The Politics of Reproductive Health in Peru: Gender and Social Policy in the Global South

Abstract

This article analyzes the politics of reproductive health policy-making in Peru in the context of healthcare reform initiatives undertaken since the early 1990s. In Latin America, women’s body politics are emerging within a complex architecture of institutionalized social stratification and religious lobbies. The case of Peru is approached from a gendered, specifically South-World analysis, revealing the deep embedding of a vast constellation of reproductive healthcare issues within the nascent social welfare policy-making process. Through limited national public health insurance schemes, a new social policy model, based on a targeted poverty-reduction paradigm, is now partially addressing the reproductive health needs of the majority of Peruvian women. Policy implementation, however, is highly contested, fragile, and has been subject to setbacks and deadly abuses. The article shows that, in addressing developing countries such as Peru, the role of international actors and the impact of unconsolidated democratic institutions are two key variables in the comparative analysis of social policy regime formation.

Body politics, a crucial site for the definition of women’s citizenship, is a realm in which public policy is a pivotal intervening
variable, as shown by the recent feminist literature on state and social politics (O’Connor, Orloff, and Shaver 1999; Stetson 2001; Mazur 2002). However, many political analyses tend to divorce the issue of abortion politics from their consideration of the broader social policies governing women’s access to a range of family planning and maternal care services. This tendency is attributable to several factors, including the salience of public debate on abortion in most industrialized nations, where most other reproductive healthcare services are widely available and therefore largely taken for granted. These preconceptions, rooted in the “Northern” experience do not apply to most countries in the “South,” where a vast constellation of reproductive issues are concomitantly and inextricably linked to broader social policy agendas.

This article seeks to advance our understanding of the main variables involved in the formulation of social policy regimes from a gendered perspective, in areas of the world that have remained understudied in the specialized literature thus far. More specifically, the case of reproductive health policy-making will be examined in the context of the social policy reforms implemented in Peru and Latin America over the past fifteen years. Both poverty-reduction objectives and polarized views on gender rights have formed the cornerstones of policy-making processes in developing countries such as Peru—cornerstones laid in the aftermath of neoliberal reforms and under the influence of diverse international forces. While poverty-reduction policies and reproductive matters have not always been pursued in tandem by policy-makers, they are not mutually exclusive in Latin American politics.

Since the early 1990s, international donor organizations have been calling for new health strategies in countries of the South to combat both maternal mortality and poverty. Women’s reproductive rights were front and center at the International Conference of Population and Development (ICPD) held at Cairo in 1994. Accordingly, since the mid-1990s, the Peruvian government’s provision of family planning and maternal care has established a distinctive trend toward gendered social policy regimes—although regimes embroiled in the political contradictions of intensive social stratification and the power of religious forces.

Two broad set of claims are made in this article. The first deals with our understanding of the formation of gendered social policy regimes and their impact on women. This case study follows in establishing the centrality of gender in comparative welfare regime analysis, by highlighting how the social policy reform process under way in Peru since the mid-1990s is significantly oriented by policy concerns around women’s health. Moreover, although in Peru, inequality in reproductive healthcare stems from the segmented
nature of the national healthcare system, and the grossly under-funded public healthcare services upon which the majority of Peruvian women depend, recent trends toward universalizing access to the key services have led to some gains in redressing inequalities. However, on the side of the impact of social policy, the Peruvian experience shows that although recently created reproductive health services in Peru were based on policies promoting the right to contraceptive choices for women, the government’s overriding “quick-fix” policies to alleviate poverty and maternal mortality have led to deadly women’s rights abuses, opening the door to a strong political backlash against family planning.

The second set of claims made in this article revolves around the specificity of social policy regime analysis in a developing country setting such as Peru’s, where global and local actors interact in the formation of public policy about women’s bodies and reproductive health. The role of international actors is determinant on several, often contradictory counts. The ongoing and well-funded influence of ultraconservative religious groups (especially in the early 2000s) in reproductive health policy formation still threatens the recent fragile policy consensus reached around publicly available family planning services. In Peru’s politically volatile context, international donors have supported a variety of policy paradigms in the context of fragile, unconsolidated democratic institutions. More fundamentally, what this article shows is that the analysis of reproductive rights in countries of the South is multifaceted and centrally connected to the national development policy-making agenda of state leaders.

The first section of this article begins with a review of the key concepts involved in a gendered analysis of reproductive health policy-making. The second section discusses initiatives to alleviate poverty and reform the healthcare system in Peru, and the third section follows up with a general overview of the main indicators of reproductive health in Peru since 1990. In the fourth and final section, an analysis of the reproductive health policy-making process is offered, highlighting the role of international and national actors and showing how national poverty-reduction strategies and the changing definition of reproductive health have been informed by the competing claims of Peru’s social actors in the area of gender and social policy formation.

Gender, Health, and Social Policy Regimes in Latin America and Peru

A comparative theoretical analysis of gender and social policy in Latin America has yet to be developed, as the scholarly literature in this field is relatively new and mostly limited to single cases. In
grappling with different histories of state formation, levels of economic development, and specific patterns of welfare production in countries of the “South,” most researchers have approached policies on women’s welfare as development policies rather than as welfare entitlements. It must be said that it was not until the late 1980s that organized women in most Latin American countries began to engage the state in a systematic fashion to address multiple forms of gender discrimination in laws and public policies. It was their initiatives that have now brought a gendered analysis of social policy to the fore as a salient public policy issue.

A closer look at the social policy reform processes in Latin America since the 1990s reveals a general trend toward increased social spending by the state (in comparison with the 1980s) and a new focus on women as the “targets” of social policy. Latin America’s transitions to democratic regimes in the 1980s at last introduced the majority of women with few-to-no political rights into the body politic and brought greater pressure to bear upon states to respond to women’s demands. This pressure also came from changes made in the policy frameworks of many international agencies. On one hand, population agencies moved from Neo-Malthusian orientations to an ICPD-style framework based on reproductive health and gender equity. On the other hand, since the early 1990s, after a decade of macroeconomic adjustment and fiscal discipline (which had, in fact, destroyed many social programs in developing countries), international financial institutions and bilateral donors have been endorsing and promoting stronger gendered social welfare policies as a central component of development strategies.

These reform initiatives have been adapted to existing social policy frameworks in Latin America, where conservative-informal welfare regimes predominated for most of the twentieth century (Gough and Wood 2004). Using Esping-Andersen’s classic typology of the welfare state, adapted to the context of developing countries, Gough and Wood argue that Latin American welfare regimes were initially designed as social security systems that were made only for a fraction of the labor force (unionized workers from the formal sector). Even these systems made only subsidiary provision for social assistance, with the family playing a central role in welfare production (Esping-Andersen 1990; Gough and Wood 2004). The conservative-informal model excluded most people from the social security system in Latin America because of their position in the labor market. Informal workers, independent wage laborers, or subsistence agriculture peasants and women performing domestic duties at home or as maids were all ineligible for state support.

Subsequent to the social reforms initiated in the 1990s, welfare regimes in Latin America were reshaped into what Gough and
Wood label liberal-informal regimes characterized by: (1) the (partial or total) privatization of financing and provision of services for those included in the former social security schemes; and (2) a concentration of state resources in the financing and (often) provision of services to the poor. State-subsidized services are distributed based on the rationale that social goods should be subject to a cost–benefit analysis and implemented through mechanisms for targeting designated segments of the population. The market plays an expanded role in these reforms, extending some social benefits to categories of the population previously devoid of any entitlements to public welfare. However, the restrictions placed on the new public schemes designed for the poor have meant that (both quantitatively and qualitatively) much social welfare production continues to be informal (Gough and Wood 2004).7

The poverty-reduction paradigm was introduced by the World Bank in the late 1980s. This new imperative (which continues to drive today’s reforms) sought to redress a legacy of deficient public policy. But attempts to meet the needs of the majority through targeted social spending have reinforced the traditional segmentation of social goods provision. In healthcare, segmentation has undermined the 1978 Alma Ata Conference objective of developing universal primary healthcare services. Models of selective primary healthcare were formulated as early as 1979 in some Latin American countries and later actively promoted by international agencies such as the World Bank (Bardález del Águila 2004, 22).8

Reproductive health is an integral part of the policy concerns addressed in Latin American health sector reforms. On two levels, reproductive health questions (as core issues defining gender relations) allow for a gendered political analysis of social policy-making. First, reproductive health issues tend to engage body rights, bodily control, personal autonomy, contraceptive choices, and women’s freedom to choose whether or when they want to have children. Second, they establish the mechanisms by which women can access quality healthcare services so that reproductive events do not cause serious health problems or death. Reproductive health therefore has a dual function in the business of advocating for women’s citizenship rights: in the area of civil rights, it can guarantee women’s individual reproductive freedom and physical autonomy; and in the area of social rights, it can stake a claim for the public provision or subsidization of access to various kinds of reproductive health services, ranging from contraception to prenatal care. While the notion of state protection for body rights is often forgotten in welfare regime analysis, it remains crucial to women’s citizenship, as shown in the work of O’Connor, Orloff, and Shaver (1999) and Mazur (2002), among others.
In Peru, as in many developing countries, Demographic and Health Surveys (DHS) were initiated in the late 1980s. The high rates of infant and maternal mortality that these surveys revealed took on a broader symbolic significance, laying bare discriminatory and inefficient health-care systems that left women (the majority of whom were poor) and their newborns exposed to easily preventable diseases or death. In order to remedy this dire situation, a number of policy changes and structural reforms in the healthcare system were added to the nation’s political agendas. However, in addition to the aforementioned segmentation problems related above, other issues have impeded Peru’s progress in achieving more equitable access to quality reproductive healthcare. Most notably, these issues (to be explained at greater length later on in this article), included the implementation of new reproductive health programs as instruments of fertility control and a as a “quick-fix” solution to poverty reduction. The contradictions embedded in subsequent state policies and public health insurance schemes reflected Peru’s polarized moral politics around women’s body rights.

The theoretical framework of this article is in line with and borrows from the work of O’Connor, Orloff, and Shaver (1999), who emphasize the political opportunity structure of feminist and antifeminist social movements, the role of the state, and the political alliances between various stakeholders. This article adds a crucial dimension that is absent from their excellent analysis of gendered social policy regime formation: the role of international actors. These actors are central to our understanding of the policy-making process in “developing” countries such as Peru. Moreover, this analysis provides a South-World perspective on O’Connor, Orloff, and Shaver’s body rights discussion by pointing out the reality that Latin American policy debates on reproductive health and rights are not limited to abortion issues (as is currently the case in most industrialized countries), but engage a multiplicity of highly consequential issues. In fact, in Peru the right to reproductive choices and access to maternal care and family planning services are all being debated at a time when abortion is only beginning to be recognized as a public health issue. More broadly, Peru’s shifting policy model is emblematic of Latin America’s recent efforts to provide social welfare entitlements to the poor, whose reproductive health has become a key concern.

Poverty and Health in Peru

Peru is one of the poorest South American countries. Its considerable regional and ethnic disparities in access to basic infrastructure, formal employment, healthcare, and education, as well as its high
national poverty figures reflect the country’s failure to fully recover from the hyperinflation and debt after its economic crisis in the 1980s. Structural adjustment, liberalization and market-oriented reforms implemented since the early 1990s have stabilized the economy and improved fiscal management control. However, this major restructuring of Peru’s macroeconomic framework has neither led to sustainable patterns of economic growth nor to adequate levels of job creation.

Poverty remains Peru’s main problem. While modest progress has been made in reducing extreme forms of poverty, in 2004, 51.6 per cent of Peruvians were still considered poor and 19.2 per cent, extremely poor (ENAHO 2001–2004). In total, approximately 49 per cent of the population lived under the poverty line between 1987 and 2000 (Human Development Report 2003). Informal employment is the main means of income generation and has grown from 52.7 per cent of Lima’s inhabitants in 1991 to 59.2 per cent in 2000 (67 per cent of all women and 53 per cent of all men classified as Lima’s economically active citizens) (ILO Panorama Laboral 2001).

Peru’s Healthcare System

Peru’s healthcare system is marked by the same historical segmentation as that of most of its neighbors, offering a patchwork of systems created to serve various sectors of the population according to their individual labor market status. This segmentation resulted from the cumulative creation of different healthcare institutions over time (Arroyo 2002, 29). So far, no government administration has been willing or able to effectively redress this segmentation, and its attendant exacerbation of social hierarchy and exclusion.

The current healthcare “system” consists of a social security health system called EsSalud (Seguro Social de Salud), which is financed by employers and employees under the authority of the Ministry of Labour. The beneficiaries of this system, state employees and a number of formal-sector workers, now have the option of contributing to a private health plan, in keeping with the targeted reform process (outlined above). This system covers approximately 20 per cent of the population. Less than 2 per cent of Peruvians, the highest income group, have a private insurance plan, while 1.3 per cent are covered by the Military or Police Health Plans and have their own private medical facilities (Bardálež del Águla 2004, 28). The rest of the population (around 75 per cent) receives medical care from the public health system under the responsibility of the Ministry of Health (MINSA—Ministerio de Salud). In practice, however, the inadequate geographical distribution and limited human and financial resources of MINSA medical establishments restrict access to quality healthcare for most citizens.
Segmentation generates waste and misuse of medical infrastructure and personnel: in many cities, there is a duplication of services offered by EsSalud and MINSA, while in rural areas there are not enough hospitals or clinics. The autonomy of each system, the absence of nationwide standards in medical services, and poor management systems have produced a chaotic situation. In 2000, between 22 per cent and 25 per cent of those insured under EsSalud, a private insurer, or a combination of both, still used MINSA establishments. Of those with no health insurance, 10 per cent received medical care in EsSalud establishments and 17 per cent went to private clinics (Guzmán 2003, 16).

But the full picture on inequality comes into focus around healthcare financing flows. While the MINSA technically serves 75 per cent of the population, its share of total healthcare financing (public and private funds combined) in Peru stood at 26 per cent in 1994, while the EsSalud and Military/Police Health Care Institutions claimed 36 per cent, and the private sector 37 per cent (Ewig 2004, 223). By 2000, MINSA’s share of total healthcare financing had dropped to 24 per cent (Portocarrero 2005, 4). Overall, most private sector financing came from out-of-pocket spending by the poorest, uninsured Peruvians.

Health Sector Reforms

The inequities described above reached their height in the early 1990s. At that time, MINSA’s healthcare system was feeling the financial aftershock of the “lost decade” of the 1980s, when Peru was beset by brutal, widespread political violence between insurgent guerrillas and the Military.10 In 1990, MINSA’s health budget represented 15 per cent of that spent in 1980 (Ewig 2004, 221). Extreme economic crisis, coupled with social and political chaos, led the Peruvian government to the brink of complete collapse at the end of the 1980s. To wit, one former MINSA executive describes the country’s public health system as being in a state of “functional collapse”11 when Alberto Fujimori was elected in 1990 and as half of the 3,500 existing public health facilities simply stood empty.12

The “second-generation” social security and health reforms were initiated in the second half of the 1990s, partly to pursue a liberalization and privatization agenda (regarded as the solution to gross inefficiencies and waste), and partly to make social goods provision a state responsibility and thereby foster greater social equity. A variety of reform initiatives have been carried out since the 1990s, but to date, no all-encompassing reform plan has been introduced to remodel the healthcare system in its entirety.

The partial privatization of the social security system that began in 1993 did not reduce welfare regime segmentation, but instead substantially contributed to establishing a liberal-informal regime.
In the health sector, under the social security system, private healthcare providers were allowed to compete with the state social security health system in the provision of primary and secondary healthcare (Ewig 2004, 239).

Concurrent with liberal-informal social security reform were initiatives to re-establish the foundations of the public healthcare system. These initiatives have been described as incipient and piece-meal (Arroyo 2002; Yamin 2003; Ewig 2004). Certainly, more recent indicators bear out this evaluation, as Peru’s per capita public spending on healthcare as a percentage of its GDP has remained consistently lower than that of its Latin American neighbors. Although public health expenditures rose from 1.1 per cent of the GDP in 1993 to 2.8 per cent in 2000, they had backslid to 1.19 per cent by 2002 (Human Development Report 2003; Francke et al. 2002, 6). This decline is partly attributable to the fact that Peru’s total public social spending represents only 9.8 per cent of its GDP, appreciably lower than the Latin American average of 12.6 per cent, or the OECD average of 20.9 per cent (Francke 2004, 48–49; OECD 2005).

The Fujimori government’s first decisions on public healthcare were wholly predicated on its new social policy strategy to provide state funding to programs benefiting the poorest sectors of the population. Between 1992 and 1996, the number of public medical facilities increased by 56 per cent, providing mostly primary and secondary care (health posts and clinics) in rural areas (Guzmán 2003, 32). The Basic Health for All Program (Programa de Salud Básica para Todos), established in 1994, also addressed shortages of medical practitioners in the poorest rural areas by providing economic incentives to work in rural public health posts and offering a comparatively advantageous, flexible public health system work contract. In 1998, 89 per cent of all primary care public health establishments were covered by the Basic Health for All Program (Ewig 2004).

Further reform initiatives were undertaken in the latter half of the 1990s under the Fujimori regime to complement reforms designed to improve supply in public healthcare through mechanisms to increase demand for public health services. In Peru (as in many neighboring Latin American countries) the poverty-reduction approach to the healthcare produced public health insurance programs that targeted specific segments of the population. Under these fully subsidized insurance programs, a limited number of health services were covered, constituting a “basic healthcare package.” This package and other health sector initiatives were endorsed in the World Bank’s 1993 World Development Report, which focused on health (World Bank 1993). The main objective of these packages was to
overcome economic barriers and provide basic coverage to citizens too poor to use public healthcare services.

The Fujimori regime’s first priority group was public school children, for whom Free School Health Insurance (SEG—Seguro Escolar Gratuito) was established in 1997. In 1998, the new Maternal–Infant Health Insurance (SMI—Seguro Materno–Infantil) sought to respond to an even greater public health priority: providing healthcare to infants, pregnant women, and breast-feeding mothers. SMI covered pregnancy control, delivery, and postnatal care and was set up by foreign donor agencies who, observing the Fujimori government’s lack of political will to implement reform in this area, stepped into the breach to support the program during its few years of existence (Ewig 2004). The program fared poorly, and as of the end of 2000, it had generated only 300,000 beneficiaries—a mere 18 per cent of its target population in the 13 departments where it was operating. (Guzmán 2003, 36 and 45).13

The year 2000 brought particularly troubled times for Peru, as the government of Alberto Fujimori crumbled under the weight of revelations of large-scale, systematic corruption, electoral fraud, and internal divisions within the regime. Fujimori fled the country in disgrace to seek refuge in Japan at the end of 2000, and a transitional government led by the President of Congress (an opposition Congressmember) was formed to prepare for a new election. In July 2001, Alejandro Toledo, then a popular opposition leader whose new party included politicians from the Left, Right, and Center became the new president-elect.

During the transitional period (which lasted less than a year), a new Public Health Insurance Plan, Seguro Público de Salud (SPS) was implemented. It was the first attempt by any Peruvian government to provide public healthcare insurance to uninsured citizens in a comprehensive fashion rather than through discrete, piecemeal initiatives. SPS had many advantageous features for women, including its extension of SMI coverage (beyond expectant and new mothers) to all uninsured women from fifteen to forty-nine years of age, adding coverage for the detection of gynecological cancers, family planning,14 and the treatment of post-abortive complications (Guzmán 2003, 36–37).

A few months after taking power in 2001, the Toledo government decided to replace SPS with SIS, a new Integral Health Insurance Plan (SIS—Seguro Integral de Salud). SIS differed from SPS in several respects. Most importantly for the purpose at hand, coverage for reproductive healthcare was significantly cut back under SIS to include only services related to pregnancy, natal, and postnatal care. Once again, only expectant and new mothers were eligible beneficiaries (Guzmán 2003; Vera La Torre 2003).
Women’s Reproductive Health in Peru

Although health sector reforms have had some positive impact on women’s reproductive health, the many restrictions placed on women’s right to reproductive choices have blocked further progress. Notably, women’s rights over their bodies and reproductive decisions have been severely curtailed by the criminalization of abortion in Peru. In concrete terms, middle and upper class women still have easy access to private clinics performing illegal abortions, while lack of access to safe abortion services places the poor majority of women—over 50 per cent of Peru’s population—at greatest risk for health complications and death. Thus, the social rights attached to reproductive health are deeply stratified along class and income lines.

After Bolivia, Peru ranks second in South America for maternal mortalities. Approximately one in eight-nine expectant mothers die because of their pregnancy, compared with 1 in 130 for Latin America and the Caribbean, and 1 in 3,700 expectant mothers in North America (WHO 1996, cited in Guzmán 2002). In 10–30 per cent of cases, maternal mortality is attributable to unsafe abortions that are self-induced or performed by nonspecialists. In Peru, state-sanctioned abortions are only allowed for therapeutic reasons, approved by a medical committee.

While estimates vary and are usually said to under-represent real figures, in the late 1980s, Peru had the highest abortion rate in Latin America, with an estimated average of 1.8 abortions per woman (Guttmacher Institute 1996). Today, annual estimates stand at 352,000 abortions, representing 4 abortions for every 10 live births, or 5 abortions for every 100 women of reproductive age (Ferrando 2002, cited in CLADEM-Peru 2003). The treatment of postabortive complications in public health facilities is widely accepted and practised, but is poorly regulated, vulnerable to restrictions, and presents major dilemmas for health sector personnel. In point of fact, the 1997 Health Law made failure to report suspected cases of abortion to police authorities a criminal offence, thereby ordering healthcare practitioners to break client–patient confidentiality and enlisting them as repressive agents.

Preventing unwanted pregnancy by protecting the right to informed choices in reproductive matters would likely reduce the high rate of unsafe abortions in Peru. But while some progress is being made in this area, Peruvian women continue to face substantial shortcomings. Statistics on unmet needs in family planning reveal that in 1990, prior to the reforms, 16.2 percent of women lacked the services that they wished to have compared to 10.2 percent most recently. In the poorest quintile, 14 percent of women indicated an unmet need for family planning to limit the number of children they
chose to have, while only 3 percent in the richest quintile reported the same problem (UNFPA 2005). Contraceptive prevalence rates for married women aged fifteen to forty-nine increased substantially in the 1990s, with those using modern contraceptive methods growing from 12.8 per cent in 1986 to 50 per cent in 2002 (Ferrando and Aramburu 1996; UNFPA 2003). However, important discrepancies remain. For example, in 2002, 24 per cent of women from the poorest economic quartile used modern contraceptives compared with 50 percent in the richest quartile.

Access to professional maternal care is another crucial reproductive health issue fraught with class and geographical discrepancies. Currently, 85 percent of all deliveries in urban areas and 28.7 percent in rural areas are attended by skilled practitioners. Infant mortality rates are 28 per 1000 live births in urban areas and 60 per 1000 live births in rural areas (UNFPA 2003). But giving birth in a public healthcare facility does not necessarily guarantee adequate care, since a significant number of facilities lack the personnel training and medical equipment required to perform emergency procedures (Yamin 2003). Geographic distance from public health care facilities and economic barriers are also key issues, especially for most indigenous women, who live in rural areas and often give birth at home, with or without the assistance of a traditional midwife.

Reproductive Health as a New Paradigm for State Policy in the 1990s

To understand policy choices and their social repercussions on the reproductive health of Peruvian women, we must return to the distinctive origins of reproductive health policy, and how power relations have shaped policy content.

Family Planning as a Poverty-Reduction Strategy

In Peru, as in most developing countries, the notion of a “state family planning policy” has been historically linked to Western pressures for population control. As early as the 1960s, US international aid was allocated for the promotion of family planning in developing countries as a security measure. The first effort to introduce family planning services in Peru dates back to a 1964 Ministry of Health pilot project for metropolitan Lima. Proponents of birth control have regularly faced off against the entrenched power of pro-natalist religious authorities in this matter. In 1965, some private initiatives, such as the Peruvian Family Planning Association (APPF—Asociación Peruana de Planificación Familiar), a not-for-profit organization affiliated with the International Planned Parenthood Federation, were launched. When the reformist
military government of General Velasco seized power in 1968, it closed down APPF and jailed its director. In the name of an anti-imperialist doctrine, which associated family planning with Western interests, the importation and sale of contraceptives in drugstores were restricted (Bonfiglio 1999).

With the overthrow of the Velasco regime in 1975 by a more conservative military government, and Peru’s very first universal suffrage democratic elections in 1980, establishing a family planning policy once again became a viable legal project. Later in the 1980s, the state very timidly embarked on the process of developing its own policy. The legal and programmatic efforts of a few Congressmembers, experts, and bureaucrats culminated in the adoption of the first Population Law in 1985, which laid the groundwork for the first official family planning program in 1988. But it was not before the election of Alberto Fujimori in 1990 that the state itself became a major force for policy change in reproductive health. President Fujimori declared 1991 the “Year of Austerity and Family Planning.” The current Director of INPPARES (Instituto Peruano para la Paternidad Responsable)—the successor of APPF—recalls that he was contacted at the time by the President’s advisors, who claimed that Fujimori wanted to start “a grand family planning movement,” based, essentially, on sterilization.19

In 1992, Fujimori declared the 1990s the “Family Planning Decade” in Peru. At the same time, the National Program on the Reproductive Health of the Family (PNASRF—Programa nacional de atención a la salud reproductiva de la familia 1992–1995) was approved to replace the older National Family Planning Program (Programa nacional de planificación familiar 1988–1991). The new program’s stated purpose was to act as an instrument in the realization of five national development objectives, most notably including: (1) the creation of a new competitive and sustainable national economy; and (2) the reduction of poverty levels and progressive improvement of the quality of life for Peruvians (PNASRF 1992, 9–10). The program explicitly sought to attain “a population growth rate conducive to reaching desired development levels through a reduction of fertility, achieved in harmony with people’s free decision to determine the size of their families and the intervals between pregnancies.” The program would be “promoted by a network of services that [would] allow free access to secure and efficient family planning methods.” (Our translation, PNASRF 1992, 13)

The PNASRF’s new strategic emphasis on family planning was to be implemented to achieve the goals of reducing the fertility rate (from 3.5 in 1991 to 3 in 1995) and increasing contraceptive use among women of reproductive age (from 36 per cent in 1991 to 41 per cent in 1995, and 45 per cent in 2000) (PNASRF 1992, 14).
The program gave priority to women belonging to a “high reproductive risk” category—consisting of the urban and rural poor (PNASRF 1992, 15). Nowhere is the link between family planning and poverty-reduction objectives clearer than in the PNASRF literature, where poverty reduction is essentially constructed from a demographic perspective. No mention is made of the contribution of family planning to women’s autonomy or gender equality. Instead, the PNASRF emphasizes the reproductive health of the family rather than that of individuals.

The new Constitution adopted in 1993 made some major legal changes in the field of reproductive health. The right to decide the timing of pregnancies and the number of children in a family was enshrined in the Constitution. The “right to responsible paternity and maternity” explicitly included women for the first time as participants in the notion of responsible parenthood. The right to health protection was also introduced, together with the right to life. The latter, however, came with the stipulation that life begins at conception—a major blow for those seeking to decriminalize abortion.

Fujimori’s dream of a “grand sterilization program” did not materialize until 1995, when the 1985 Population Law was amended to include tubal ligation and vasectomy as legal family planning methods to be provided by public health services. It was also in 1995 that a ministerial resolution made family planning, counseling, and contraceptive care (including sterilization surgery) free services in all public health establishments. These historic decisions to provide free access to and increase the range of family planning methods for the majority of Peruvians had long been delayed by impediments in the broader political context. Between 1992 and 1995, Peru’s political landscape was dominated by Fujimori’s “self-coup,” perpetrated in 1992 with the support of the armed forces and condemned by the international community. After shutting down democratic institutions, dismantling the judiciary, and declaring a state of emergency, a Constituent Congress (the CCD—Congreso Constituyente Democrático) was elected, with Fujimori’s party holding a majority of seats. The CCD drafted the 1993 Constitution, further concentrating powers in the hands of the President (Cameron and Mauceri 1997) and in 1995, a new election confirmed the “popularity” of Fujimori, who won with a strong majority in Congress, notwithstanding accusations of rampant election fraud.

After the 1995 election, Fujimori was empowered to take bold steps in upgrading his family planning program, which absolutely required the support of international cooperation agencies in order to be implemented. Until that time, only the United Nations Population Fund (UNFPA) provided financial and technical
assistance to the government for population issues, while the US Agency for International Development (USAID) was focusing its support on NGOs (Coe 2004, 60). In the new political institutional framework of 1995, Fujimori had both the benefit of leading an apparently democratic regime (the *sine qua non* for expanding international cooperation) and of controlling the Legislature (which was not the case prior to his self-coup). The government’s powerful strategic positioning made audacious reforms like its family planning initiative far more feasible than they would otherwise have been. It is also worth noting that Fujimori’s willingness to confront the Catholic Church’s historic opposition to state-funded family planning programs only became politically viable after the dramatic political crisis of the early 1990s had been overcome (Coe 2004, 59). The President’s initiative was facilitated by the fact that Fujimori himself was not a Catholic. The new confrontation coincided with a shift in focus among Church representatives, who began to spend more time criticizing the President for his human rights abuses (Conaghan 2000). The international climate surrounding the Cairo Conference (ICPD) and the International Conference on Women held in Beijing in 1995 added yet another layer of legitimacy to what was described as a modernizing move by the state to address the needs of most Peruvians for free and enhanced public family planning services.

Fujimori presented his new policy on family planning in his July 1995 Presidential Address. He openly criticized the “sacred cows” of the Catholic Church, and used a pro-poor discourse to justify state intervention in redressing unequal access to contraceptives and family planning information. A few months thereafter, Fujimori pursued his crusade at the Beijing Conference. As the only attending male head of state, he stole the spotlight and proudly presented his new program. The reaction within Peruvian civil society was immediate: consternation and outrage from his conservative Catholic opponents, and widespread praise from the women’s movement and the Colegio Médico (the highest medical authority), who became the reluctant *de facto* allies of a notoriously authoritarian President (Azaña et al. 1999, 11).

The ICPD Program of Action became an important reference in the new Reproductive Health and Family Planning Program (PSRPF—*Programa de Salud Reproductiva y Planificación Familiar 1996–2000*). Most significantly, within the PSRPF’s conceptual framework was its stated goal to promote the reproductive health of individuals, especially women. A 1996 MINSA administrative resolution further specified that free individual decision-making in contraceptive choice also applied to permanent methods, such as tubal ligation and vasectomy, thus explicitly abolishing the need for
spousal approval to undergo the operation. The General Health Law adopted in 1997 further entrenched individual reproductive health rights by requiring that the widest possible range of family planning methods be made available to Peruvians and that written, informed consent be obtained from patients undergoing tubal ligations or vasectomies.

The PSRPF defined the state’s role in promoting and serving the reproductive health needs of all. It also clearly indicated the government’s commitment to preventing sexually transmitted diseases and gynecological cancers as well as providing pre-natal, natal, and post-natal care. Most significantly, for the first time in Peru and in keeping with the ICPD Program of Action, the Fujimori government recognized unsafe abortion as a public health problem that had to be prevented through family planning and education, also asserting that adequate medical treatment had to be provided for postabortion complications (PSRPF 1996, 5).

Notwithstanding the major advances made by the new policy framework and the increased state resources afforded to the PSRPF, a number of alarming problems emerged in relation to its implementation. In 1996, feminist lawyers began to collect testimonies regarding a number of human rights abuses committed in the context of tubal ligation operations performed by MINSA medical personnel. In 243 cases, women had been coerced or pressured into accepting the surgery, or had not received proper postoperative care. Lack of follow-up led, notably, to severe complications and seventeen cases of death. There were also reports from women who had been sterilized during caesarean section operations in the absence of prior consent (CLADEM 1999). Peru’s national Ombudsman’s Office (Defensoría del Pueblo), a public body, confirmed the accuracy of these feminist non-governmental reports and investigated at least 157 cases (Defensoría del Pueblo 2002).

The Ombudsman identified a number of contributing factors in these violations. To begin with, in several cases procedures for obtaining informed consent had not been respected. Many women were not informed of the existence and characteristics of other contraceptive methods before accepting tubal ligation surgery, or were offered food in exchange for accepting the surgery. The government’s prioritization of tubal ligation was also reflected in target quotas and incentives offered to medical personnel, creating a climate unconducive to guaranteeing women’s freedom in decision-making. Quotas were pursued, notably, by holding “tubal ligation and vasectomy festivals,” organized by MINSA staff in various poor regions of Peru.

These revelations resonated at the international level, causing the United States’ Senate to call for an investigative commission on the participation of the USAID in Peru’s family planning program.
President Fujimori refused to acknowledge these problems and accused the women’s movement of siding with his conservative opponents in a bid to sabotage state efforts in family planning. The Health Minister and officials in charge of the family planning program were called in to testify at the Permanent Commission on Women at the Congress, and were asked to make changes to the program’s procedures and operating standards. New national family planning guidelines were subsequently adopted in 1999 and PSRPF targets were partially modified to reflect recommendations from the Ombudsman’s Office. Still, new cases continued to be reported in 1999 and 2000, even as the number of tubal ligations performed by MINSA practitioners dropped off significantly (from 81,762 in 1996 and 109,689 in 1997 to approximately 26,000 in 1998 and 1999).

In sum, although the policy framework adopted by the Peruvian state after the ICPD (and supported by massive funding from USAID, UNFPA, and others) made important strides in establishing a more accessible and comprehensive reproductive health program, the government’s approach to program implementation attracted widespread criticism for its failure to respect its own guidelines. Fertility reduction and contraceptive promotion were bluntly conceptualized as instruments for poverty reduction, to the great detriment of women’s rights, physical integrity, and safety (Coe 2004, 61–62).

**Maternal and Infant Mortality as Basic Health Indicators**

Among the indicators used to measure poverty, Peru’s high rate of maternal and infant mortality motivated another set of state policies in the realm of reproductive health. Peruvian experts identified two causes for high maternal and infant mortality levels: the low proportion of births taking place in health establishments, and the reluctance of and barriers faced by rural women regarding professional prenatal care (Mannarelli 1997; Anderson 2001). Both factors negatively impacted the health system’s capacity to detect potential complications and to treat them correctly.

Peru’s high rates of maternal and infant mortality also attracted the priority interest of international donor agencies such as the World Bank and USAID at the outset of reform efforts. These two agencies, respectively, financed two major projects, the Health and Basic Nutrition Project (Proyecto de Salud y Nutrición Básica 1994–2000) and the Proyecto 2000 (1995–2000), both of which were focused on improving MINSA’s maternal and infant medical services through technical training and assistance. The Proyecto 2000 explicitly sought to reduce maternal mortality. The Inter-American Bank of Development also financed a pilot study in 1997 for the design of the Public Health Insurance Plan, Seguro
Materno–Infantil, discussed above. When the SMI was subsequently established, over 50 per cent of its financing came from international donor agencies (Yamin 2003, 117–8). According to Yamin, between 1994 and 2000, the three afore-mentioned international agencies were financing over half of MINSA’s maternal health budget (Yamin 2003, 121).

Maternal mortality truly became a priority for MINSA as of 1997 when, despite substantial increases in the number of rural health posts and clinics, it was obvious that no significant improvements had been made, and when international agencies and national women’s organizations started more systematically denouncing the state’s lack of action in this area (Yamin 2003, 144). The release of international reports on women’s health in the Americas by the World Health Organization and the Pan-American Health Organization, revealing dramatic maternal mortality rates in Peru, coincided with the government’s problems with its family planning program (the abuses of MINSA sterilization campaigns). The continued high rate of maternal mortality in poor and rural areas was seen as a clear indication of unequal access to healthcare. In 1998, the National Committee to Reduce Maternal Mortality was struck by MINSA and presided by the Minister of Health himself. In the same year, the Multi-Sectoral Working Group on Healthy and Safe Motherhood was founded and commenced operations in 1999, staffed by state and civil society representatives (Yamin 2003, 144–64).

These attempts to address maternal mortality did make some valuable gains. However, the various projects implemented outside regular MINSA programs created service fragmentation as they were financed by international agencies and therefore established their own personnel and mechanisms, which paralleled the MINSA structure. As such, their achievements did not generate broader change within the various levels of MINSA healthcare administration and provision. Another crucial problem was the rapid turnover of MINSA executives. There were no less than ten Ministers of Health under the Fujimori regime (1990–2000), and four ministers under the Toledo government (2001 to 2006).

The state’s failure to resolve problems contributing to maternal mortality also stemmed from its quasi-exclusive focus on prenatal care and professional delivery attendance, at the expense of developing the obstetrics emergency response capacity in public healthcare establishments, as underlined by Yamin’s study. In recent years, the strategic importance placed on increasing prenatal examination rates and institutional birth deliveries has also, paradoxically, led to new patterns of abuse. The Ombudsman’s Office has reported several cases in which women were charged different prices for obtaining birth certificates, according to whether they had given
birth in a public health facility; in other cases health authorities imposed fines on women who had not undergone a prenatal examination or who had not given birth in a public healthcare facility. Denounced as illegal by the Ombudsman’s Office, these practices demonstrate a serious disjuncture between women’s need for maternal healthcare and the state’s repressive use of public health authority (Defensoría del Pueblo 2002).

Reproductive Rights: Politics and Opposition

Over the years, both the state and international agencies have acted as the policy-makers in developing reproductive healthcare in Peru, carrying out significant family planning, maternal care, and health sector reforms. Within civil society, the opposing lobbies shaping policy have fought pitched battles.

Women’s NGOs and organizations of health professionals like the Sociedad Peruana de Ginecología y Obstetricia (Peruvian Society for Gynaecology and Obstetrics) have used their ideas, claims, and technical-political weight to effectively bring pressure to bear upon the state in developing reproductive health policy. Peru has a vibrant women’s movement. Feminist NGOs were created in the 1980s and remain important political actors to this day, together with a number of specialized nationwide networks of grassroots women’s organizations that have become important conduits for mobilization. Feminist NGOs have worked on abortion and sexuality issues from their inception, but only started to work on reproductive health as a set of policies in the 1990s, around the Cairo and Beijing Conferences and the reproductive health reforms introduced by the Fujimori government. This new focus was made possible, in part, through new sources of funding from international bilateral donors such as USAID, which viewed NGOs as appealing allies for the implementation of the Cairo framework in reproductive health programs. As one feminist activist explains, the women’s rights violations committed under Fujimori’s family planning program also marked a turning point for the women’s movement in its monitoring and advocacy work.

The criticisms levelled against the state’s family planning program by some women’s groups (i.e., reports on women’s rights violations) and the Catholic authorities (who accused the government of violating the poorest Peruvians’ right to life), led to a politicization of the program that took on unforeseen proportions. The Fujimori regime’s reputation for authoritarianism and corruption and its increasing unpopularity in the later 1990s eventually tainted all who were associated with it. The family planning program was no exception to the rule and found itself in a compromised position after the fall of Fujimori in 2000.
The Program’s staunch opponents were quick to take advantage of this situation. The antireproductive healthcare lobby is affiliated with the Catholic Church, namely: the Peruvian Episcopal Conference, *Opus Dei*, and another far-Right Catholic lay association called *Sodalicio de Vida Cristiana*. Their views began receiving considerable resources and gained more visibility around 2000. Some groups also found support from US private funds after the 2001 visit of Chris Smith, an ultraconservative US Congressmember known for his antichoice activities. While their opposition to the state’s family planning program was not new, the political context was ripe for their criticisms after the fall of Fujimori’s regime, when a spate of inquiries and legal actions were undertaken against various individuals connected to the Fujimori regime.

The ability of ultraconservatives to ascend to the highest positions of authority within the health sector displaced the lobby within the ranks of bureaucracy. It was an entirely new tactical shift that came to represent an incalculable advantage for their cause. The first and second Health Ministers nominated by Peru’s president, Alejandro Toledo, were two doctors: Luis Solari, a member of *Sodalicio de Vida Cristiana*, and Fernando Carbone, previously a representative in Peru for Human Life International, an international association known for its antichoice lobby activities. During the two doctors’ successive mandates, lasting from 2001 to 2003, MINSA was fundamentally transformed by their intensive efforts to destroy and distort the family planning program and the Program on Women’s Health (Coe 2004).

The Solari-Carbone “crusade” against the existing reproductive health policy was implemented at several levels. First, some of the professional staff members within the MINSA bureaucracy were fired or transferred—especially those working on reproductive health. They were replaced by individuals who subscribed to the same religious beliefs as the Minister. This bureaucratic shake-down not only ideologized the Ministry’s work along religious lines, but also generated serious management problems. The new personnel were not adequately trained, and the consequences on the program implementation and administrative planning for a variety of programs were soon felt. Francke (2004) reports that in 2003, the MINSA failed to spend 117 million soles (about 34 million USD) of its budget, especially in the area of service provision, while its administrative costs surpassed that year’s projections by 62 million soles (about 18 million USD) (cited in Chávez 2004, 36).

The two Health Ministers left their mark on policy orientations. A new model of integral healthcare was established in the new Health Policy Guidelines for 2002–2012, whose strategic emphasis was on maternal and infant health, within a framework that
promoted “respect for human life, starting at impregnation.” No mention was made of family planning in the Guidelines’ section on maternal and infant mortality, which focused on the importance of meeting the nutritional needs of infants and children (MINSA 2002). Notions of gender equality were totally eliminated as well, replaced by a principle of social equity based on traditional notions of complementarity between men and women (MINSA 2002). In the new Peru Life Strategy, adopted in 2003 by MINSA, the “protection of the unborn child” and “prenatal stimulation” were central priorities, while no mention was made of sex education for teens, access to contraceptives, postabortion care, or the prevention of domestic violence (Chávez 2004, 37; Coe 2004).

Not surprisingly, the Women’s Health and Development Program, created in 1990 to foster a gendered perspective within MINSA, was terminated. The family planning program ceased to be an independent entity and was integrated into the new Integral Health Care Program. Minister Carbone also attempted to alter the list of contraceptive methods accepted by MINSA’s family planning program, arguing, among other things, that the IUD was abortive. His goal was to change MINSA’s contraceptives protocol so that it could claim a 90 percent efficiency rate for the Billings or Rhythm method, a natural family planning method advocated by the Catholic Church (Chávez 2004, 42). While these attempts were unsuccessful, MINSA did succeed in restricting access to contraceptives in its establishments. An Ombudsman’s investigative report on this issue showed that stock in contraceptives at MINSA establishments was abnormally low throughout the country, and that specific types of contraceptives were entirely absent in some areas. These shortages had dramatic consequences for contraceptive users and led many public health establishments to impose fees for the contraceptives they purchased on the private market to compensate for contraceptive shortages created by their own Ministry of Health (Defensoría del Pueblo 2002).

The partial coverage and stringent restrictions applied to the SIS (the public health insurance program established by the Toledo government in 2001) achieved the ultraconservative objectives set by MINSA executive. By excluding family planning from the SIS and covering only maternal care (during pregnancy and delivery) and limited (six-month) postnatal care, MINSA effectively hobbled the reproductive health program decreed by Fujimori’s government in 1995, which had sought to institutionalize universal access to a full range of family planning services. While the policy of universal access remained by virtue of the Fujimori regime’s ministerial resolution, lack of further institutional-legal protection left it open to attacks.
The influence of ultraconservative elements was also felt in Congress. Since the early 1990s, Peru’s party system has been characterized by the near disappearance of the old Left and Right parties and the rise of new “parties” with ad hoc membership lists that lack any clear political program or institutionalized rules for internal operations. This situation has led to anarchic Congressional sessions in which issues like reproductive health have been treated as individual Congressmembers’ initiatives. The collaboration of a group of Congressmembers from different parties was essential for Ministers Solari (who was also Congressmember) and Carbone in introducing a series of legislative measures to promote their religious agenda. The “Day of the Unborn Child” was declared an official national day in Peru, based on the international agenda of the Opus Dei. Moreover, a bill seeking to create a “conscientious objection” opt-out clause for health providers, allowing them to refuse to perform any medical act that violated their own moral or ethical beliefs, was approved by the Permanent Health Commission of the Congress. However, because of the strong opposition raised by civil society, the bill was later shelved (Chávez 2004, 35).

Peru’s ultraconservative policy shift in 2001 had many international dimensions, including support from US private religious groups, as previously mentioned. But equally notable was the influence of religious Right conservatives on US politics, which seriously undermined both USAID’s programs and US support to key international agencies, such as UNFPA (Coe 2004, 65). Henceforth, President George W. Bush has reinstated the “Gag Rule” forbidding recipients of USAID funds to work on any abortion-related issue. Following suit, USAID decided against promoting emergency contraception in Peru, even when it officially became part of Peru’s public family planning program in 2004, after a hard-fought battle and the nomination of a more liberal Health Minister (CHANGE 2006).

The feminist movement and medical professionals have played critical roles in discrediting these ultraconservative sectors, and eventually caused the Toledo government to reverse its conservative stance. One of their main strategies was to form a Citizens’ Monitoring Group on Sexual and Reproductive Rights (Mesa de vigilancia en salud, derechos sexuales y reproductivos), bringing together women’s organizations, health sector and development NGOs, health professionals, and academics specializing in public health. The Monitoring Group won over public opinion with its human rights approach to health, sexual, and reproductive freedoms through its savvy use of the media. It has now weathered one battle in an ongoing struggle against the opponents of reproductive healthcare services. But the war is not over.
Conclusion

The predominant policy paradigm now shaping both social sector reforms and reproductive health policy-making in Peru is a poverty-reduction framework focussed on targeted, selective service financing by the state. Welfare continues to be provided in a segmented fashion, based on occupational category. The state’s role remains subsidiary, leaving the primary functions to the market and informal mechanisms of welfare production. This said, the state has now taken on a greater role in the provision of some healthcare services. Most notably, the emerging liberal-informal social policy regime has targeted women in its new public health sector policies, recognizing their central role in reproduction and the considerable related health risks involved for them, their newborns and their infant children. This marks a new chapter for women in the body politics of Peru.

While the limited nature of new public healthcare schemes clearly indicates that many health needs will continue to be met informally, the state’s role in providing reproductive health services has increased substantially over the past fifteen years, with some positive effects on women’s health. However, the case of reproductive health policy-making in Peru since the 1990s has shown that women’s access to contraceptives, maternal care, and abortion are the subject of intense political debate. Within a remarkably short period of time, the country’s reproductive health policy has undergone a flurry of changes in its programs and priorities. These changes are symptomatic of the country’s internal contradictions and the high-stakes politics involved in these vastly consequential issues. It was, more particularly, the combination of poverty-reduction objectives with control over reproduction (a core element of gender relations) that unleashed the unprecedented mobilization of diametrically opposed stakeholders in Peru. Their demands run the gamut of polemics, including gender rights, the right to life, reproductive health, human freedoms, morality, religious beliefs, ethics, and technical-medical rationale.

One of the strongest arguments, used by international agencies and the state alike, for investing in an operational reproductive health policy was the importance of redressing unequal access to essential social goods. This line of argument, which has found its resonance in other Latin American countries, is indicative of a larger, distinctly South-World phenomenon. Simply put, in Peru and other developing countries, the welfare state has yet to be established. It follows that social welfare debates in Peru have embraced a wide range of critical social issues, including various combinations of reproductive health issues. The development of nascent social policy regimes in the South is concurrent with the development of policies and programs targeting the reproductive health needs of
women. In industrialized countries, abortion has generally emerged as a public policy debate following the formation of welfare states. The Peru case study confirms that social policy regime analysis needs to pay more attention to the interconnected nature of several policy issues including how the body is regulated and how reproductive rights are defined through social policy.

It may be said that the lives and health of women hang in the balance when access to the full range of family planning services is jeopardized by ultraconservative campaigns against public healthcare programs. As established earlier, the might of the ultraconservative sector in Peru has been bolstered by the US religious Right and its remarkable influence on US foreign policy. Just as remarkably, in Peru, these sectors have ascended to positions in government and directly influenced policy-making rather than lobbying through the Catholic Church, as was previously the case. With the downfall of the Fujimori regime, ultraconservative sectors gained the upper hand and turned back the clock in reproductive health policy. What is also important to underline is that the success of these sectors was facilitated by prior abuses committed under the national family planning program instituted by Fujimori’s government.

International variables are more complex than they may first appear. In the early days of health reform in Peru, it was agencies like the Inter-American Bank of Development, USAID, and the World Bank that championed the cause of reducing maternal and infant mortality, bringing their financial resources and policy influence to bear on several projects undertaken in collaboration with or by the Ministry of Health. The preponderant levels of external financial resources dedicated to various health sector reform projects indicates a very high degree of “interference” by international agencies in Peru’s state reproductive health policy agenda. Therefore, although I concur with Ewig and Nelson in saying that international agencies do restrict themselves to providing general policy advice and technical expertise rather than imposing fixed reform models, it remains that access to the external funds they provide appears to have been a necessary pre-condition for the Peruvian state to embark upon its reproductive health initiatives (Ewig 2004; Nelson 2004). The piecemeal character of the reforms and the mitigated results they have produced bespeak a lack of political will or capacity within the state to design and implement more comprehensive health sector reform strategies.

Integrity and continuity in policy design and implementation have been notably absent in the successive episodes of reproductive health policy battles, reflecting broader weaknesses of the institutional framework, notably the lack of democratic accountability. Abuses committed under the quota- and target-based Fujimori family
planning program flouted the same ICPD principles the state had so enthusiastically endorsed. Using the ostensive priority of reducing maternal mortality to impose medical control over expectant mothers and failing to provide contraceptives also reflected the ideologically charged institutional cultures at work within MINSA and the Peruvian health system. Similarly, during the first years of the Toledo government, policy emphasizing maternity to the detriment of family planning and other aspects of reproductive health reduced the list of reproductive health services covered by its Healthcare Insurance Plan, effectively reversing prior state initiatives to universalize access to family planning and contraceptives, as well as the policy orientations of a number of international agencies.

Major works in the literature on gender and social policy have associated successful policy development with the initiatives or power of Left or center–Left parties (Huber and Stephens 2001; Mazur 2002). But one of the most notable characteristics of the reproductive health policy-making process in Peru has been the absence of political parties as distinctive entities in policy debates. For example, President Fujimori’s party was irrelevant to the decision-making process, as his political clout overwhelmed party members and opponents alike. The pioneering progress made and the shocking abuses perpetrated under his regime were equal to his ruthless determination to get results, regardless of any established policy—even his own. In a similar vein, during the Toledo regime, the power of individual politicians and their extra-parliamentary sources of support, either within the state or in civil society, were eminently more relevant than party politics to explaining the nation’s policy-making dynamics. National women’s and health sector advocacy groups, refusing to watch another Peruvian government govern alone, have tipped the policy balance. But for how long? We can say with certainty that, contrary to the tenets of the main literature, Peru’s history has shown that Left-wing party centrality has not been the key factor in furthering policies that advance women’s reproductive health and rights. Further research is needed in this area to compare Peru to other Latin American or South-World countries and to better theorize the role of both domestic and foreign actors in contexts where democratic institutions are weak.

Methodology Appendix

Data for this article was collected during my 2004 field research, conducted in Peru over a period of two months. Over 20 semi-structured, in-depth interviews were held with individuals from different sectors involved in the health sector or reproductive healthcare. NGO staff, researchers, international agency program
officers, doctors, nurses, civil servants, politicians, and feminist activists were selected for the interviews, with the assistance of Ana Guezmes, coordinator of the Observatorio de la Salud at the Consorcio de Investigación Económica y Social in Lima, Peru. Direct observation of healthcare service delivery took place at the family planning unit of a public hospital, located in an impoverished neighborhood in Lima. The author also participated in some public events and meetings organized by stakeholder NGOs. Secondary sources, such as monographies, policy papers, research reports, official policy statements, and program descriptions, were collected and analyzed.

NOTES

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1. Notable pioneering works include Giménez (2003) and Razavi and Hassim (2006).

2. For interesting case studies on social policy reform from a gendered perspective in Latin America, see Arenas de Mesa and Montecinos (1999) and Ewig (2001).

3. Exceptions include Arenas de Mesa and Montecinos (1999), Ewig (2001), Giménez (2003), and Razavi and Hassim (2006). The literature on “women and development,” “women in development,” or “gender and development” is vast and diverse. For a review of policy debates and paradigms, see Jain (2005).

4. Reproductive health emerged as a policy paradigm after a few decades of struggle and negotiations between population control agencies (largely based in industrialized countries), the international and national women’s health movements, and the governments of developing countries. Together, these interests and perspectives came to a relative and contested “consensus” embodied in the ICPD Program of Action, and adopted by
heads of state (Smyth 1998). Broadly speaking, the notion of reproductive health as adopted in Cairo “implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. (…) [this includes] the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice for regulation of fertility which are not against the law, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.” ICPD Program of Action, paragraph 7.2, 1994.

5. For a review of shifting policy paradigms, see Standing (2002), Weyland (2004), and Deacon (2005).

6. Gough and Wood’s notion of “welfare regime” is “a more generic term [compared to “welfare state regimes”], referring to the entire set of institutional arrangements, policies, and practices affecting welfare outcomes and stratification effects in diverse social and cultural contexts.” (Gough and Wood 2004, 26) A welfare regime encompasses the different dimensions of the welfare mix, including the state, the market, the community, and the family, together with the international actors who participate in the production and distribution of welfare in developing countries. The notion of social policy regime as set forth by O’Connor, Orloff, and Shaver (1999) considers a broadly defined state policy, that is, one that includes the state’s regulatory power over the body and reproduction for example. See O’Connor, Orloff, and Shaver (1999) for a discussion of the merits of the term “social policy regime” over “welfare state regime.”


8. In the 1990s, the World Bank’s own policy statement, World Development Report 1993: Investing in Health, took on hegemonic proportions, at a time when the World Bank had become the main source of international funding in Latin America.

9. Demographic and Health Surveys are carried out periodically to provide essential data for policy-makers. The USAID sponsors these surveys in collaboration with national statistical agencies (DHS 1996; DHS +2000).

10. In Latin America as a whole, the 1980s were characterized as the “lost decade” since most (if not all) economic and social development indicators show that debt and fiscal crises caused major setbacks. For more details on the extent of the extreme political violence, which started in Peru in 1980 and lasted in until the early 1990s (with a death toll of over 69,000), see the Report of the Truth and Reconciliation Commission, Lima, Peru, 2003.

11. Víctor Zamorra, Former Director of the Regional Office of the Ministry of Health in the San Martín District, and Former Advisor on
Social Themes at the Lima office of DFID (British Cooperation). Interview with the author, Lima, 2 June 2004.


13. Peru has a total of 25 departments (subnational administrative-political units).

14. Family planning services, including the provision of free contraceptives, voluntary tubal ligation or vasectomy, and counseling, had been free services in MINSA establishments since 1995, as will be explained later in this paper.

15. The maternal mortality rate was 240 per 100,000 live births in 2002, a little less than in the period 1990–96, when it was 265 per 100,000 live births (DHS 1996; UNFPA 2003).

16. Various other reasons, including cultural obstacles to women’s access to public health care establishments, also explain the high rate of maternal mortality. Yamin’s study shows that maternal mortality rates are not higher in the regions where there are no hospitals (hospitals being the establishments that should normally be equipped and prepared for emergency obstetric care). In 2000, it was estimated that 32.5 per cent of maternal deaths occurred in a public hospital (MINSA, reported in Yamin 2003, 106).

17. Yamin (2003) explains that the high prevalence of delivery at home among indigenous populations is also due to the discriminatory practices, maltreatment, and lack of sensitivity to cultural differences that women face when seeking medical care in a public healthcare establishment.


19. Daniel Aspilcueta, Personal interview, Lima, 26 May 2004. Aspilcueta also explained that he tried to dissuade these advisors from pursuing a program based exclusively or predominantly on tubal ligation or vasectomy as family planning methods.

20. The previous Constitution of 1979 was suspended in an authoritarian fashion by President Fujimori, who simultaneously closed down political and judicial institutions in 1992. Certainly, this course of action was only very marginally or not at all prompted by Fujimori’s agenda on the issue of family planning per se.

21. Law 26530, 8 September 1995. Tubal ligation and vasectomy were previously excluded from the list of authorized family planning methods, although they were practised by doctors for “medical reasons” without requiring individual consent. Not surprisingly, more tubal ligation operations were performed than vasectomies.


25. Jorge Parra, who was the Director of Family Planning Program at MINSA from 1990 to 1992 and then from 1998 to 2001, saw a major
difference in the political and financial resources provided for this program by the state in each respective period. In 1990, the program functioned with an annual budget of around $100,000, but by 1998 this amount had climbed to $10 million. The proportion of these funds coming from the National Treasury went from 20 per cent in 1990 to 70 per cent in 1998, the rest being financed by international cooperation funds. Jorge Parra, personal interview with the author, Lima, 31 May 2004.

28. Interview with Jorge Parra, op. cit. note 25.
29. Ombudsman’s Resolution No. 03-2000, Lima, 28 January 2000. It is difficult to say whether women had fewer tubal ligation operations after 1997 because of fears, amply fed by the rhetoric of the Catholic Church and the Political Extreme Right in Peru, or whether a normalization of the rate of operations occurred after the initial period when many women who had been wanting a tubal ligation for years could finally get it free of charge.
30. Movimiento Manuela Ramos and the Centro de la Mujer Peruana Flora Tristan are the two largest feminist NGOs in Peru.
32. The first report issued by women’s NGOs is Nada personal. Aplicación de la anticoncepción quirúrgica en el Perú 1996–1998. Lima: CLADEM. CLADEM stands for the Comité de América Latina y del Caribe para la Defensa de los Derechos de la Mujer (Latin American and Caribbean Committee for Women’s Rights Defense), and its national office is located in Lima, Peru. Another important initiative was the mobilization of Movimiento Amplio de las Mujeres (Broad-based Women’s Movement), that protested against the abuses and mounted legal defences for some of the victims.
33. The notion of reproductive health as a legitimate subject of public policy was explicitly rejected by two interviewees representing these sectors: Congressmember Hector Hugo Chávez Chuchón, President of the Permanent Commission on Health at the Congress in 2003–04, who pursued the ultra-conservative crusade of Ministers Solari and Carbone after they left the Health Ministry (see below); and a program staffer from the Peruvian Episcopal Conference. Personal interviews with the author, June 2004.
34. This information was confirmed by several interviewees.
36. Congressmen Hector Chávez Chuchon and Víctor Velarde, each representing opposite sides on reproductive rights issues, explained how they were debated by the Congress and its Health Commission. Interviews with the author, Lima, June 2004.
37. One of the anonymous reviewers insisted on this distinction and I am indebted to her.
REFERENCES


Conaghan, Catherine. 2000. “The irrelevant right. Alberto Fujimori and the new politics of pragmatic Peru.” In *Conservative Parties, the Right,


Defensoría del Pueblo. 2002. La aplicación de la anticoncepción quirúrgica y los derechos reproductivos III. Casos investigados por la Defensoría del Pueblo (Informe Defensorial no. 69). Lima, Peru: Defensoría del Pueblo.


Ewig, Christina. 2001. “Gender Equity and Neoliberal Social Policy: Health Sector Reform in Peru.” PhD diss., Political Science, University of North Carolina at Chapel Hill.


Vera La Torre, José Carlos. 2003. Cobertura y Financiamiento del Seguro Integral de Salud en el Perú. Lima, Peru: ForoSalud and CIES.


