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Overcoming Operational Policy Barriers to the Provision of Services Essential to Safe Motherhood in Peru

POLICY Project

March 2005

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The POLICY Project is funded by the U.S. Agency for International Development (USAID) under Contract No. HRN-C-00-00-00006-00. POLICY is implemented by Futures Group in collaboration with the Centre for Development and Population Activities (CEDPA) and Research Triangle Institute (RTI). The views expressed in this report do not necessarily reflect those of USAID or the United States government.



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Abbreviations

ANC	antenatal care
CCR	Regional Coordinating Council
CRS	Regional Health Council
CSO	civil society organization
DHS	Demographic and Health Survey
DIRES	Regional Health Directorate
MMR	maternal mortality ratio
MOH	Ministry of Health
NGO	nongovernmental organization
RNPM	Red Nacional por la Promoción de Mujer (National Network for the Promotion of Women)
SIS	Integrated Health Insurance
SMI	Maternal Infant Insurance



I. Executive Summary

Peru has one of the highest levels of maternal mortality in Latin America. Although maternal mortality has declined in the past decade, the maternal mortality ratio (MMR) remains high at 185 per 100,000 live births (DHS, 2000). Moreover, the MMR varies significantly by urban and rural areas and by geographic region, with some low-income regions reporting maternal mortality ratios of above 500 (Ministry of Health statistics). Underlying the high mortality is the fact that women in Peru often opt to deliver at home, in many instances, with unskilled birth attendants and with no possibility of accessing professional care in case of a complication. This is particularly true of rural, low-income settings, where almost 75 percent of births occur in noninstitutional settings (DHS, 2000). In Puno, Huancavelica, Amazonas, and other regions with very high incidence of maternal mortality, less than 30 percent of births are assisted by medical professionals. There is a very high correlation between the prevalence of unassisted deliveries and maternal death at childbirth. These less than ideal delivery practices have persisted, despite the government of Peru's efforts to provide free prenatal and delivery care services through various social insurance systems since the late 1990s, particularly in low-income areas.

Working on the assumption that operational policy barriers prevent access to maternal health services even when such services are provided free, the POLICY Project (POLICY) provided a focused technical assistance package between September 2002 and June 2004 to help identify and eliminate operational barriers¹ that stand in the way of access to safe delivery care for low-income women, particularly in areas with high maternal mortality. Our research and analysis identified barriers to delivery care. Key stakeholders at both the regional and national levels assessed the most significant barriers as follows: the severe lack of financial resources and absence of appropriate personnel at health establishments; multifaceted problems with the implementation of the Integrated Health Insurance (SIS) resulting in poor quality services that clients must pay for; and lack of respect for local cultural practices and customs at health facilities that serve as a disincentive for women seeking institutional care for their deliveries.

POLICY research and technical assistance contributed to the following policy² developments directed at addressing some of the identified barriers:

¹ Operational policies are the rules, regulations, guidelines, operating procedures, and administrative norms that governments use to translate national laws and policies into programs and services. These policies may pose barriers to service delivery due to a lack of policy guidance, misguided design of the policy, or misguided implementation of an appropriate policy (Cross, Hardee, and Jewell, 2001).

² Policy refers to any formal government statement including officially approved laws, national policies and plans, operational policies, and resource allocation decisions. National policies provide the general framework, rationale, objectives, and/or direction regarding an area of concern. In contrast, operational policies are the rules, regulations, guidelines, plans, budgets, procedures, and norms needed to translate laws and national policies into programs and services (Cross, Hardee, and Jewell 2001). Some pronouncements of high-level government officials, standard norms of practice, or traditional procedures, though unwritten, are also considered policies.

1. A new resolution issued by the Regional Health Directorate (DIRES) mandating the development and implementation of new prenatal and delivery care protocols that incorporate local cultural practices in health establishments in the region of San Martín; and the subsequent inclusion of these protocols as priority interventions in the 2005–2006 DIRES Operational Plan.
2. A normative document issued by the DIRES in the region of Piura with specific guidelines for redistributing staff among different health centers in the network to ensure the adequate availability of a skilled medical team to respond to demand at each facility.
3. A Maternal Health Plan directed at reducing maternal mortality/morbidity in Piura, which addresses key access barriers to maternal care services, developed by the regional Multisectoral Maternal Health Committee.

This paper documents the role of the POLICY Project in achieving these policy changes. The next section of the paper describes the socioeconomic and maternal health context in Peru, the policy environment for maternal health, and the policy stakeholders involved in this area. Section III discusses POLICY's response to the issue at hand by briefly describing the activities undertaken to identify and eliminate access barriers to maternal health services in four regions with high maternal mortality. Section IV discusses some of the key access barriers that were identified, as well as recommendations for addressing them. Section V focuses on each of the policy changes that have come about as a result of this process, and describes POLICY's technical assistance role in achieving such policy actions. In summary, the paper presents POLICY's approach in Peru to eliminating access barriers to maternal healthcare using a strategy that emphasized policy analysis, research, and multisectoral policy dialogue that led to several policy decisions at both the national and regional levels.

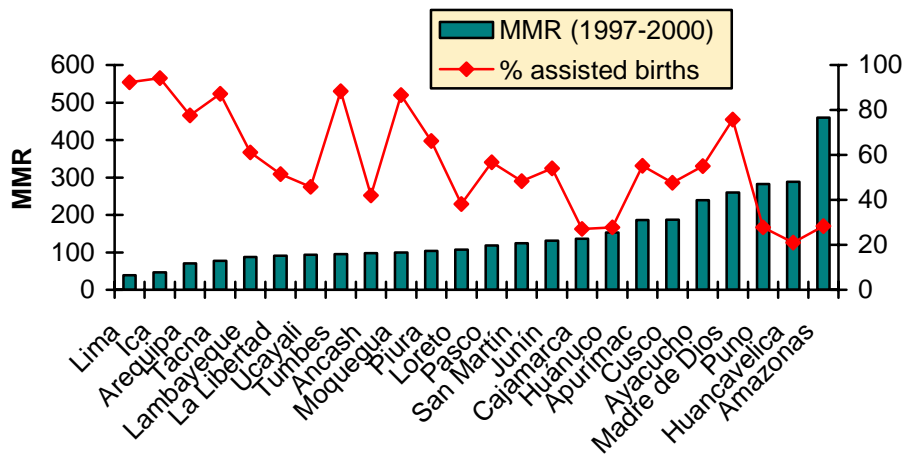


Context, Policy Environment, and Stakeholders

Maternal Health Context

Although the MMR has declined in the last decade, it remains among the highest in the region. The principal causes of maternal deaths in Peru are hemorrhage (49%), hypertension (14%), sepsis (11%), and abortion (6%). Maternal deaths are also associated with high levels of poverty, low levels of education, and social marginalization. In some of the poorer regions—Ayacucho, Puno, Huancavelica, Amazonas—the MMR is above 200. The probability of a woman dying during her reproductive years is 14 times higher in these poor regions than in those that are more developed, such as Lima and Arequipa. There is also a strong correlation between unassisted deliveries and maternal deaths across all regions.

Figure 1. Maternal Mortality Ratios and Institutional Delivery



Assisted births in low-income rural areas in Peru are a rarity, with less than 30 percent of them occurring in the presence of a healthcare professional (relative to 59 percent at the national level). There is clearly a strong preference for giving birth at home, without skilled assistance, in Peru’s rural areas.

Policy Environment for Maternal Health: The Government’s Response

There is national consensus that maternal mortality is a problem in Peru. The central government has, over the years, shown commitment to addressing this problem although the approach has changed with each successive change in government. Between 2001 and 2003, when conservative forces dominated the Ministry of Health (MOH), strategies

to reduce maternal mortality were completely devoid of any mention of family planning and its role in reducing unintended pregnancies and associated maternal deaths. The focus was entirely on maternal health services. Since 2003, the new Minister of Health has taken a more progressive and holistic approach to maternal health and the reduction of maternal mortality. Family planning has once again entered the debate, along with prenatal and delivery care.³

The practical application of Peru's approach to reducing maternal mortality has been its *seguros* (insurance schemes). In 1998, through the establishment of the Seguro Materno Infantil (SMI—Maternal Infant Insurance), the Fujimori government mandated that delivery care be provided free-of-charge to pregnant women and infants that belong to low-income segments of the population. Public sector funds were set aside to directly reimburse health facilities for services provided to eligible groups. In 2001, the Toledo government instituted its own insurance—the Seguro Integral de Salud (SIS). At its inception, SIS focused on the same population groups as the SMI—pregnant women and children. However, over time, its mandate expanded to include children and adolescents, aged 5–17 years, as well as specific adult groups. In keeping with the government's expectations and wishes, the SIS has increased demand for maternal health services. Institutional births rose by 10 percent between 2000 and 2004. However, financially, the national insurance systems have been unable to keep up with demand, and complaints of inadequate and delayed reimbursements abound at health facilities. These financial problems have put the burden of payment back on the shoulders of clients. Recognizing this dilemma, and understanding the negative impact that this will have on poor women, the current Minister of Health has set in place a pilot strategy to target the SIS to the poorest segments of the population.

Policy Stakeholders

Peru's health system is in the process of decentralizing and gradually giving more authority to its 25 regions. Funding and program responsibilities will eventually be devolved from the central government to regional authorities. As such, stakeholders in Peru's policy process include actors at both the central and regional levels. The stakeholders who influence maternal health/safe motherhood decisions at the central level are authorities in the MOH and the Director of SIS, which is an autonomous organization that relies on the Public Treasury for its funding. Working with key stakeholders at the central level has proven difficult in the past few years because of frequent changes in leadership. For example, between 2001 and 2004, Peru saw four different Ministers of Health with completely differing political viewpoints, as well as four corresponding Directors of the Directorate of People's Health, the MOH office responsible for health programs, including safe motherhood. These frequent changes have made working with the MOH in the past three years a repetitive process with few rewards, punctuated by periods of complete standstills when extreme conservatives were in control.

At the regional level, the governing structure is composed of a Regional President and a Regional Coordinating Council (CCR), which is responsible for policy and budgetary

³ However, for a number of reasons, inclusion of family planning in SIS was not included as part of this package's advocacy activities.

decisions. Principal stakeholders for health at the regional level include the Regional Health Council (CRS), which is responsible for approving and monitoring the implementation of the Regional Health Plan, and the Regional Health Directorate (DIRES), which serves an executive function and is responsible for implementing the Regional Health Plan and making policy and normative decisions regarding the operations of health networks and facilities. Addressing operational policy barriers at the regional level requires working closely with the Director of the DIRES and his/her functionaries. Working with DIRES at the decentralized level, in some cases, proved no easier than working at the central level. In Puno and Huanuco, two of POLICY's selected study sites, the directors of the DIRES, who were selected through a competitive process, changed three times in the course of 12 months because their selection was contested by their opponent. This made it impossible for planned activities to proceed in a timely fashion.

Civil society advocates for maternal health are also critical stakeholders in the policy process. In regions where multisectoral Regional Maternal Health Committees formed during the past decade and are still active, civil society groups are in a good position to influence decisions related to maternal health. In other regions, these committees were integrated into Poverty Alleviation Commissions that were in charge of developing the Regional Plans prior to 2002, and still have an influential role in health decisions. The Foro Salud, a coalition of civil society organizations (CSOs) that functions at both the central and regional levels, constitutes another important new stakeholder in the maternal health dialogue, and has, along with the Red Nacional por la Promoción de Mujer (RNPM – National Network for the Promotion of Women), played an important role in POLICY's activities.



POLICY Project's Response and Actions

POLICY's approach to identifying and devising policy interventions to reduce operational and cultural barriers that impede poor women's access to prenatal and delivery care services consisted of the following:

- Secondary data analysis, primary research, and a review of existing policies and norms to identify and analyze operational barriers that stand in the way of client utilization of maternal healthcare.
- Policy dialogue with key stakeholders at the regional and national levels to discuss and prioritize barriers, reach consensus on their causes, and formulate recommendations to reduce them through policy change.
- Assistance to DIRES, as well as to the central MOH and SIS, to institute recommended policy changes.

1. Policy research and analysis

POLICY's research was designed to address the following types of questions:

- Are free maternal health services indeed free, or are women who deliver in government facilities required to pay for medicines, supplies, and other incidental costs, which may render facility-based care unaffordable to many?
- Are reimbursements through the insurance system for delivery care at health facilities adequate to cover the actual costs of the services provided?
- Do prevailing health facility norms and policies pertaining to delivery or antenatal care (ANC), or the absence of such norms, serve as barriers to women seeking delivery services?
- Do pregnant women in remote rural areas receive adequate information about free delivery care services and other characteristics of maternal health services, such as time schedules, type of available providers, home visits, and others?
- How do cultural preferences and tradition affect a woman's decision whether to seek professional medical care at delivery?
- Are there opportunity costs related to costs incurred by women and their families to reach the health center/hospital that are deterrents to seeking services?

Research components included the following:

- A. *Secondary analysis of Demographic and Health Survey (DHS) data.* Secondary analysis of DHS data (1996 and 2000), as well as data from the National Household Survey and the National Income Survey, served the primary purpose of identifying key variables related to health-seeking behavior, socioeconomic status, and household power relations that are correlated to the low use of prenatal care and/or high levels of unassisted deliveries. Relevant variables were then used in a cluster analysis to select study sites for the operational barriers study. The cluster analysis grouped Peru's 25 regions by maternal health profile into five groups, one of which was eliminated on grounds of having the best

indicators. The region with the highest maternal mortality rate was selected from each remaining group, resulting in the following study sites: Piura (MMR 190.4), Huanuco (MMR 272.2), Puno (MMR 361.2), and San Martín (160). The similarity of relevant characteristics in all the regions belonging to a particular group ensures that policy findings and recommendations in each study site will be relevant for other regions in the group.

- B. *A review of existing studies on maternal mortality and use of maternal health services.* Over the years, the government and various nongovernmental organizations (NGOs) in Peru have conducted qualitative and quantitative studies analyzing the possible causes of persistently high maternal mortality rates in Peru. A review of such analyses conducted over the past 10 years served as the foundation for POLICY's work. Findings from these studies identified costs of medicines, lack of respect for cultural practices, absence of skilled staff at facilities, long wait times and distance, and service provider attitudes and disregard of clients' opinions as some of the principal barriers to use of maternal health services. POLICY used this information to design its research activities and delve into the policy and normative roots of these and other potential barriers.
- C. *An analysis of existing national policies and norms that pertain to maternal health services.* This consisted of a review of policies and norms that were in effect at the time and made specific reference to maternal health or maternal mortality. The most relevant policies reviewed included national policies passed by the government that came into power in July 2001 and those that pertained to the Integrated Health Insurance (bylaws and statutes, financing law, and organizational and operational norms and procedures). The analysis of these policies showed that there was a clear recognition at the national level that maternal mortality and access to services are problems. There are also written policies outlining possible solutions but with little effort devoted to translating them into action. The creation of SIS represents the government's principal mechanism to confront maternal mortality. However, while SIS *partially* addresses the issue of financing, it does not begin to address equally important problems related to quality control, supervision, socio-cultural diversity, and staff training and skills.
- D. *Individual interviews and focus group sessions with pregnant women and women who have recently given birth, both at their homes and at the health service delivery points.* In order to better



Interview with a woman in Huanuco who had an unassisted delivery.

understand, from the client perspective, the barriers that women confront when they seek maternal health services, POLICY conducted 194 interviews with women, their partners and family members, and traditional birth attendants, and 19 focus groups with women who had sought professional care for both deliveries and prenatal visits. These interviews and focus groups at the regional level were designed to gather information about operational, social, and cultural barriers to access for maternal health services; availability of transport; recognition of alarm signals during pregnancy; quality of attention received; awareness about SIS and free services; and indirect costs of seeking professional care.

POLICY staff encountered several difficulties in finding women outside the health system who were willing to be interviewed. Many of these women refused to discuss their decisions out of fear that the interviewers were affiliated with health facilities and were on a mission to coerce them to seek prenatal care or reprimand them for having had unassisted births. Interviewers experienced similar difficulties with the partners and some relatives of these women, particularly in Puno and Huanuco, where the decision to use health services lies with the women's husband and/or mother-in-law. Data collection in Puno and Huanuco was delayed considerably and ultimately had to be cut short because of these difficulties, which in their own way shed light on women's health-seeking behavior.

- E. *Interviews with administrators and service providers.* Interviews (71) and focus groups (11) with service providers (directors of facilities, obstetricians, midwives, and junior medical professionals) at health facilities proved to be another valuable source of information for identifying access barriers and learning about service



Interview with a midwife in Piura.

delivery practices and protocols. POLICY also interviewed 20 health administrators, including directors of the DIRES, those responsible for women's health and people's health within the DIRES, and SIS officials. Information gathered pertained to problems and bottlenecks in health facility operations and financing; cultural sensitivity, or lack thereof, in service delivery practices; the functioning of SIS and the adequacy/timeliness of reimbursements; and staff skills and training. Providers also often gave their opinions on what they believed to be barriers to access for women seeking health care.

- F. *A costing study to estimate the actual costs of providing delivery care services in a hospital compared with reimbursement rates.* Anecdotal evidence at the inception of the study indicated that pregnant women may well be reluctant to

seek delivery care at hospitals and health centers because, in reality, these services are not free; women would often be required to pay for medicines, supplies, and other incidental costs. In order to understand the root of this problem, POLICY conducted an extensive costing study in all four regions to assess whether SIS reimbursements were adequate to cover the actual cost of providing prenatal and delivery care services in hospitals and health centers. Elements that were costed included labor, drugs, supplies, equipment, transport, infrastructure (buildings and utilities), and support services that went into providing maternal health services. The results of the costing study clearly show that personnel costs account for the most significant part of service delivery costs. Sixty percent of these personnel are contracted (not appointed) directly by the health facility and are not paid for by the regional government. However, SIS reimbursements do not cover the cost of these contracted personnel and, as such, in many instances, the reimbursements fall far short of covering the actual cost of providing the service.

2. Policy dialogue and discussion on research findings

POLICY conducted workshops in two of the four regions (Piura and San Martín) to disseminate the results to local stakeholders. The directors of the DIRES in both regions, in a show of commitment, took responsibility for organizing the workshops and inviting participants. Although similar workshops were planned in Puno and Huanuco, political problems and frequent changes in the DIRES leadership made it impossible to follow through. In addition to being a forum for disseminating the results, the workshops in Piura and San Martín also served as an invaluable opportunity for local stakeholders to discuss the findings, add more depth to them, select the barriers to access that need immediate attention, and propose potential solutions. The presence of DIRES officials, including the directors, health providers from the regional networks, and representatives from CSOs, provided a multisectoral forum for lively discussion, and both workshops resulted with concrete proposals for change, as well as commitments by the DIRES directors to institute specific changes in the service delivery systems and practices under their control.



Participants working on a task at the workshop in Piura.

POLICY also presented findings from the studies at the central level, to SIS and MOH officials, including the director of SIS. However, changes in the MOH that took place in January and March 2004 made follow-up activities and continued dialogue difficult during the final stage of the core package.

3. Small grants and technical assistance to implement select interventions

The final phase of POLICY assistance at the regional level consisted of small grants and follow-up technical assistance to groups in Piura and San Martín to implement recommendations that emerged, with DIRES support, from the workshops.

IV.

Operational Barriers and their Impact on Access

Key operational barriers that were identified through the research studies and deemed priorities during the national and regional workshops fall into three broad categories: finance and SIS-related issues; cultural barriers; and problems related to the organization and staffing of health networks. Some of the specific problems are described below.

- Health establishments do not have adequate funds to meet the rising local demand for prenatal and delivery care services. The implementation of SIS and the corresponding availability of free prenatal and delivery care services for all pregnant women led to an increase in demand for maternal care. Institutional births rose by 10 percent between 2000 and 2004. However, this rising demand was not accompanied by increased funding for local health establishments. With some exceptions (normal births in some regions, for example), the reimbursements that health facilities receive from SIS are simply not sufficient to cover the cost of service provision. Table 1 clearly demonstrates this fact for tertiary level facilities in the four study sites.

Table 1. SIS Reimbursements as a Percentage of Service Delivery Cost at Hospitals

Region	Prenatal visit	C-section	Surgical intervention at delivery	Emergency obstetric care	Ultrasound	Intensive care (ICU)
Huanuco	77	56	44	63	39	38
Piura	67	66	53	68	179	NA
Puno	83	37	18	57	76	25
San Martín	72	50	63	65	264	376 ⁴

In health facilities at all levels of the referral system, while SIS reimbursements cover the cost of drugs and supplies, they do not cover other recurrent costs such as equipment depreciation and maintenance and salaries of contractual staff. Because facilities are no longer permitted to charge clients for these services, which are ostensibly paid for by SIS, they lack institutional funds to cover the deficit. As a result of this funding shortfall, facilities frequently ask clients to pay for drugs and supplies as well as lab tests. The situation is further exacerbated by up to three-month delays in reimbursements, causing some facilities to suspend the provision of services under SIS for several weeks. During this period of suspension, facilities charge clients for services provided. All of these issues serve as deterrents to the use of maternal care services.

- Application of the SIS by individual health establishments is arbitrary and inconsistent, leading to confusion and uncertainty for clients who rightly expect,

⁴ The tertiary hospital in San Martín does not have a full Intensive Care Unit. Instead, there is a Unit of Intermediate Care, without sophisticated equipment, where costs of providing services are one-fifth of what ICU services typically cost. However, SIS reimburses the hospital with the same amount of money as it does the ICUs in Huanuco and Puno.

but do not receive, free services. Although the SIS guidelines clearly define the services that pregnant and postpartum women should receive free of charge, personnel at health facilities often modify these criteria, either because they are ignorant of the guidelines or because the facility's funding situation does not permit provision of the entire gamut of free services to all who are eligible. Hence, in San Martín, some facilities require that women pay for two prenatal visits before they qualify for free prenatal care. In Huanuco and Puno, certain health centers charge women for lab tests during the first trimester prior to providing them with free care, and in others they simply do not offer them more costly tests such as the ELISA, which is theoretically covered by SIS. Confronted by these unanticipated payments, women choose to forego prenatal care, and/or deliver their babies at home, at no cost.

- The SIS restricts the provision of delivery services to certain health provider types at tertiary level hospitals because it only reimburses those services provided by physicians. This policy is based on referral guidelines and technical norms that are rarely adhered to in practice—namely, that only women with high-risk pregnancies/deliveries use hospital services. The costs of care provided by midwives in cases of low-risk pregnancies are not reimbursed and must be absorbed by the facility. Hence, at this level, there is an undue burden placed on physicians to either provide the service or sign the paperwork for services provided by midwives. In hospitals where there are only 1–2 physicians, which is generally the case in non-metropolitan areas, this translates into disempowerment of midwives and long wait times and repeat visits for clients.
- Professional attendance at home births and transport from home to a health facility are not covered by SIS. This has a significant impact on low-income rural women's decisions on whether to have skilled attendance at birth, either at a health facility or at home. Faced with the option of paying out-of-pocket for the “privilege” of delivering with skilled assistance or delivering at home without professional care, many poor women choose the latter.
- Maternal health service delivery practices fail to take local customs and culture into consideration. The majority of women who do not seek professional care at childbirth cited lack of respect for local customs and cultural practices as reason for preferring to deliver at home. Rigid protocols such as a reclining birthing position, not allowing the husband's presence in the delivery room, and not being permitted a hot beverage immediately following childbirth were some of the requirements at health facilities that went against the customs and traditions of women in all four study sites, but were particularly pronounced in Puno and San Martín.
- Health networks are not organized in a manner that permits the smooth functioning of the referral process. DIRES have, as yet, not been successful in assigning and ensuring the availability of staff and equipment that match the level of medical attention and capacity to resolve problems required at each level of the referral system. For example, in San Martín, one health center has an abundance of surgical instruments but does not have an operating room where

they can be used; however, another health center lacks instruments and an obstetrician but has an operating room.

- Availability of personnel at different facilities within the health network (hospitals, health centers, and health posts) does not correspond to the volume of clients for which each facility is responsible. For example, in the tertiary hospital in Piura, where all high-risk deliveries and surgical interventions occur, there is often one physician, with a student intern, to provide care for 40–45 patients, leading to low quality of attention and long wait times. Similarly, at all levels of Piura’s health network, there is a deficiency of appropriately skilled staff to attend to deliveries that take place at night and during weekends. For example, in the health centers, night and weekend shifts are arbitrarily rotated among a midwife, obstetrician, nurse, and dentists. Women in labor who appear at the health center on a night or weekend shift when the nurse or dentist is present cannot deliver at the health center and will be required to seek attention elsewhere. In Piura, many women stated these serious inconveniences as a disincentive to seeking delivery care at health facilities.



A focus group with service providers in San Martín.

Solutions and recommendations proposed by stakeholders at the regional and national workshops fall into the following broad categories:

- *Improving sensitivity to and respect of local culture, traditions, and customs in the delivery of maternal health services.* Local DIRES representatives and health providers, in conjunction with civil society groups, could work together to modify service delivery protocols such that they permit local customs, particularly during delivery. The implementation of these norms would also require the wide dissemination of the new protocols and training and sensitization for service providers to ensure that their actions and attitudes do not conflict with and are respectful of these cultural practices. The recommendations stressed the importance of giving women the choice to deliver in an environment they deem most comfortable.
- *Reorganizing the health networks to maximize their efficiency and effectiveness.* DIRES could work together with representatives of health networks to identify the bottlenecks, staffing problems, and equipment deficiencies at each level of the referral system. The process would entail clearly defining the role of each health facility and ensuring that it had the necessary providers, equipment, and drugs to provide the medical attention required at that level. Because this process

could involve reassigning equipment, ambulances, and staff among existing facilities, involving service providers, health facility directors, and community representatives in the decisionmaking process is critical.

- *Reducing the financial burdens on individual health facilities and clients by improving the effectiveness of SIS.* A first step in this process would be to present the results of POLICY's costing and qualitative study to the MOH and SIS at the central level. As a next step, POLICY and other cooperating agencies, with support from regional governments and DIRES, could work with SIS officials to modify norms and procedures, on the basis of the study results, to ensure that, among other things, reimbursements cover the cost of providing prenatal and delivery care services; that certain provider types are not restricted from providing the services that fall within their skill set; and that the application of SIS is consistent across facilities and does not place financial burdens on poor clients.



V. Policy Changes and Decisions Achieved with Technical Assistance from POLICY

The POLICY assistance package achieved the following results in San Martín and Piura:

1. A new resolution issued by the Regional Health Directorate (DIRES) mandating the development and implementation of new prenatal and delivery care protocols that incorporate local cultural practices in health establishments in the region of San Martín; and the subsequent inclusion of these protocols as priority interventions in the 2005–2006 DIRES Operational Plan.
2. A normative document issued by the DIRES in the region of Piura with specific guidelines for redistributing staff among different health centers in the network to ensure the adequate availability of a skilled medical team to respond to demand at each facility.
3. A Maternal Health Plan directed at reducing maternal mortality/morbidity in Piura, which addresses key access barriers to maternal care services, developed by the regional Maternal Health Committee.

In Peru's current health system, which is in the process of decentralizing, the DIRES is responsible for making policy and normative decisions regarding the functions of health networks and service delivery. Representatives from the DIRES, including the director, attended the workshops in both Piura and San Martín, at which POLICY presented the findings from the research studies. In both regions, the directors of the DIRES, backed by CSOs and health providers, were quick to respond to the study findings and made open commitments to follow through on key recommendations. The discussion below provides an account of the main steps involved in the ensuing policy decisions, the key actors and their roles, as well as POLICY's involvement in the process.

- 1. A resolution by the DIRES mandating the development and implementation of new prenatal and delivery care protocols that incorporate local cultural practices and customs in health establishments in the region of San Martín; and the subsequent inclusion of these protocols as priority interventions in the 2005–2006 DIRES Operational Plan.**

During the results dissemination workshop conducted by POLICY in San Martín (March 2004), participants discussed and prioritized many of the barriers described in Section IV and proposed recommendations for addressing them. The issue of cultural barriers—backed by the numerous comments and complaints of focus group participants who opted not to seek professional care for deliveries, as well as the observations made by health care professionals who had both been interviewed by POLICY and were present at the workshop—received special attention, and was identified as a barrier that could be reduced with little resistance and controversy. The director of the San Martín DIRES pledged to take action at the normative level, specifically to issue a resolution requiring health facilities to follow new, culturally sensitive delivery and prenatal care protocols that would make maternal care services more palatable for local women.

Following the workshop, POLICY continued to provide assistance to this initiative through a small grant to a local NGO, CADES. In the summer of 2004, a representative of CADES, a medical professional, worked closely with a handful of representatives from the regional health networks to draft the language for the resolution, which was then sent to the DIRES for review and approval. The proposed resolution not only mandates the adoption of culturally sensitive maternal healthcare practices throughout the region, but more specifically, sanctions the implementation of new protocols on a pilot basis in the health network of Moyobamba. During this same period, POLICY worked closely with CADES, DIRES officials, and key local health providers and administrators to develop the new protocols, which clearly detailed specific cultural practices and customs that should be made available to women who request them. The new protocols were largely based on findings from POLICY's interviews and focus groups with women who had not opted for professional care during childbirth, as well as on the personal and collective experiences of the health providers that were involved in the endeavor. The resolution and protocols were approved by the director of the DIRES on October 10 and November 4, 2004, respectively, after which they were printed and widely disseminated by the DIRES.

In November and December 2004, the approved protocols were implemented on a pilot basis in the 10 health establishments of the Japelacio micro-health network in the Moyobamba health network. The pilot test consisted of workshops to raise awareness and train health personnel on the new protocols, as well as implementation of the new culturally sensitive delivery practices. The costs of the training workshops were borne partly by POLICY, but largely by the health network itself. Based on the successful experience in Japelacio, the DIRES has now included the adoption of culturally sensitive delivery practices by health establishments as a priority intervention in its 2005–2006 Action Plan and has requested POLICY assistance to expand the effort to 10 additional micro-networks in 2005. POLICY will follow through on this request with field support.

2. An official normative document issued by the DIRES in the region of Piura with specific guidelines for redistributing staff among different health centers in the network to ensure the adequate availability of skilled medical personnel to respond to demand at each facility.

In Piura, stakeholders at the workshop were galvanized into action when confronted by the pervasive fact that women who went into labor at night and during weekends were often unable to find personnel with the skills necessary to deliver their babies at the hospital and health centers. This was identified as a definite deterrent to seeking delivery care at health facilities. While symptomatic of larger organizational problems in networks where health facilities are not appropriately staffed and equipped, participants at the workshop chose to begin by tackling the issue of night and weekend shifts.

As described above in Section IV, personnel at the hospital and health centers in Piura are randomly assigned night and weekend shifts with little regard to the medical needs of clients who might seek care at those times. Thus, on any given night, a health center is just as likely to have a sole dentist attending patients as it is to have a midwife or obstetrician. Similarly, the Piura hospital might have an anesthesiologist and a nurse during a weekend shift, neither of which is qualified to deliver a baby. Women who

come to the facilities on these “off” shifts would be forced to seek care elsewhere or return home for their delivery.

The director and other representatives of the Piura DIRES expressed their commitment to reorganize the staffing system to address the problem at hand and ensure the presence of a health provider with the skills to deliver at all times.

With minimal follow-up assistance from POLICY, the DIRES drafted and issued a Norm in April 2004 ordering the reorganization of staffing during night and weekend shifts. It specifically charges health networks with the responsibility of putting in place mechanisms to ensure the availability of appropriately skilled staff to cover 24 hour shifts. The norm states that the type of professional slotted to cover a particular shift should directly respond to the types of services demanded during each shift and should not be based on past shift allocations.

3. A Maternal Health Plan directed at reducing maternal mortality/morbidity in Piura, which addresses key access barriers to maternal care services, developed by the regional Maternal Health Committee.

During the regional workshop, while discussing various maternal health problems and access barriers to safe motherhood services in Piura, stakeholders identified the absence of a Maternal Health Plan as an impediment to their ability to set priorities for improving maternal health in the region. Stakeholders felt that a solid, information-based Maternal Health Plan was a critical step toward including maternal health issues and activities in the Regional Health Plan, which is funded by the regional government and the MOH. At present, Piura does not have a Regional Health Council which, in Peru’s decentralized health system, is responsible for preparing regional health plans. However, workshop participants decided that having a Maternal Health Plan in hand to present to the Regional Health Council, once it was formed, would go a long way toward ensuring the inclusion of maternal health issues in council’s agenda.

Within this context, POLICY worked closely with RNPM and DIRES representatives to provide technical assistance to Piura’s Multisectoral Maternal Health Committee⁵ to do the following:

- Conduct meetings and workshops to raise awareness about the principal maternal health issues in the region. The findings from POLICY’s studies in Piura featured prominently in these awareness-raising activities;
- Form a Consultative Group, made up of committee members, to spearhead the development of a Maternal Health Plan;
- Develop a Maternal Health Plan, which would, among other things, address key barriers identified through POLICY activities; and
- Widely publicize the existence and contents of the plan among the public, with an eye to raising general awareness and generating demand.

⁵ The Maternal Health Committee is composed of representatives of local NGOs; professional colleges (obstetricians, physicians, nurses, journalists); universities; RNPM; Foro Salud; the Provincial Committee on Poverty; the regional government; DIRES; regional health facilities; municipal health commissions; and grassroots organizations.

Piura's Maternal Health Plan was finalized in August 2004 and was endorsed by representatives of the health, education, and other social sectors, all of whom would be responsible for its implementation. When Piura's Regional Health Council is established and functional, the Maternal Health Plan will be submitted for inclusion in the Regional Health Plan.

In addition to policy changes and new plans, the core package paved the way for a ground-breaking encounter between local authorities and civil society in Piura. Following the dissemination of the study results, and motivated by the discussion and insight of civil society groups present at the workshop, the director of the DIRES convened a Public Audience in Health in July 2004, with 70 participants from citizen surveillance committees, CSOs, NGOs, associations of persons living with HIV or AIDS, and the Ombudsman's Office to receive input on problems with the health system. This public meeting, at which citizens were invited to have a frank and open dialogue with public sector health authorities, was a rare occurrence in Peru—to the best of our knowledge, no such meeting has ever been conducted in any other part of the country. During the audience, participants identified problems with the health system and recommended solutions to improve healthcare in Piura. The director of the DIRES then signed an agreement with representatives of NGOs, Citizen Surveillance Committees, and the community committing to implement the recommendations, which seek to address issues around quality, availability of drugs, access to services, and unauthorized payments for health services.



POLICY's Impact and Future Perspectives

POLICY's work on safe motherhood issues in Peru presented a much needed opportunity to identify, study, and address a range of access barriers at the central and local levels that contribute to high numbers of unassisted deliveries and maternal deaths in low-income regions with high incidences of maternal mortality. The findings from the qualitative and quantitative studies that POLICY conducted in Piura, San Martín, Puno, and Huanuco provided local decisionmakers, health providers, and civil society groups in these regions with an understanding of the main barriers that poor women face when they try to access maternal healthcare services at regional health facilities. It also gave them a clear perspective of why significant numbers of women opt to forego prenatal care and/or have unassisted deliveries at home. Workshop participants commended POLICY on the analyses and claimed that the results helped enrich their knowledge base and would serve them well as they “continued to work with the community to achieve the objective of reducing maternal mortality.”

The discussion and dialogue around the findings among workshop participants and the subsequent policy actions taken by the Regional Health Directors, with the full support of their medical counterparts and civil society, only serve to underscore the importance of POLICY's contribution. Although many local officials and service providers had preconceived opinions and suspicions about why poor women opted out of the formal health system, the information gathered from users and non-users of maternal health services, and from health administrators and providers, helped strengthen and expand this knowledge base and, more importantly, served as a call to action. Regional policy changes have occurred in San Martín and Piura. A Maternal Health Plan now exists in Piura. These changes will have a positive impact on women's access to maternal health services.

However, much remains to be done. Working in a decentralized context requires that change that begins in a few localities then be spread to other regions. The results of policy studies are applicable to other regions in the country. The issues of cultural barriers, staffing, and financing shortages are pervasive throughout the country. POLICY will continue to widely disseminate the findings of this core package and, where possible, will work to affect policy changes that reduce identified operational barriers to delivery and prenatal care. In the immediate future, the intent is to continue efforts in San Martín and Huanuco.

Reducing operational barriers to maternal health services on a national scale requires focused attention on the operations of the government's Integrated Health Insurance (SIS). Many of the key challenges and barriers identified through POLICY's studies pertain to problems with the SIS. Based on the priorities set by stakeholders in Piura and San Martín, discussions with key actors at the central level, and the assessment by POLICY staff, the implementation of several fundamental changes in the norms and procedures of SIS are critical to reducing barriers to access at the service delivery level. Toward this end, it is still necessary to affect changes in SIS norms and implementation procedures to:

1. Increase reimbursement rates for certain maternal health services such that they cover the actual costs of service delivery, including the cost of contracted health personnel and equipment depreciation and maintenance; this change would help reduce financial deficits at facilities.
2. Reimburse tertiary level hospitals for services provided by midwives to pregnant women with low- and medium-risk pregnancies (prenatal care), and reduce reliance of physicians for all services provided in these facilities.
3. Ensure that the application of SIS is consistent across all health establishments by widely disseminating SIS norms, complete with services covered and eligibility criteria, and thereby eliminate arbitrary charges for services covered by SIS.

Achieving the aforementioned changes, particularly those related to reimbursement rates, was part of the original intent of the core package. To this end, in October 2003, POLICY presented preliminary results of its research and analysis to the SIS director and others at the central level. Although initial interest in the findings was high, a change in the Ministry of Health, the appointment of a new minister, and anticipated (still to be implemented) changes in SIS delayed follow-up activities considerably. As a result, POLICY was unable to affect changes in SIS policies within the time frame of the core package. However, during the next few months, POLICY/Peru will use field support funds to build on completed core package activities and work closely with other cooperating agencies, PARSALUD (a project funded by the World Bank and IDB), and SIS at the central level, and specific regional governments and DIRES in the northern part of the country (USAID's focus region) to implement a top-down and bottom-up approach to bring about much needed changes in SIS norms and procedures.

Despite the challenges and work that remain, POLICY's experience in Peru has shown that targeted assistance, research, and information can lead to policy actions and change in the area of maternal health. This activity provided policymakers and stakeholders with information and assistance that they could act on. Some policy changes occurred soon after information and assistance was provided, while in other cases, particularly at the central level, policy action awaits further efforts on the part of POLICY and local stakeholders.



References

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