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# **The Peruvian response to the COVID-19 pandemic**

The role of evidence-based governance and structural violence

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**Abstract:** Why does a state like Peru, dedicated to fulfilling development goals and sustained good macroeconomic performance, appear incapable of dealing with the COVID-19 pandemic? Using the case of maternal mortality, this paper argues that the tremendous impact of the pandemic is rooted in the adoption of health policy reforms that prioritized targets, vertical programmes, and an empty understanding of health coverage over quality, the need for social change, and the strengthening of the system as a whole. This approach to health policy, dominant in Peru since the 1990s, is part of the global indicator culture of international development, which oversimplifies complex health problems such as the high number of maternal deaths, narrowing it to a focus on certain indicators without analysing their feasibility. This approach to policy-making is a form of exercising of state power and structural violence that has created a weak health system which cannot rapidly restructure and deliver remotely regular care to pregnant women in remote areas.

**Key words:** maternal mortality, targets, indicators, international development

**JEL classification:** I18, I38

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## 1 Introduction

At a global level, there is a growing consensus regarding the critical role of the state's capacity to guarantee resilient health systems able to effectively respond to health emergencies, such as the one generated by the COVID-19 pandemic. Less consensus exists around what features of the state are critical in explaining the performance and outcomes of the conditions when dealing with the pandemic.

For example, emerging evidence shows that although a country's income level relates to the state's capacity to face crises like the one generated by COVID-19, this is not the only factor or the most prominent (Pitterle and Lennart Niermann 2021).

Latin America offers an excellent example of this. The region has been hit hard by the pandemic. In recent years, most countries in the region have become recognized as middle-income countries after decades of being classified as poor. Yet the devastating impact of the pandemic revealed the extent of structural problems, such as unequal wealth distribution, low levels of investment in public services, and labour informality, which have contributed to the spreading of the disease and limited the recovery in economic activity. The COVID-19 pandemic has prompted the most significant GDP contraction in the past 100 years and triggered a decline in employment not seen in the past seven decades, with the regional informal sector the one that experienced the most significant job destruction (ECLAC 2021).

Within Latin America, the case of Peru has been particularly striking. The country has shown more significant weakness than countries of similar income when responding to the crisis generated by the pandemic. This in turn has contributed to the 213,000 COVID-19 deaths in a population of less than 33 million (Our World in Data 2021).

Before the pandemic, this upper-middle-income country was regarded as a capable state. Peru had experienced 18 years of sustained growth at rates above the Latin American average. In addition, the country had an unusually low debt of 26 per cent of its GDP and had managed to control inflation (at less than 2 per cent). In recognition of its macroeconomic performance, the International Monetary Fund referred to Peru as a rising star (Montenegro 2020; ProInversión 2019). Besides macroeconomic indicators, Peru was on track to fulfilling Sustainable Development Goals (SDGs) and was making good progress on improving health coverage.

Also, the Peruvian government had the authority and legitimacy to adopt mandatory social isolation to stop the spread of COVID-19. Unlike other Latin American countries severely affected by the pandemic, such as Brazil or Nicaragua (as addressed in Jarquín 2022), authorities in Peru did not deny the threat of the pandemic. They ordered a state of emergency that was supported by the majority of the population. In March 2020, when former president Martín Vizcarra adopted the general lockdown, the presidential approval rating grew from 52 per cent to 87 per cent.

Compared with other countries in the region, Peru's ability to deliver sustained macroeconomic performance and progress towards international development goals suggests a comparatively 'capable' state. We would expect such a state to also engineer an effective pandemic response. It is a puzzle, then, that it did not.

Using one core health programme—maternal health—labelled as successful for the reduction of maternal mortality since 2000 (UNFPA 2017; WHO 2019), this paper argues that in contrast to what is described in Asante (2022), in Peru, previous public health programmes have not

contributed to building the health system's 'residual capacity'. The focus on maternal mortality is not a random choice. Literature has already described the fact that this indicator is sensitive to the health system's capacity to provide quality health services at the primary level and refer to complex care. Besides, maternal mortality is sensitive to social inequity and socioeconomic marginalization (Physicians for Human Rights 2007; Pinzón-Flórez et al. 2017; Thaddeus and Maine 1994). Since the mid-1990s, Peruvian authorities have invested in and rolled out various programmes, strategies, and national plans to prevent and reduce maternal deaths, including activities to decrease domiciliary deliveries and improve health services' accessibility and quality of care (Del Carpio 2013; Ministerio de Salud 2009).

An increase in maternal mortality during the COVID-19 pandemic has been reported in other countries; the more concerning reports come from low- and middle-income countries, i.e., countries that already carry the majority of the global burden of maternal mortality (Chmielewska et al. 2021). The achievements of Peru in the last years should, in theory, have prevented the dramatic increase in maternal deaths observed in 2020 and 2021. Before the pandemic, Peru had managed to reduce the maternal mortality ratio from 144 to 88 per 100,000 live births (a decline that kept pace up until the year 2019) and expand coverage of maternal care services, reaching 94 per cent of births attended by skilled professionals at a health facility. The country also had in place a national network for the surveillance of maternal mortality; this network provides weekly updates to characterize the maternal mortality profile in the 24 regions (Carrillo-Larco et al. 2022). In other words, Peru was in a good place to design interventions to address maternal mortality, according to subnational patterns, by age or specific causes. However, during the first year of the pandemic, it increased by 50 per cent (Carrillo-Larco et al. 2022).

Before the COVID-19 pandemic, scholars pointed to the risks of oversimplifying global indicators in implementing the Millennium Development Goals and designing the SDGs. For scholars such as Merry (2016), the emergence of numeric targets reflects a global trend where quantification of governance is perceived as the goal standard. Evidence-based governance represents the 'indicator culture' (Merry 2016), where indicators become the governance technology. However, by translating social phenomena into measurable outcomes, indicators can redefine concepts intended to measure and set policy priorities, including at the national level (Fukuda-Parr et al. 2014).

The power of the indicators has been reinforced by the 'measurement obsession' in global development (Fukuda-Parr and McNeill 2019; Fukuda-Parr et al. 2014), which emphasizes the prioritization of vertical programmes that rely heavily on technical solutions, avoiding ideas of social justice and neglecting the need for social change and the strengthening of national institutions (Birn and Nervi 2019; Fukuda-Parr et al. 2014).

In addition to concerns regarding the risks of the oversimplification of 'indicator culture', another corpus of the literature has stressed the need to understand how evidence-based governance is implemented and what is telling about the relations between the different layers of the state, and between the different layers of the state and the citizens. Authors such as Gupta (2012) have referred to targets being decided from above, without consultation with the implementers about their feasibility and desirability as structural violence. For this author, this type of violence is systematically produced by the frictions between the agendas, ministries/offices, levels, and spaces that make up the state (Gupta 2012). This violence is also exercised by domination (Auyero 2009), which works by yielding to the power of more powerful others at the different levels of the implementation of the policies. The authority of powerful agents surrounds implementers of the policies. Citizens targeted by social programmes are also surrounded by the rules of the 'experts' who decide the policies and by the power of implementers (Cookson 2018). This dynamic provides inaccurate information regarding the services that the population needs, undermining the state's

real ability to provide, as well as the capacity to make the state accountable for neglecting population needs.

I argue that the poor performance of the Peruvian state during the COVID-19 pandemic, including the increase in maternal deaths, is an expression of ‘structural violence’ (Gupta 2012), which is rooted in the adoption of evidence-based governance detached from structural reforms to reduce inequities. The adoption of evidence-based governance by the health system in Peru and, more broadly, Latin America, is related to the period of neoliberal macroeconomic reforms adopted at the end of 1980s beginning of 1990s, with a typical pattern of policies enshrined in the so-called Washington Consensus characterized by a targeting approach, the shrinking of the state, and the prioritization of cost-effectiveness analysis in designing policy.

The health system, particularly maternal health services, offers an excellent case to analyse this structural violence. Health systems are core social institutions (Freedman 2006; Yamin and Norheim 2010) similar to the judicial or democratic political systems. In this sense, health systems are providers of health and healthcare and a vital part of the social fabric—structures where societal values and norms are communicated and reinforced. These societal values and standards influence how health systems design and assess health policies and interventions. Thus, selecting criteria and indicators to evaluate health systems’ and interventions’ performance and results is contentious and embedded in normative judgements and moral considerations that are not value neutral and often not explicitly presented by the literature. In the case of maternal health, the indicator of maternal deaths, while valuable in providing information about a particular phenomenon, do not provide a complete picture of the underlying determinants of health that could contribute to the maternal deaths, such as access to safe and potable drinking water and adequate sanitation facilities, hospitals, trained health workers, and essential drugs. Literature has showed how the lack of availability can influence the decision to seek care when health facilities are so scarce that distance is a discouraging factor. The lack of availability and geographic accessibility can make travel to a health facility long producing delays in arriving to treatment (Physicians for Human Rights 2007; Thaddeus and Maine 1994).

The paper is organized as follows: first, it describes the state of maternal mortality in Peru during the COVID response through 2020 and 2021. This description includes the policies and programmes deployed to address maternal mortality during those years. Second, it analyses the policy’s efforts in targeting maternal health and maternal mortality. Section 4 presents final remarks.

## **2 COVID-19 and maternal healthcare services**

On 15 March 2020, with 28 confirmed cases and no reported deaths, the Peruvian government issued Supreme Decree 044-2020-PCM, declaring a national state of emergency. Early on, the government implemented a series of extreme measures based on recommendations of the World Health Organization (WHO), such as closing borders, restricting freedom of movement nationwide, banning crowds, closing schools, universities, and churches, and generally restricting all non-essential activities and services, such as outpatient care (including immunization, prenatal, obstetric, contraception, paediatric, adult, nutrition, and health promotion activities). As a result, 8,723 primary health centres close down outpatient services for more than three months.

Also in March 2020, the Peruvian state ordered health workers with comorbidities to take health leave and work remotely (DU 026-20). To address the human resources shortage within and increasing demand for COVID-19 services, Peruvian health authorities reorganized and reassigned

the available health workforce to cover COVID-19 services. New staff were hired to work exclusively in these services (Murillo-Peña et al. 2021).

However, these measures were not enough to respond to the needs created by the pandemic. Peru had the highest COVID-19 mortality rate among health workers of any country globally. This rate began to decrease once vaccination for health workers was provided during the first quarter of 2021 (Mayta-Tristan 2021). Despite this, by mid-2021, many health workers remained on leave—and the proportion was higher in rural areas (see Table 1).

Within a context of rapidly increasing numbers of COVID-19 cases and deaths, a shortage of health workers, and restrictions on the availability and accessibility of maternal health services, Peruvian health authorities ordered some measures aimed at attending to the non-COVID-related health needs of the population, without any study of their feasibility. In the case of maternal health, in April 2020, the Ministry of Health (MoH) issued Directiva Sanitaria 094-MINSA/2020 DGIESP to guarantee antenatal, perinatal, and postpartum care access during the COVID-19 emergency, and Directiva Sanitaria 097-MINSA/2020 DGIESP establishing the procedures to be followed to attend to the health needs of pregnant women and newborns who were at risk from or who tested positive for COVID-19. Both regulations included monitoring strategies via mobile phones and video calls.

It was not clear how these directives were to be implemented. The orders were not accompanied by concrete measures ordering the opening of non-emergency maternal care services or hiring new personnel. Moreover, assuming the closedown of maternal health services, some national programmes, such as Juntos (the conditional cash transfer programme), stopped collecting and reporting data on maternal health.

Another measure announced in April 2020 was ‘telemedicine’, as a means to protect health workers and guarantee access to health services. But the measure did not take into consideration the fact that eight out of ten primary care centres in Peru do not have internet access (Seinfeld et al. 2021); besides, while 84.4 per cent of poor households have access to a mobile phone, only 7.1 per cent have access to the internet (Mesa de Concertación Para la Lucha Contra la Pobreza 2020). Thus, this measure was not helpful in addressing the demand for maternal health services at primary healthcare centres. Research performed with health personnel from sexual and reproductive health services in Lima during the pandemic found that one outstanding feature of the MoH COVID-19 response, described by health workers, was the lack of planning. There were no clear indications on how, under these new circumstances, non-COVID health services should be organized, how patients’ follow-up should take place, or how patients’ access would be guaranteed to their regular drugs or other supplies (Pesantes and Cortez 2021).

To respond to this situation, health workers on leave implemented strategies to follow up with their patients using their mobile phones. Personal phones were used to send patients reminders of their appointments or information regarding where to go for the delivery. This demonstrates that health workers did not receive the equipment or financial resources required to follow up their patients remotely as ordered by Directiva Sanitaria 094-MINSA/2020 DGIESP and Directiva Sanitaria 097-MINSA/2020 DGIESP. In addition, formal procedures were not adapted. Pharmacies required the physical prescription of medicines (from contraceptives to iron), making it impossible for health workers working remotely to prescribe any medication to their patients.

Table 1: Health leave

	2020					2021											
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
% MoH and regional government health workers on leave	5.0	9.6	9.6	9.7	8.9	8.7	8.6	8.5	8.1	8.4	7.8	7.5	6.9	6.8	6.8	6.7	6.5
Peru	12,879	24,671	24,672	25,027	22,894	22,352	22,243	21,888	20,931	21,722	20,146	19,392	17,765	17,634	17,463	17,170	16,784
Rural	12,113	23,445	23,446	23,832	21,696	21,150	21,059	20,716	19,833	20,616	19,160	18,435	16,916	16,798	16,665	16,410	16,061
Urban	766	1,226	1,226	1,195	1,198	1,202	1,184	1,172	1,098	1,106	986	957	849	836	798	760	723

Notes: N = 257,566.

Source: author's construction based on data obtained privately from the MoH.

Table 2: Percentage of health workers (MoH and regional government) on health leave

Profession	2020					2021											
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Medical doctors	5.25	9.82	9.83	10.17	9.20	8.95	8.93	8.81	8.47	8.23	7.79	7.25	5.62	5.43	5.54	5.34	5.23
Nurses	4.10	8.52	8.52	8.66	8.16	8.14	8.14	8.01	7.64	8.21	7.59	7.25	6.26	6.22	6.14	6.01	5.87
Midwives	4.28	8.16	8.16	8.27	7.43	7.06	6.97	6.80	6.58	6.37	5.77	5.42	4.72	4.67	4.59	4.59	4.43

Source: author's construction based on data obtained privately from the MoH.

The poor implementation of policy measures such as Directiva Sanitaria 094-MINSA/2020 DGIESP and Directiva Sanitaria 097-MINSA/2020 DGIESP happened despite the efforts made by lower-level officials who were, for many reasons including lack of material conditions, incapable of implementing the ‘desires’ of the high-ranking officials who had planned a response without undertaking any feasibility analysis. As a result, 34.4 per cent of maternal deaths in 2020 occurred without any antenatal control; in 2020 and 2021 together this figure reached 41.2 per cent. By contrast, in 2019 it was 29.9 per cent (Centro Nacional de Epidemiología Prevención y Control de Enfermedades 2021).

By June 2020, available data already showed an increase in maternal deaths (Centro Nacional de Epidemiología Prevención y Control de Enfermedades 2020). However, no measures were taken to amend the shortfalls of the previous orders. Pregnancy was not considered a risk factor in the COVID-19 clinical guidelines and regulations issued by the MoH. Moreover, despite the increase in maternal deaths and the information on the lack of health personnel (see Tables 1 and 2), there were no specific or emergency measures to address maternal mortality as part of the COVID-19 response, nor even to supervise the implementation of Directiva Sanitaria 094-MINSA/2020 DGIESP and Directiva Sanitaria 097-MINSA/2020 DGIESP.

Despite maternal deaths increasing by 45.4 per cent in 2020, pregnant women were not prioritized for vaccination—i.e., they were not considered among the risk groups. Only in June 2021, when immunization by age groups was already on track, were women at 28 or more weeks of pregnancy prioritized for vaccination. In August 2021, this changed to 12 weeks of pregnancy.

Besides, some hospitals become COVID-19 hospitals, i.e., they stopped providing care to those with other health conditions, including antenatal control and deliveries; others refused to care for anyone suspected of having COVID-19. All this created geographical and economic barriers (due to the cost of transport) to access to healthcare, thereby producing delays in the receipt of timely care, including in the case of obstetric emergencies. The majority of maternal deaths took place in a health facility’ during 2020 and 2021, the number of institutional maternal deaths increased from the number in previous years (83.21 per cent against 75.5 per cent in 2020 and 74.5 per cent in 2019). For these women, reaching a health facility was not enough to save their lives.

That a lack of planning contributed to preventable deaths is illustrated in the case of Mrs NB, a 32-year-old woman who died on 29 April 2021, after delivering a stillborn baby. Mrs NB lived with her husband and daughter in a rural community in Rio Negro, Satipo, Junín, where they grow and trade pineapples. According to official data, around 30 per cent of Rio Negro’s population lives in poverty. In this district of 34,427 inhabitants, 1,043 families belong to the Junto conditional cash transfer programme.

Despite a public health post 4 km away from the community, Mrs NB’s family and neighbours prefer to travel 50 km to Pichanaki to seek healthcare. Even if they have to pay for the services and the transport, Pichanaki offers better services. During her pregnancy, Mrs NB went to her antenatal care; all was normal. At the health post, they ordered some tests and referred her to Satipo, a town two hours away. Even if she had to pay, she preferred to travel to Pichanaki, closer.

Two days before her death, she started to experience fever and headaches. These are emergency symptoms during pregnancy. However, Mrs NB and her husband thought first of COVID-19, went for a private test, and got a negative result. After this, they thought that the symptoms were related to the imminent delivery (she was around 39 weeks). Mrs NB and her husband decided to travel to Pichanaki to seek healthcare. Even though their relatives supported them to cover the transport costs, it was not easy to find private transport to take them to Pichanaki. April was among the worst months of the COVID pandemic in Peru. When Mrs NB arrived at Pichanaki, the



hospital was ‘full’. Although her case was an obstetric emergency, the staff told Mrs husband to take her to La Merced, 73 km away from Pichanaki. With their resources, Mrs NB and her husband travelled to seek healthcare. At La Merced, the staff told Mrs NB’s husband that she had delivered a stillborn baby; after some hours, he was informed that his wife had had COVID-19 and died. They told him that Mrs NB’s Symptoms (headache and fever) were COVID-19 symptoms. Besides her, no one in the family had reported any COVID 19 symptoms.<sup>1</sup>

If pregnant women, such as Mrs NB, had been prioritized along with the first group vaccinated, she would have had the chance to get at least one shot of the vaccine.

Mrs NB’s case also shows the lack of referral capacity of primary health services in Peru. In Peru, antenatal care coverage is not linked to the timely referral of emergencies. As Mrs NB’s case shows, even in cases where the pregnant woman visits a health centre for antenatal care, in a matter of obstetric emergencies, the woman and her family have to deal with the costs of the referral, as well as with the bureaucracy.

### 3 Maternal mortality

In contrast to other Latin American countries, and despite limited attempts to implement redistributive policies within the welfare system, Peru has kept the neoliberal core of the welfare model (Mintegiaga and Ubasart-González 2021), maintaining a segmented welfare system that institutionally separates social insurance and social assistance programmes. The health system, as part of the welfare system, maintains a tripartite segmentation: public (social assistance programmes), social insurance, and private (Cotlear et al. 2015), and health policies, such as the maternal health programme, have retained core components of the neoliberal approach.

The first is the ‘targeting’ approach; Peruvian health policies designed since the 1990s have centralized this feature. One example of the targeting system is the conditional cash transfer schemes implemented across the region. These schemes were framed as policy tools to reduce poverty and expand access to nutrition, education, and health to marginalized groups who could not afford or access market-based services (Cookson 2018). With some variations, conditional cash transfer programmes use the census to identify eligible households; some of them, as in the case of the Peruvian version, use two-step identification: the government first recognizes the poorest districts, and then, within the community, the families. The programmes involve the payments of a small sum of money and incentive contingent on the fulfilment of certain programmatic goals, such as school attendance, use of health services and pregnant women’s attendance at prenatal care (controls).

The Peruvian version of a conditional cash transfer scheme, which includes maternal health, is *Juntos*. This programme, created in 2005, targeted women to increase demand and use of health services, especially maternal and child healthcare.

*Juntos* presents an excellent example of the limits and problems of the targeting approach and how structural violence and domination are exercised. The programme goals were designed without public debate and are the same, independent of the context and challenge implementers face. Women are subject to domination by the programme implementers, arbitrarily creating shadow

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<sup>1</sup> Interview with Mrs NB’s husband, 1 November 2021, Rio Negro, Satipo, Junín.

conditionalities (such as participating in workshops, growing a garden, using the smokeless stove, or participating in the other social programmes) that women perceive as mandatory (Cookson 2018; Huber et al. 2009). Moreover, the programme is rooted in the idea of health status as, primarily, an outcome of individual decisions, and therefore in the need to make poor people co-responsible for their health, without reflection on whether a mother's poverty should be taken as evidence that she acts irresponsibly (Cookson 2018) or about the social determinants of health. This approach is blind to any reflection and debate regarding histories of exclusion and violence and the need for social change.

A second component is the promotion of vertical programmes linked to specific outcomes. In Peru, from 2007, as part of national budget reform, the Ministry of Economy and Finance (MEF) introduced new payment mechanisms to encourage the more efficient allocation of resources across national health strategies. In particular, the Budgeting for Results Programmes (Presupuestos por Resultados, PpR), defined as a public management strategy that links resource allocation to products and measurable results for the population (OECD 2017), switched from budget lines (human resources, goods and services, etc.) to a productivity-based approach. In the case of health, interventions are selected based on health priorities that are closely linked to goal and target commitments by the Peruvian state at the international level.

While some studies have found some positive impacts of PpRs, in terms of expenditure and increases in coverage, there are also some risks linked to this tool. PpRs are established for specific health problems or population groups. Their use therefore risks failing to address questions of the total financial resources needed for the health sector (OECD 2017). PpRs also do not consider institutional strengthening within the health sector. National health strategies come under the guidance of the MEF, and supervision of their results does not involve the MoH. The predominance of the Ministry of Economy and Finances in policy-making began in the 1990s when Alberto Fujimori called on a group of economists to implement a set of neoliberal reforms. The success of these reforms, framed as 'technical and independent', in controlling hyperinflation, contributed to consolidating the power of the technocrats of the Ministry of Economy and Finances in policy design, through different governments (Dargent 2011). This explains the maintaining of the neoliberal core of the welfare model in Peru.

A third central component is the over-focus on coverage. Healthcare coverage has become the leading indicator of the healthcare system's performance, neglecting supervision, quality, and other critical components of health services (Gianella and Yamin 2018).

A fourth component is the shrinking of public services and promoting of private sector participation in the provision of healthcare. One indicator of this is the low level of investment in public health services. While it is true that, in general, Latin American countries report public health expenditure below the Pan American Health Organization (PAHO) recommendation of 6 per cent of GDP (CEPAL 2021), Peru's public health expenditure has remained one of the lowest in the region (CEPAL 2021; Du Bois et al. 2004). Moreover, despite significant advances in universal health coverage in Peru in the last decade, increasing from 64 per cent of Peruvians with some health insurance in 2010 to 95 per cent in 2020 (SUSALUD 2021), out-of-pocket expenditure remains high and has even increased in recent years (Kanavos et al. 2019). Studies have found that Peruvian households are at higher risk of incurring catastrophic health expenditure (CHE)—i.e., when families use more than 40 per cent of non-food expenditure to pay for medical care—than those in other Latin American countries (OECD 2017).

The shrinking of public services has allowed the maintenance of a highly fragmented health system in terms of its organization and structure that constrains the state's capacity to deliver high-quality healthcare for all; the fragmentation of the Peruvian health system is expressed in its various

funding sources, diversity of insurance schemes with varying coverage, and multiple health service delivery channels. One key characteristic of the Peruvian health system, specifically of Peru insurance schemes, is the relationship between income level, access to formal employment, and health plan coverage (healthcare basket). In contrast to what has happened in other Latin American countries—like Colombia, where health reforms have transitioned into the unification of public health plans—in Peru, EsSalud (a scheme that provides healthcare, as well as pension and welfare coverage, financed through payroll discounts among those in formal employment and public sources) offers more services to its insurers than the Seguro Integral de Salud (SIS), which is funded through general taxes and primarily targets those in poverty to provide free healthcare for those with certain conditions.

These components have contributed to creating a health system that reports a high level of insurance coverage but has poor conditions for the provision of care. By January 2020, according to the MoH, 77.8 per cent of first-level healthcare services had inadequate capacity, expressed in the precariousness of the infrastructure and obsolete, inoperative, or defective equipment (ComexPeru 2020). By the beginning of 2021, this had reached 97 per cent of first-level healthcare services, and 100 per cent in 5 out of 25 regions (Callao, Lambayeque, Loreto, Madre de Dios, and Ucayali). Before the pandemic, Peru had 29 intensive care beds per million inhabitants, below the ratio in other countries in the region, such as Brazil, (which had 206), Colombia (105), Chile (73), and Ecuador (69) (Comité de Alto Nivel sobre el COVID-19 2021).

The fragmentation creates significant barriers in accessing critical services, such as the COVID-19 vaccines. Even though vaccines were purchased with public funds, the National COVID-19 Vaccination Plan stated that vaccines would be distributed through the various public health service delivery channels. As a result, during March and April 2021, the vaccination of the elderly was highly fragmented, with massive inequities in access. EsSalud began first with vaccination of those who were insured by the scheme, offering at-home vaccination. SIS began later, and those insured under that scheme had to travel to vaccination centres: no options were provided to those without the capability or mobility to do so. Vaccination centres were also segmented by type of insurance. In May, a new vaccination plan was adopted; from then on, all vaccination centres were for the whole population, independently of insurance.

In the case of maternal mortality, before the COVID-19 pandemic the leading causes of maternal mortality in Peru were hypertension induced by pregnancy (related to eclampsia and pre-eclampsia) and abortion complications; in the case of pregnancy-related death, the causes were suicide, cancer, and respiratory tract infections (Centro Nacional de Epidemiología Prevención y Control de Enfermedades 2020; Gil 2018). As mentioned above, Peru had reported a decrease in maternal mortality before the pandemic—of 72 per cent between 1990 and 2015—and was considered on track to achieve SDG target 3.1 (reduce the global maternal mortality ratio). However, maternal mortality had been unevenly distributed across the country. The Amazon regions of Ucayali, Amazonas, Madre de Dios, and Loreto report maternal mortality ratios (MMR) that are far above the national ratios and the SDG goal of an MMR of under 70 maternal deaths per 100,000 live births (167.8, 157.5, 151.8, and 133.8 respectively) (Gil 2018).

Regarding the most recent policy and programmes designed to address maternal mortality, one of the programmes that played a central role in the reforms of the Peruvian health sector in 2021 was the Programme to Support Health Sector Reform (Programa de Apoyo a la Reforma del Sector Salud, PARSalud I and II). The program started in 1999 with a loan from the World Bank and the International Development Bank (IDB). After 2002 the scope of the programme was narrowed to focus to a considerable extent on maternal and child health and the reduction of maternal mortality to improve the overall health sector (Physicians for Human Rights 2007). PARsalud specifically targets the regions with the worst health outcomes.

PARSalud's strategy covers two areas in which improvements were crucial to reducing maternal mortality. The first consisted of promoting greater access to perinatal care. The second was to improve maternal healthcare services' quality through investment in infrastructure and equipment, staff training, a system of referrals and counter-referrals, and the implementation of protocols to ensure proper case management (for example, the use of oxytocin to prevent postpartum haemorrhage).

Programme evaluations have shown positive outcomes in the coverage of skilled birth attendance, the coverage of a ferrous sulphate supplement, delivery of corticoids to women in the case of premature birth, and the use of magnesium sulphate in cases of hypertension induced by pregnancy.

Since 2008, there has been a budgetary programme for maternal and neonatal health that shares outputs with PARSalud. Some evidence exists of the impact of the fiscal programme for maternal and neonatal health and neonatal, as in the case of PARSalud's positive impacts, such as an increase (at a higher rate among women living in rural areas) in the percentage of institutional deliveries performed by skilled health workers (medical doctor, midwife, and nurse) (OECD 2017).

Peru's primary and comprehensive emergency obstetric care (EmOC) services remain a challenge. An assessment of basic emergency obstetric and newborn services (FONE 1) showed that none of the 619 health facilities assessed had reached 100 per cent resolution capacity for prenatal care (comprehensive care that seeks the participation of the pregnant woman, couple, and family in preparation for institutional childbirth, puerperium, and care of the newborn); that is, they did not have the professionals, equipment, instruments, or medicines required for antenatal care. The same assessment showed that only one centre was in the '90 per cent or more' resolution capacity range for hypertension induced by pregnancy, eclampsia, and pre-eclampsia (Instituto Nacional de Estadística e Informática 2016).

In the case of complex emergency obstetric care, such as severe pregnancy-induced hypertension and eclampsia, which involves specialized management of complications in general intensive care, of the 45 hospitals (13 of them located in Metropolitan Lima and two in Callao) that should have the capacity to provide this level of care (FONE 2), none reached the '90 per cent or more' range of resolution capacity. Five, all located in Metropolitan Lima, reached 'from 70 per cent to 79 per cent' of resolution capacity.

Moreover, human resources are also insufficient. In a 2021 publication, the Colegio de Obstetras del Perú (Peruvian Professional Association of Obstetricians) stated that the number of midwives working in public health services before the pandemic (around 17,000) was already insufficient to cover population needs.

Besides, as Mrs NB's case shows, women cannot access adequate care without a referral. Even if Mrs NB had attended her antenatal controls at the health post closer to her home, and if that had been insured, the health post and her insurance (SIS) were unable to provide Mrs NB with the conditions for the referral: there were no emergency services, and Mrs B and her family were forced to search and pay for private transport to reach a health centre that could provide emergency obstetric care.

## 4 The perfect storm

Why is it that a state like Peru, dedicated to fulfilling development goals and with sustained good macroeconomic performance, appears to be incapable of dealing with the COVID-19 pandemic? This puzzle cannot be addressed detached from a recognition of the approach that Peruvian health policies have adopted since the 1990s. The over-focus on certain numeric indicators as a means to assess the outcomes of prioritized vertical programmes, neglecting supervision, quality, and other critical components of health services such as out-of-pocket expenditure or the assessment of total financial resources needed for the health sector, has undermined the capacity of these programmes to build up residual capacity within the health system. In the case of maternal health, the national information system provides information on key maternal health indicators such as the increase in maternal deaths and the decrease in the number of routine antenatal care consultations. The weakness of the health system has made it impossible to rapidly restructure and deliver remotely regular care to pregnant women.

This weakness has been built and sustained by the different layers of the Peruvian state, which, adopting mainstream evidence-based governance, designed and implemented a set of reforms and programmes aimed at improving performance against certain numeric targets, without a deeper analysis of structural conditions that allow and reinforce health inequities. The narrow approach has shown significant weaknesses in the health system that have been actively ignored by the Peruvian state. Improvements against some targeted indicators, such as the MMR, have not been linked to improvements in the whole health system, and have contributed to providing an inaccurate image of the Peruvian health system. Despite considerable progress towards achieving the SDGs, including targeting health and wellbeing (SDG 3), by March 2020, the Peruvian health system was a system in crisis, underfunded, with poor resolute capacity. This lack of ability reflected how the Peruvian state has been functioning, and the structural violence the state has been exercising across its different areas of responsibility. In this paper, I have referred to certain vertical programmes with targets that local-level public servants have had to fulfil without thinking about their working conditions or about quality. The indicator has become the goal, and the implementers of the policies, at different levels, work to reach the targets even if this implies forcing subordinates to walk for many hours to get some villages, sacrificing the quality of care, forcing poor women to travel for many hours to reach a health post, or blaming poor women for their health status or ‘risks’.

By 2020, there was a corpus of literature showing the dramatic limitations of evidence-based governance in social policies, including health (Cookson 2018; Ewig 2012; Gianella Malca 2019; Huber et al. 2009; Petrera and Jiménez 2018; Physicians for Human Rights 2007; Yon 2017). Reports on the Peruvian health system showed the significant weakness of the health system (Instituto Nacional de Estadística e Informática 2016; Ministerio de Salud 2021; OECD 2017), revealing that good performance against the prioritized indicators does not indicate a robust health system. Moreover, a year of good performance in certain key programmes and indicators does not guarantee the building of a health system’s ‘residual capacity’. The over-focus on certain indicators, and the active ignoring of the underlying determinants of health, has contributed to the deaths of many.

Debates on post-COVID recovery should consider a redesign of the tools used to assess health system performance and should take seriously the criticisms already raised of the weaknesses and risks of focusing too exclusively on indicators such as the SDGs in health systems design.

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