raising awareness of contraceptive practices.

In the 1980s, however, economic realities provided a harsh counterpoint to the progress achieved at the 1974 Bucharest Conference and prompted the return to neo-Malthusian approaches in development programs. In the 1990s, high population growth in the developing world was viewed mainly as a threat to environmental sustainability. This emphasis had been a main factor in the revival of neo-Malthusian population control policies that often fail to recognize the true cause of high fertility rates in LDCs, which, usually, correlate high levels of poverty with illiteracy. The United Nations Fund for Population Activities (UNFPA) *State of World Population 2002*, for example, contends

that "poverty, poor health and fertility remain highest in the LDCs where population tripled since 1955 and is expected to nearly triple again over the next 50 years" and concludes that "promoting Reproductive Health and Rights is indispensable for economic growth and poverty reduction." This ideology is also reflected in the aggressive population control policies of IFIs in the South. In Peru, for example, in a 1993 project USAID provided $30 million to expand family planning services to "rural and marginal urban areas." In 1996 and 1997, it made several loans to the Peruvian government. The WB made a $150 million social development loan, which included assistance for birth control and institutional capacity building (Human Rights Internet 2000).

The United Nations International Conference on Population and Development (UN-ICPD) held in Cairo in 1994 was heralded as a "paradigm shift in the discourse about population and development" (Presser and Sen 2000: 3). Its *Programme of Action* was the first and most comprehensive international policy document to promote the concepts of reproductive rights and health. It came into existence largely because of the organizing and lobbying efforts of various women's health groups. It promoted the common ground between women's groups, population organizations, donor agencies and governments by articulating a neo-Malthusian agenda to reduce fertility rates combined with a reproductive rights agenda. It accepted the neo-liberal economic approach to the detriment of its rights agenda and encouraged governments to promote the role of the private sector in the delivery of high-quality reproductive health and family planning services to communities. It also urged countries to review legal issues and import policies that unnecessarily prevent or restrict the greater involvement of the private sector (UN-ICPD 1994).

Neo-liberal social-economic restructuring supported by the IFIs financed many pro-health initiatives. In view of the increasing salience of the population and development agenda in UN conferences, the WB started the Safe Motherhood Initiative to reduce the burden of disease related to pregnancy and childbearing. Between 1993 and 1998, it lent $383.5 million to Latin America for this initiative (WB 1999a). Then, in 1999, its Executive Board approved an $80 million loan to finance reforms to the health system, aimed at improving maternal and child health as well as reducing illness and premature death among poor people. Pierre Werbrouck, the WB resident representative in Peru, stated that the loan would support the Peruvian government's effort to design and implement new policies seeking to guarantee access to a wide range of healthcare services for Peru's poorest population groups (WB 1999b).

Initiatives such as Safe Motherhood were the result of the increasing salience of reproductive health on the UN forum, which has led to a more holistic approach and increased interest of the IFIs in the issue of reproductive rights.

On the fifth anniversary of the Cairo Conference, 1999, a formal ICPD +5 review was undertaken to assess how far countries had come in implementing the ICPD Programme of Action. Although it is too early to assess 5 years' progress into the 20-year life span of the program, in most regions of the world, ideas and realities are changing with respect to sexual and reproductive health standards. For example, laws and policies are being revised and new partnerships formed at international, national, district and local levels. The next section will provide an overview of health reforms undertaken by the Fujimori government. This will be followed by an outline of the steps taken to comply with the recommendations of the Cairo Conference.

Health Reforms in Peru

In Peru, health sector reforms began in 1991 with the introduction of fee for service in most Peruvian public health establishments and hospitals in particular. These reforms, rather than arising through a change in socio-economic philosophy, were a reaction to a critical financial situation.

Fujimori took little interest in social policy in his first two years in office, and during this time the already weak state of the health system rapidly collapsed under the stress of the economic crisis and civil war. In 1990, spending on social programs such as health was just less than one quarter of that spent in 1980 (Portocarrero Suarez and Aguirre Guardia 1992). Fujimori's economic shock

therapy, set into motion in August 1990, hit health institutions harshly, and the introduction of fee for service in 1991 was a stop-gap measure to help desperate health establishments self-finance until economic stabilization was achieved. By 1993, the economy had begun to stabilize and the State apparatus was restructured. The Ministry of Health (MoH) established reform policies in the public health sector to improve equity in healthcare by optimizing the allocation and utilization of resources through restructured healthcare financing. A basic package of health services was developed as a way of controlling health spending and regulating health services, and it was decided that the focus should be on family planning rather than primary healthcare services.

After the advent of SAPs, the Population Law enacted in 1985, which required the government to give priority to "basic maternal and child healthcare" free of charge, lost currency. The budget squeeze that led to the closure or emasculation of public hospitals in favour of an increased number of health centres affected women particularly, because these public hospitals were the only institutions that provided qualified staff and adequate equipment for obstetrical–gynaecological services. At the same time, a *de facto* fee system was imposed in all healthcare facilities, making services less accessible to low-income women. Thus, medical care for childbirth in public hospitals remained subject to fees established by each institution, whereas contraceptive methods including surgical contraception were the only reproductive healthcare services free of change.

The Follow-up of the ICPD in Peru

Since the end of 1994, diverse public and private institutions in Peru have worked to disseminate the ICPD recommendations. Non-governmental organizations (NGOs), particularly women's groups, are also monitoring the implementation of the ICPD Programme of Action in order to hold governments accountable for the progress made.

In the 1990s, the field of reproductive health and family planning in Peru underwent significant changes. The enactment of the Population Law in 1985, which had been a major advance in increasing recognition of the right to sexual and reproductive health in terms of determining the number of one's children and access basic healthcare, lost momentum. In the 1990s, the government's interpretation of the concept of reproductive health contributed to its decision to implement more aggressive family planning programs. This phase was initiated with the launch of the National Population Program 1991–1995, which was supported by Fujimori who declared 1991 the "Year of Austerity and Family Planning." The objectives of the National Population Program 1991–1995 were in part to reduce the rate of national population growth to more than 2% annually, by promoting a decrease in the fertility rate conducive to improving maternal and child health (The Center for Reproductive Law and Policy 2001).

In 1995, family planning programs implemented by the MoH at national level were given fresh impetus. The National Population Law was modified to include sterilization as one of the methods of family planning to be provided in government programs. Pursuant to this law, the MoH began an intensive campaign to raise awareness to induce women to make use of irreversible contraceptive methods in an effort to control the birth rate, especially in peasant women (Inter-American Commission on Human Rights 2000a). That same year, a regulation established that "the widest range of contraception methods" would be available completely free of charge at public health establishments (Center for Reproductive Law and Policy 1998).

In 1996, the Program of Reproductive Health and Family Planning (PRHFP) 1996–2000 proposed to consider family planning a priority of reproductive health. Its aim was to ensure for men and women the capacity and freedom to decide on the number of their offspring. Among its priority problem areas, the PRHFP identified high levels of unsatisfied demand for contraception and the increase of high-risk reproductive behaviour among adolescents. One of the program's goals was to reach a total contraceptive prevalence rate of no less than 50% of women of childbearing age. The PRHFP emphasized free services along with the provision of contraceptives including surgical sterilization. However, free medical services in the event of complications resulting from surgical sterilization were not expressly included.

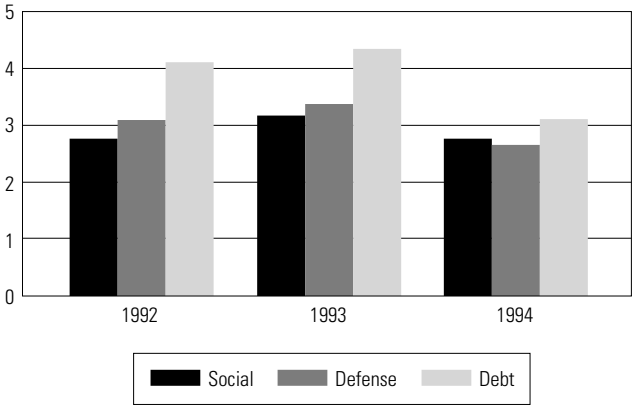
Recent media reports concerning the scandal of a program of forced sterilization, which has affected 300,000 women in Peru, have provoked widespread condemnation both domestically and internationally (Population Research Institute [PRI] 2000). According to the Population Research Institute, there is evidence that coercive family planning practices with a view to reducing poverty have occurred in the framework of a $36 million family planning program established in Peru and funded by USAID (PRI 2000). This illustrates Malthusian thinking in donor agencies and the government. It has also been reported that the government had fixed a quota of sterilizations to be performed per month and gave incentives to doctors to carry out these interventions. In addition, many women claimed to have been threatened with denial of access to public health services if they did not consent to sterilization.

A Socio-economic Overview of Peru

The Impact of Structural Reforms on Poverty Levels

Despite the publication of official figures showing a spectacular growth of GDP in Peru from 1990 to 1997, foreign debt repayments continued to be an important priority, diverting increases in GDP away from development programs aimed at raising standards of living. In 2000, Peru's total foreign debt was equivalent to 50% of GDP, well above the 19% regional average in Latin America (Social Watch 2000). Debt repayments represented 30% of the budget in 2000 and approximately 20% in the period 1995 to 1999. As shown in Figure 2, produced by Social Watch, budget allocations for the repayment of foreign debt continued to exceed social spending during the 1992–1994 period. Social spending was equivalent to approximately 3% of GDP during that same period. By 2000, official figures claimed that social spending had been increased to 6% of the GDP, equivalent to 40% of the national budget. However, it is very difficult to obtain accurate data on how much was actually spent on basic social services, as budgetary information is inadequate, a fact already noted in the 1994 report of the technical mission of the IMF's Public Finance Department (Social Watch 1996).

Figure 2. Types of spending in Peru



Social Watch (1996). Graph reproduced with the permission of Social Watch.

In accordance with the program negotiated with the IMF, the Peruvian government agreed to dedicate 1% of total GDP to social expenditure in order to alleviate the effects of the structural adjustment programs. Therefore, in 1991 the Fujimori administration implemented a National Fund for Compensation and Social Development. This project focused on social programs, social

development and reproductive health for the most vulnerable sector of the population, those living in absolute poverty. Throughout the 1990s, there was little evidence of a significant reduction in overall poverty levels that had resulted from SAPs. According to a living-standards survey in 1991, half of all households surveyed were poor and one in five was extremely poor. In 1997, the majority of Peruvians continued to live in conditions of relative poverty, with 54% of households unable to generate sufficient income to pay for the basic family market basket (Pan American Health Organization [PAHO] 1999). The Inter-American Commission on Human Rights (2000b) stipulates that the minimum wage should be sufficient to cover the cost of the basic family market basket.

According to official government figures, levels of absolute poverty were reduced from 26.8% to 14% of the population from 1991 to 1997. However, despite an overall trend for levels of absolute poverty to drop slightly, levels of relative poverty have remained constant. In *Poverty, Growth and Inequality: Peru 1991–1994*, Andrés Medina Ayala showed that the richest 20% of Peruvian society consumes nearly 50% of national expenditure, while the poorest 20% barely takes 6% of total spending, with women being particularly affected by poverty (Social Watch 1997). In 1996, according to the National Institute of Statistics and Information on Peru (INEI), 50% of women lived in conditions of relative poverty and 25% in absolute poverty (Social Watch 1997). Contributing to this increase in poverty among women had been the abolishing of the Convention 100 of the International Labour Organization. Signed in 1959, this Convention should have guaranteed equal salaries between men and women for equal work. Its abolishment was a direct consequence of neo-liberal SAPs (Social Watch 1997), as women were disproportionately represented in part-time jobs and in the economy of the informal sector, in occupations usually not covered by social security and health insurance. Social security coverage was reduced from 40.7% of the economically active population in 1987 to 23.4% in 1995 (Ministerio de Salud del Peru [MINSA] 1996). In 1994, the year in which major reforms began to be implemented, the large majority of the population (73.8%) had no insurance at all and depended on the network of public health posts, clinics and hospitals overseen by the MoH (MINSA 1996). About 25% of those without medical insurance did not use any formal means of health services (MINSA 1996), relying instead on pharmacies, market vendors, traditional healers and homemade herbal remedies (MINSA 2003).

In many respects, structural adjustment has also intensified the marginalization of the indigenous population. In Peru, indigenous populations can be classified according to language or place of residence, with a significant disparity of wealth between Spanish-speaking indigenous and non–Spanish-speaking indigenous persons. Based on native language (Quechua, Aymara or other indigenous language), a 1993 census identified 4,035,300 indigenous persons, or 17% of the population (PAHO 1999). Of this population, 75% resided in the Highlands, 9% in the Jungle and 17% in Coastal regions, including the Lima Metropolitan area. Then, 42% of this indigenous population lived in conditions of absolute poverty, double the national average. As most of the indigenous population lives in the regions, this leads to a significant discrepancy in standards of living and poverty levels between the capital, Lima, and the rest of the country.

Analyses of Reproductive Health Indicator Tendencies in Peru

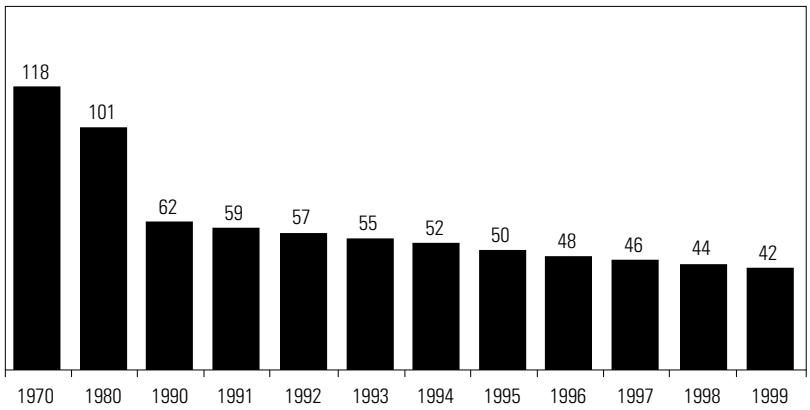
The following UN/OECD indicators – fertility, infant mortality, maternal mortality and female literacy – have been selected and analyzed in order to assess whether economic growth is the primary vehicle for poverty reduction. The importance placed on family planning to reduce fertility rates is indicative of the impact of the neo-Malthusian approach promulgated by the IFIs. Female fertility rates were, therefore, selected as a good indicator of the impact of this approach. Infant and maternal mortality rates have been selected as the most representative and important indicators for reproductive health in order to assess whether economic growth entails a corresponding improvement in the overall reproductive health situation. Female illiteracy was also included in the analysis because this indicator is widely recognized as providing the most important correlation between poor reproductive health with high fertility rates. The graphs included in this section were all produced by INEI.

However, in order to establish an accurate overview of these indicators, additional statistical information on these indicators from other sources was also assessed and summarized in the Appendix in tabular form.

Indicator 1: Infant mortality rates (See also Table 1 in the Appendix.)

As shown in Figure 3, infant mortality has generally shown a decreasing trend in the decades prior to the implementation of structural adjustment, falling from 118 per 1000 live births in 1970 to 101 in 1980 and 62 in 1990. Following the implementation of structural adjustment, there has been a further steady decrease in national infant mortality rates, from 62 in 1990 to 42 per 1000 in 1999.

Figure 3. Peru: Infant mortality rates, 1970–1979



Number of children under one for every 1000 live births.
INEI (n.d.). Graph reproduced with the permission of the National Institute of Statistics. (Note. Site available in Spanish only.)

It is important to note, however, that this trend is not evenly distributed over the entire country. The 1993 ENDES data in Table 1 of the Appendix illustrates this disparity very well, with mortality rates of 22.9 per 1000 in Lima compared to 113.9 in the Highlands. Efforts to meet immunization targets set out by the Extended Immunization Program were hampered by economic barriers as, according to INEI, only 25% of those living in absolute poverty had access to health services in 2000 (Social Watch 2000).

Indicator 2: Female fertility rates (See also Table 2 in the Appendix.)

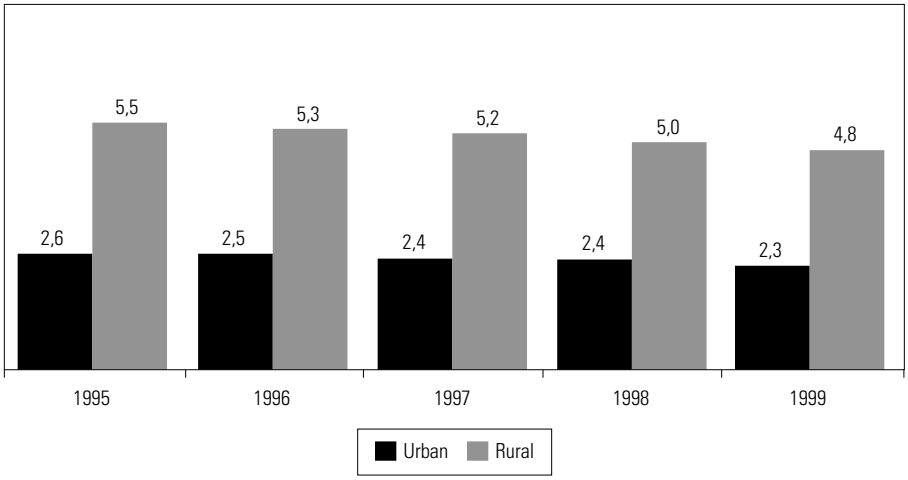
According to the US Bureau of Censuses International Data Base in Table 2 of the Appendix, overall female fertility rates have displayed a steadily decreasing trend from 4.24 in 1986 to 3.04 in 2000.

From 1995 to 1999, with an average of 5.16 children per rural woman versus 2.44 per urban woman, we observe an unprecedented reduction of 0.70 child per rural woman versus 0.30 per urban woman (Figure 4). The disparity between rural and urban fertility rates remained steady, as in previous years, with fertility rates in rural areas double those of urban areas.

Comparing Figure 4 with Table 5 in the Appendix, the official data from the Ministry for Women's Promotion and Human Development (PROMUDEH n.d.) shows a very late and sudden reduction in the number of children in rural areas versus an earlier and steadier one in urban areas. Thus, we observe a reduction of 1.50 children per rural woman versus 0.54 per urban woman within two 5-year periods, 1985–1990 and 1995–2000, whereas the reduction in the periods 1975–1980 and 1985–1990 was 0.75 child per rural woman versus 1.22 per urban woman. It is noteworthy

that this unprecedented reduction in the rural fertility rate, culminating in the period 1995–2000 (5 years after President Fujimori's ascendance to power) in a reduction of one child per rural woman versus 0.28 per urban woman, was more likely the result of an aggressive Neo-Malthusian approach than of a long educational process.

Figure 4. Peru: Global fertility rate, 1995–1999



Average number of children per woman.
INEI (n.d.). Graph reproduced with the permission of the National Institute of Statistics. (Note. Site available in Spanish only.)

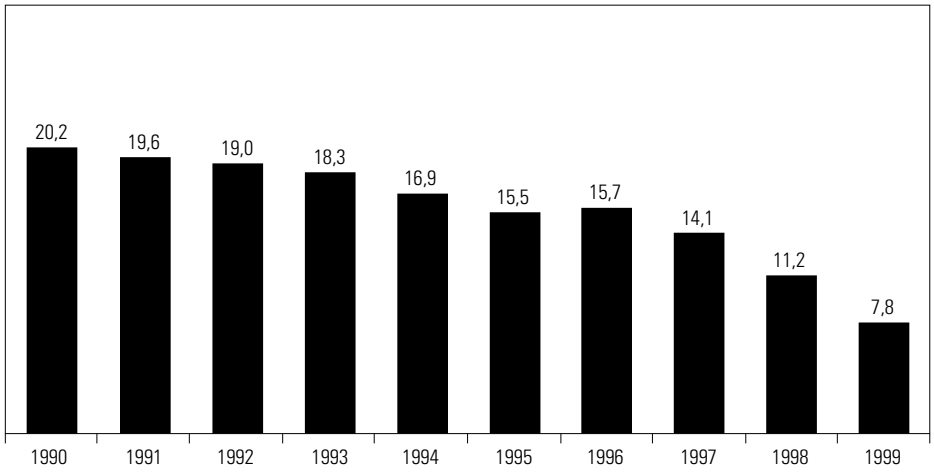
It was not possible to find precise data assessing the extent to which fertility rates had decreased in the late 1990s, possibly due in part to the increased prevalence of a contraception program that resorted unofficially to forced sterilizations on poor uneducated women. Now, Health Ministry officials estimate that the 110,000 sterilizations performed on women would have resulted in 26,000 fewer births in 1998 (The Shawnee News-Star 1998) affecting infant mortality as well as maternal mortality in the following years.

Indicator 3: Female illiteracy rates (See also Table 3 in the Appendix.)

As shown in Figure 5, official sources indicate that at the national level, female illiteracy was reduced from 20.2% in 1990 to 7.8% in 1999. However, as with indicators mentioned earlier, a reduction in female literacy rates had already taken place prior to the implementation of SAPs. According to the US Bureau of Censuses, International Data Base in Table 3 of the Appendix, rates fell from 51.7% in 1961 to 35.6% in 1972, then to 16.9% in 1981 and 15.7% in 1996. Again, this database also shows that improvements in female literacy occurred at a disproportionate rate in the Lima Metropolitan area compared with other regions. From 1981 to 1996, female illiteracy in rural areas fell only from 51.6% to 36%, whereas it fell from 14.3% to 6.9% in urban areas.

Investment in sexual health education programs with a view to complying with the ICPD objectives has limited effect on demand for reproductive healthcare. Improvements in women's status through education and economic opportunity have a strong influence on demand for reproductive health services, including family planning and delivery care. Female literacy studies have shown a strong relationship between literacy and health. Even when mothers have attended school for only 1 year, infant mortality rates decline because the women can take better care of their babies (Oxfam n.d.).

Figure 5. Peru: Evolution of female illiteracy rates, 1990–1999 (%)



INEI (n.d.). Graph reproduced with the permission of the National Institute of Statistics. (Note. Site available in Spanish only.)

Indicator 4: Maternal mortality rates (See also Table 4 in the Appendix)

Whereas the three other indicators have continued to decrease in the 1990s, the fourth, maternal mortality, shows a slight increase if anything. According to ENDES in Table 4 of the Appendix, maternal mortality rates rose from 260 in 1992 to 265 per 100,000 in 1996. However, reliable data on maternal mortality does not exist in Peru, with under-reporting of deaths at the national level estimated at 508 per 100,000 in 1992 (PAHO 1999). In some regions, for example, in the Jungle areas, under-reporting is as high as 805 per 100,000, or 990 per 100,000 in Ayacucho in the Highlands and the in Amazonas (PAHO 1999). Data shown in Figure 6 and collated in Table 4 do, however, illustrate to some degree the high disparity of maternal mortality rates between the Lima Metropolitan area and the rest of the country. For example, for 1996, INEI shows a disparity of 114 per 100,000 in urban areas versus 448 in rural areas. Also indicative of this disparity are statistics collected in 1996 in Huancavelica, the poorest province of Peru (a Highland region with a mainly indigenous population), showing a staggering rate of 713 maternal deaths per 100,000 births (Portillo n.d.).

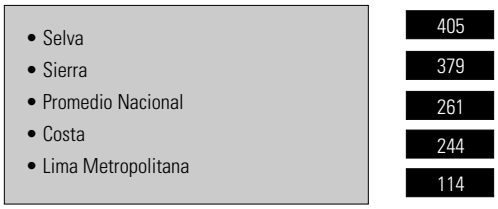
In Peru, high rates of maternal mortality were unusually predominant in rural populations and marginalized urban zones, where vulnerable groups lacked health insurance (Oxfam n.d.). According to the Demographic Health Survey 1996, rural women were twice as likely to die from childbirth complications as their urban counterparts. In 1996, 73% of births occurred at a healthcare establishment in urban areas, versus only 15% in rural areas (Center for Reproductive Rights 2003). This highlights the inadequacy of the basic package, which did not emphasize obstetrical needs.

One can also identify regional inequities in spending patterns. Paradoxically, state health expenditure was concentrated in the Lima area, where incidence of poverty in 1994 was globally less prevalent than in rural areas, which were not able to self-finance their health expenditures (Gonazalo and Francke 1997). Consequently, healthcare centres in these locales had a low capacity for addressing obstetrical complications and emergencies.

Of note is that Peru has one of the highest abortion rates in Latin America. Since most abortions are performed clandestinely, it is difficult to accurately calculate the extent of this practice. Nevertheless, the results of the study "Clandestine Abortion in Peru" indicate that for every two pregnancies that end in birth, at least one is terminated (Ferrando 2002). The cases of hospitalization for abortion complications in Peru are estimated to represent only one woman of every seven who have abortions, as data available on hospitalization, cause of deaths and other health statistics are inaccurate, incomplete and outdated. In 1998, the death rate for illegal abortion was estimated

at 400 to 600 per 100,000 procedures. In the ICPD+10 review, fewer deaths from illegal abortions can be expected as a result of voluntary or forced sterilization.

Figure 6. Peru: Maternity mortality rates, 1996



Average number of women who died per 100,000 live births, according to regions: Selva (Jungle), Sierra (Highlands), Costa (Coast), Lima Metropolitana (Lima Metropolitan area) and Promedio Nacional (national average) (INEI n.d.). Graph reproduced with the permission of the National Institute of Statistics. (Note. Site available in Spanish only.)

Important impediments in reducing maternal mortality stem also from cultural misunderstandings and estrangement between healthcare providers, who perceive themselves as being westernized, and indigenous women from isolated areas. As one NGO respondent described, indigenous women generally prefer to give birth at home because healthcare providers do not follow traditional practices, which include giving soup to the mother after childbirth and returning the placenta to them to be buried in the field. By "designing projects and fitting women into them," development programs at both the international and national levels fail to incorporate local cultural elements that are of utmost importance for indigenous women (Hardee et al. 1998: 51). Moreover, reproductive health and family planning programs of the MoH, such as the Emergency Plan for the Reduction of Maternal Mortality, which fail to address the linguistic needs of non–Spanish-speaking women, tend to reinforce the ethnic division prevailing throughout the country.

Overall Conclusions on the Analyses of These Indicators

Although a common feature worldwide, an important overall trend shown in the analyses of these reproductive health indicators is that national averages mask a marked difference between social groupings and geographical areas within the country. Analyses of fertility, maternal mortality, infant mortality and female illiteracy rates by social class and region demonstrate a distinct reality. Although there was a continuing trend of reductions in infant mortality and female illiteracy, from these statistics it is shown that the situation in Peru at that time was far from meeting the 2015 OECD/UN/WB reproductive health objectives of achieving a two-thirds reduction in infant mortality rates and a three-quarters reduction in maternal mortality rates (OECD 1999). Disparity in literacy rates between men and women was to be reduced by increasing female literacy rates.

In Peru, maternal mortality rates had, if anything, increased during the Fujimori government, illustrating the emphasis placed on reducing fertility rates to the detriment of comprehensive reproductive healthcare.

Economic reorientation, together with the ensuing social repercussions, does not appear to have had an overall effect on the course of demographic transition processes. Declining fertility rates have been the distinguishing feature of demographic trends and patterns among the populations of Peru and the Latin America and Caribbean regions over the last 30 years (ECLAC 1998). Infant mortality has also continued to decline, yet the improvements shown in the statistics were no greater in the 1990s when neo-liberalism gained dominance than in the 1980s.

However, the increase in maternal mortality rates is the indicator that throws into contention most significantly claims that economic growth entails "trickle down." Unlike the other indicators, which have demonstrated downward trends since the implementation of SAPs, maternal mortality

rates have continued to increase under the Fujimori government. This is likely the result of cutting health services and adding fee for services. In Latin America, it was calculated that the lifetime risk of dying from pregnancy- or childbirth-related causes was 1 in 130, a ratio almost 14 times higher than that of developed countries (ECLAC n.d.b.). Peru remained, along with Bolivia and Haiti, one of the countries that could be identified as having the highest maternal mortality rates in the region as a whole, at over 250 maternal deaths per 100,000 births (ECLAC n.d.b.). Due to an under-reporting of mortality in Peru, one can only partially observe the magnitude of the problem. From the data provided, it would seem that Lima and its metropolitan area benefited from neo-liberal policies to the detriment of other regions. Given Lima's economic and cultural heterogeneity, the impact of neo-liberal policies on reproductive health will need to be disaggregated according to socio-economic status.

In line with the ICPD and the IFIs' neo-liberal tenets, the bulk of available resources were allocated to family planning within publicly supported services, and the market relied on promoting efficiency for everything else. Analyses of the selected reproductive health indicators highlight the disastrous health effects that the imposition of user fees for basic reproductive services has wielded over women. They also highlight the inadequacy of the basic package of health services, which were much narrower than the essential services outlined in the Programme of Action and that public health systems now attempt to provide.

Contrary to the WB's guidelines that collected fees stay in local health facilities to improve services, health services had deteriorated in quality due to the scant ability to self-finance, which hampered efforts to meet immunization targets and obstetrical aid. This situation had contributed to the widening of the gap between affluent and destitute areas. In light of this widening gap, the central government should have determined the total state health expenditure according to the population's characteristics and capacity to self-finance.

Socio-economic factors affecting reproductive health in Peru, such as income, educational levels, ethnic and cultural backgrounds, should each be considered. Extreme poverty and lack of economic power resulting from lack of education constrain women's ability to seek and receive maternal healthcare throughout pregnancy and birth. Educated mothers are not only more open to receive information about health matters and nutrition; they are also far more likely to resort to preventive healthcare services and demand timely treatment. Also, the scope of psychological violence, especially against Andean and low-income women in public health facilities, including maternity wards, has been well documented and found to considerably deter these women from seeking healthcare.

Conclusion

In Peru, it was premised that economic growth would eventually trickle down to all sectors of society if neo-liberal programs were not interfered with. Through the '90s, Fujimori implemented reforms, designed by the WB and other donors, aimed at improving the cost-effectiveness of public health systems. Market principles of efficiency and viability in the vital social sector were introduced in the health sector.

A decade later, it is possible to assess the impact of the SAPs, which were implemented between 1990 and 2001 when President Fujimori was in office, a period that coincided with the ICPD+5 review. This paper has sought, in particular, to address the question of whether the development model is compatible with the UN/OECD/WB objectives for ameliorating reproductive health. From this study, it appears that the socio-economic consequences of political–economic restructuring have been felt most keenly by the weakest members of society, such as rural indigenous Quechua-speaking women from the Huancavelica Highland area, where persistently high infant-mortality rates and increasing maternal mortality rates have been registered.

Compounding this cultural alienation has been the top-down approach of national reproductive healthcare policies, which, by failing to consider Peru's social, cultural and linguistic needs, has led to further alienation of the indigenous communities in Highland and Jungle areas from the wealthier, more Western-oriented areas of metropolitan Lima.

This study has highlighted the incompatibility of campaigning for reproductive and sexual rights within both a neo-Malthusian and a neo-liberal framework. As illustrated in the case of Peru, placing reproductive health in a family planning rather than in a development context has had the effect of relegating maternal and infant health to the background, with "reproductive health" used as an euphemism for "fertility control." The sterilization scandal in Peru demonstrated, in particular, how sinister the neo-Malthusian model could be when applied in its extreme form.

From this analysis, it appears that strategies for achieving objectives of equity and quality have been poorly formulated. It would be valuable to explore the effectiveness of the Program of Integrated Care in Sexual and Reproductive Health, embraced by former President Toledo, within the "growth with equity" framework, focusing on promoting private investment to stimulate job creation to reduce poverty, while freezing public spending, and that of his successor, the reformed neo-liberalist, Alan García. In this respect, the upcoming ICPD+15 will undoubtedly reveal the true ability of the State to overcome the inequalities of the market.

Notes

1 The objective of the *Frameworks to Measure Sustainable Development* report was to focus on the key long-term goals of significantly reducing levels of poverty in LDCs by year 2015, and contributing to a "stable, sustainable future for this planet."

2 The term "trickle-down effect" was used by Ronald Reagan in January 1981 when he announced huge tax-cuts for the wealthy, to benefit the poor

3 The import-substitution path taken by Latin American countries was characterized by a series of stages during which these countries moved from the export of primary commodities toward developing an indigenous industrial base.

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Acronyms

Economic Commission for Latin America and the Caribbean	ECLAC
Gross Domestic Product	GDP
Instituto Nacional de Estadística e Informatica del Peru, (National Institute of Statistics and Information on Peru)	INEI
International Conference on Population and Development	ICPD
International Financial Institutions	IFIs
International Monetary Fund	IMF
Less-Developed Country	LDC
Ministerio of Salud	MINSA
or (Ministry of Health)	MoH
Non-governmental Organization	NGO
Organisation for Economic Co-operation and Development	OECD
Pan American Health Organization	PAHO
(Ministerio de) Promoción de la Mujer y del Desarrollo Humano (Ministry for the Advancement of Women and Human Development)	PROMUDEH
Structural Adjustment Program	SAP
United Nations	UN
United Nations Fund for Population Activities	UNFPA
United Nations International Conference on Population and Development	UN-ICPD
World Bank	WB

Appendix

The Appendix shows diverse official tables of statistics on four core reproductive indicators for Peru.

Sources of these statistics:

A INEI: Instituto Nacional de Estadistica e Informatica del Peru
B BUCEN: US Bureau of Censuses, International Data Base (projections)
C CIHI: Centre for International Health Information (based on BUCEN and UN date)
D CHILDINFO: UNESCO: Childinfo Data Base
E PAHO: Pan American Health Organization. A regional Interagency Coordinating Committee (RICC) Task Force (coordinating IDB, UNFPA, USAID, UNICEF, ZB)
F ENDES: National Demographic and Health Survey (1986, 1991-2, 1995)
G UNICEF: United Nations Children Fund

H WB: World Bank
I PROMUDEH Peruvian Ministry for Advancement of Women
J CID: Celade Boletin Demografico
L FE: Fuentes' source

Table 1. Peru: Infant Mortality Rates, 1960–2000

	Source							
Year	**A**	**B**	**C**	**D**	**E**	**F**		
1960				142				
1970				115				
1980				89				
1988								
1989								
1990				58				
1991								
1992							Urban	Rural
1993	55	51				59[a]	22.9[a]	113.9[a]
1994								
1995	50	48	52	46				
1996						42.8		
1997								
1998								
1999								
2000		41	43	43		45a		

[a]Results are also provided for rural and urban areas.
Infant mortality rate is defined as the estimated number of deaths in infants (children under one) in a given year per 1000 live births. This rate may be calculated by direct methods (counting births or deaths) or by indirect methods (applying demographic models).

Table 2. Peru: Fertility Rates, 1978–2000

	Source												
Year	**A**	**B**	**C**	**E**	**G**	**H**	**J**	**I**			**F**	*Urban*	*Rural*
1978												4.5[a]	7.4[a]
1986		4.24	4.2									3.1[a]	6.3[a]
1988		4.16											
1989		1.13											
1990		4.09	3.6			3.7	4[b]						
1991		3.98										*Urban*	*Rural*
1992		3.88										2.8[a]	6.2[a]
1993		3.77											
1994		3.66											
1995		3.53	3.3				3.6		*Urban*	*Rural*			
1996		3.43						3.5[a]	2.5[a]	5.6[a]			
1997		3.33			3								
1998		3.24		3		3.1							
1999		3.14											
2000		3.04	3										

[a]Results also provided for rural and urban areas.
[b]Averaged over 5 years (i.e., 1990 = 1985–1990.)
Fertility rate is an estimate of the average number of children a woman would bear during the given age-specific fertility rates.

Table 3. Peru: Female illiteracy rates, 1961–2000

	Source													
Year	**A**	**B**	***Urban***	***Rural***	**E**			**H**	**I**			**L**		
1961		51.7[a]	15.9[a]	76.3[a]										
1972		35.6[a]		64.1[a]										
1981		16.9[a]	14.3	51.6[a]										
1988														
1989														
1990	20.2							21					*Urban*	*Rural*
1991	19.6											17.4[a]	6.3[a]	45.6[a]
1992	19				*Urban*	*Rural*								
1993	18.3				13.3[a]		42.9[a]							
1994	16.9													
1995	15.5		*Urban*	*Rural*						*Urban*	*Rural*			
1996	15.7	15.7[a]	6.9[a]	36[a]					15.7[a]	6.9[a]	36[a]			
1997	14.1													
1998	11.2							16						
1999	7.8													
2000														

[a]Results also provided for rural and urban areas.
Female literacy rate is defined as the percentage of adult women (aged 15 or over) possessing basic reading skills.

Table 4. Peru: Maternal mortality rates, 1988–2000

	Source						
Year	**E**		**H**	**G**	**A**		
1988							
1989							
1990							
1991							
1992		261					
1993							
1994							
1995						*Urban*	*Rural*
1996					261[a]	114[a]	405[a]
1997				260[b]			
1998	265		270				
1999							
2000							

[a]Results also provided for rural and urban areas.
[b]UNICEF Average for 1980–1987.
Maternal mortality rate is defined as the estimated number of deaths during childbirth in a given year per 100.000 live births. This rate may be calculated by direct methods (counting births or deaths) or by indirect methods (applying demographic models).

Other data from INEI

Table 5. Peru: Fertility rates, INEI (cuadro 1)

5-Year Periods	National	Urban	Rural
1970–1975	6.00	5.09	7.55
1975–1980	5.38	4.36	7.45
1980–1985	4.65	3.64	7.08
1985–1990	4.10	3.14	6.70
1990–1995	3.70	2.88	6.20
1995–2000	3.20	2.60	5.20

Average number of children per woman.