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Global Processes, Local Consequences: Gender Equity and Health Sector Reform in Peru

Abstract

This article brings into relief the gendered tensions and contradictions that have resulted from Peru's neoliberal health sector reforms. Previous studies were clear that economic adjustment had a negative impact on women and gender relations. I show more nuanced effects of neoliberal policies when applied to health sector reforms. To evaluate these policies, I utilize the distinction between redistribution and recognition. I depart from the supposition that policies serve either redistributive or recognition ends and show that single policies can have both types of effects. I conclude that policies based on neoliberal principles in some instances have a negative impact on women, in other instances reify existing unequal gender relations, while in still others open up spaces for positive change. On the whole, however, neoliberal health reforms have had a negative impact on gender equity.

In the 1990s the global phenomenon of restructuring economies and systems of governance using neoliberal principles began to reach beyond macroeconomic policy to social policy. Advanced industrialized states started processes of welfare state retrenchment. In Latin America, as economies stabilized following the debt crisis of the 1980s, governments began to apply market principles to their

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pension, health, and education systems. Portions of Asia, Africa, and Eastern Europe followed suit. The similarity of trends across regions is evidence of the globalized nature of social policy restructuring. In this article I focus on the local—the effects of globally inspired neoliberal health sector reforms on gender equity in poor communities in Peru.

Most studies of social policy reforms have focused on the politics or processes of social policy reform (e.g., Altenstetter and Björkman 1997; Castiglioni 2005; Hunter and Brown 2000; Kaufman and Nelson 2004; Lloyd-Sherlock 2000; Nelson 1999). Few have considered the effects of neoliberal reforms (Weyland 2004, 144). Even fewer have considered the consequences of these reforms for gender equity.[1] Employing the distinction between redistributive and recognition effects of policies—the first related to socioeconomic effects and the second to cultural or symbolic effects—this article brings into relief the gendered tensions and contradictions that have arisen in poor communities as a result of Peru's neoliberal health reforms. In so doing, I seek to extend feminist understandings beyond the well-studied effects of economic adjustment to the effects of neoliberal-inspired social policy reforms.[2] Studies of gender and economic adjustment were clear in their findings that economic adjustment had a negative impact on women and gender relations. I find more nuanced effects of neoliberal policies when applied to health sector reforms. Policies based on neoliberal principles in some instances have a negative impact on women, in other instances reify existing unequal gender relations, while in still others open up spaces for positive change. In general, however, these policies have had a negative effect on gender equity. Moreover, I demonstrate that the division of policies into distributive or recognition categories is not so neat. A single policy can have both distributive and recognition effects.

Peru, with its typical health reforms, midsize economy, medium to high poverty rates, and medium to low health indicators in comparison to other Latin American nations, provides a good starting point for evaluating the effects of reforms on gender equity in poor Latin American communities.[3] The reforms implemented in Peru were neither as concertedly market-oriented as those in Chile nor as steadfastly solidarity-oriented as those in Costa Rica or Brazil. In terms of depth and breadth, Peru implemented significant, but not radical, reforms (Kaufman and Nelson 2004).[4]

In the early 1990s Peru had a two-tiered state health system, social security health care for formal sector workers and public health care for the poor—the latter serving 73.8 percent of the population (Ministerio de Salud [MINSA] 1996, 18).[5] I evaluate the effects of four reforms to the public health system initiated in the early 1990s:

fees for services, means-testing, a targeted basic package of health services, and administrative decentralization—reforms typical of many developing nations.[6] I begin by defining gender equity. I then provide background on Peru's health reforms and how these constituted part of the global diffusion of neoliberal social policies. Finally, I evaluate the effects of the reforms on gender equity.

Evaluating Gender Equity: Distribution and Recognition

I use the well-known work of Nancy Fraser, in which she argues that justice is composed of redistributive and recognition dimensions, as a general guide for analyzing the effects of health sector reform on gender equity. I chose Fraser's conceptualization because it brings into relief elements of equity that are often overlooked in health sector analyses—elements related to recognition, or identity-based claims.[7] Distributive claims, which relate to the distribution of labor, goods, and services, are clearly of consequence and have long been a focus of analyses of equity in health service delivery.[8] However, I depart from Fraser's supposition that most policies serve either distributive or recognition ends (Fraser 1997, 25). This analysis will show that the division of policies into distributive or recognition categories is not so neat. A single policy can have both distributive and recognition effects.

According to Fraser, redistributive policies are an appropriate remedy for socioeconomic forms of injustice, such as exploitation of one's labor, economic marginalization, or deprivation of an adequate standard of living (Fraser 1997, 13). The quintessential form of distributive injustice is class inequality. Examples of redistributive policies include reorganizing the division of labor and subjecting investment to democratic decision-making (Fraser 1997, 15). Recognition policies are the appropriate remedy for cultural or symbolic forms of injustice. Examples of cultural or symbolic injustice include domination by another culture that is hostile to one's own, being rendered invisible by the dominant practices of one's own culture, and being subject to disrespect or disparagement in cultural representations or everyday practices (Fraser 1997, 14). Policies that address recognition injustices could include positively valorizing cultural diversity or changing cultural patterns that deny equal respect to women or gays and lesbians (Fraser 1997, 17–19).[9]

Fraser explains that the divide between distribution and recognition injustices is analytical only. In practice, these two injustices often occur in tandem. Race and gender, for example, combine socioeconomic and cultural injustice, as people of color and women tend to be denied good jobs and equal wages and are simultaneously

viewed with disrespect by others. Fraser emphasizes the fact that policies tend to focus on either redistribution or recognition and therefore are ineffective in addressing the whole of injustice, and especially injustices based on gender and race, which combine issues of redistribution and recognition. I demonstrate through analysis of health policies that a single policy can have both redistributive *and* recognition effects.

Applied to the health sector, I conceptualize distributive issues as including economic and geographic access to health care, as well as how policies distribute the health-related tasks essential to social reproduction.[10] Women, due to their lower levels of workforce participation, lower wages, and greater levels of poverty, are more likely than men to have difficulty paying for basic needs such as health care services. The hypothesis is similar for the culturally marginalized who are concentrated in the lower-paid and subsistence sectors of the economy. Women and men, dependent on geographic location, may have greater or fewer health service options, with rural populations at greatest risk of lack of services. Finally, care work does not enter directly into Fraser's concept of distribution. Health care, especially primary health care, is laden with gendered understandings that hinge on women's assumed responsibility for caring for the young, the elderly, and the sick, either unpaid or at very low wages. Greater distributive gender equity would entail a just distribution of health services across socioeconomic levels and geographic regions and a just distribution of health care responsibilities between men and women or between the state and the family.

Social policy systems also reinforce or change value judgments in the realm of recognition politics. On an individual level, health care workers reinforce broader cultural constructions of recognition through their everyday interactions with health care users. The attitude of the health care provider can change depending on the client's gender, race, sexual preference, or class position—or some combination of these. These attitudes, in turn, can serve to open or close access to health care services. The "bedside" manner of health personnel, for example, has been shown to be a key barrier to women's access to healthcare (Mensch 1993). At an institutional level, social policies also value or demean clientele by the range of services that the institutions offer. If services essential to women's health, such as reproductive health care or breast cancer treatment, are unavailable, health services not only neglect to distribute essential services, but they also devalue particular populations. For particular cultural groups, moreover, specific health practices or beliefs may need to be recognized for these groups to feel that health services address their needs.

How health reforms effect gender equity depends on the reform in question; some reforms may have equity-producing effects, while others may produce or reinforce inequity. Key to the evaluation of health reforms is to examine each reform along both distribution and recognition dimensions.

Peru's Primary-Level Neoliberal Health Reforms in the 1990s

By "neoliberal" health reforms, I refer to reforms that have been globally diffused by international consultants and financial institutions and that are based on the principles of market allocation of resources and minimal state intervention, with the presumed objective of achieving greater economic and social progress. Neoliberal economic reforms were introduced on a widespread basis in Latin America following the region's economic crisis of the 1980s.[11] At that time, there existed agreement among the dominant international policy-makers on the prescription necessary for curing the region's economic ills, the so-called Washington Consensus (Williamson 1990). The widespread criticism of the toll that these early economic reforms took on human livelihoods and the significant declines in population health and education forced proponents of neoliberal reforms to rethink their prescriptions and to value strong social policy systems. Neoliberal social policy reforms thus differentiate themselves from neoliberal economic reforms. In the post–Washington Consensus period of the 1990s there existed flexibility in form—there was no one prescription, rather a menu of options—and encouragement of social spending so long as that spending was guided by basic neoliberal principles.

The major reforms of Peru's primary-level, public health system in the 1990s were fees for services, means-testing, a targeted basic package of health services, and decentralization of the administration of local health clinics. These were not the only reforms of the 1990s, but they were among the most important and are the most comparable across countries.

Peru instituted user fees for health care services in its public health care system in the early 1990s. In a system previously free of charge, user fees were a response to the devastating economic situation at the time. In 1990 government spending on health was just 15 percent of what it had been in 1980, and health establishments were desperately seeking ways to remain open (MINSA 1996, 26). In this context, the health ministry gave health establishments free reign to institute fees. With economic stabilization and new funding for social spending in the mid-1990s, the ministry maintained fees under the premise that they would deter "free-riders"—those who had the ability to pay for

private health care but used the public system anyway. In addition, policy-makers thought fees would enable cost recovery and encourage public institutions to operate more like private entities. By 1999 fees for services accounted for 19.7 percent of the Ministry of Health budget (Ministerio de Economía y Finanzas [MEF] 1999).

Simultaneously with the introduction of fees, Peru's public health system implemented means-testing, in which clients' incomes and familial resources were scrutinized in order for persons to receive reduced fees or fee waivers. There were no official criteria for means-testing, but it was a practice promoted by the Ministry of Health and carried out in most health establishments.[12] Means-testing was encouraged as part of targeting only the poor and avoiding "free-riders."[13] Pressure on health establishments to generate income through fees was added incentive for these to practice means-testing to maximize income. Means-testing followed on the neoliberal premise of reducing state benefits as much as possible; only those most in need ought to benefit from free public services.

In 1994 Peru introduced a "basic package" of health services provided though a program called "Salud Básica Para Todos" (Basic Health for All). The Basic Health for All program was connected to a national policy of targeting social spending toward the poor approved by the Paris Club creditors. The basic health package sought to expand the reach of basic public health services in remote rural and urban poor areas at minimal cost. The concept came from the World Bank, which advocated low-cost primary care interventions as the most cost-effective manner to increase disability adjusted life years, or "DALYs." In keeping with the post–Washington Consensus thinking, a basic package of services involved necessary but minimalist government intervention to boost human capital (World Bank 1993).

Finally, also in 1994, Peru began to implement administrative decentralization of some of its health centers. The concept came in part from the idea of subcontracting, in which smaller entities take over components of administration or service provision to create mini-markets within a larger market. In theory, these small markets will produce greater efficiency and be more responsive to client needs. Applied to state health sectors, the idea is that smaller administrative units closer to clients, as opposed to one centralized health ministry, will more efficiently manage health resources. Given the right incentives, these smaller units will compete with one another to produce better services at lower cost. Better services, in turn, are thought to generate greater client disposition to pay for services.

Most countries in Latin America that applied administrative decentralization to their health sectors decentralized these services to

municipalities or states. Peruvian policy-makers looked to a community health participation model developed in West African nations, called the "Bamako Initiative," which had been described in World Bank documents.[14] Drawing from this, Peru developed a program called the Programa de Administración Compartida (the Shared Administration Program). This program created Comités Locales de Administración en Salud (CLAS)—Local Health Administration Committees.

The CLAS program decentralized local health clinic administration to a board of six community members and the clinic head doctor. The community elected three members, and the head clinic doctor selected the other three from local community health-related groups, such as mothers clubs.[15] These boards had significant responsibilities, including hiring and firing personnel, deciding how money raised through fees would be spent, and approving an annual community health plan. The independent nature of each CLAS created mini-markets; each CLAS competed with nearby health clinics to attain more patients. Successful committees benefited from more clientele by earning more user fees.[16] The participatory component of the CLAS draws from a unique intersection of proponents of democratization, who seek to promote empowerment through participation, and a post–Washington Consensus move by international financial institutions away from top-down prescriptions to local-level approaches to economic development.

Consequences for Gender Equity

Guided by the general proposition that equity has both redistributive and recognition dimensions, in this section I evaluate the impact of these health sector reforms on gender equity. My evaluation is based on a study of the implementation of these reforms in four Peruvian communities in 1998 and 1999. These communities included eight primary-level health centers, six in urban areas and two in rural zones.[17] These communities were all poor: the urban areas were considered poor, and the rural areas were extremely poor.[18] I employed a number of methods. One was a stratified survey of 193 community residents in the geographic areas served by each health center.[19] Survey questions measured gender equity in terms of access to services, the distribution of care work, and intrafamilial health dynamics. To flesh out the relationship between the health centers and communities, I carried out sixty-five positional interviews with communal leaders, health professionals, and administrators, as well as six group interviews with residents. Finally, I spent hours conducting ethnographic observation, including participating

in health center events and observing health center and neighborhood activities.

Fees for Services

Both distribution and recognition are relevant for the evaluation of the effects of fees for health care services on gender equity. In terms of distribution, fees may impede some groups from accessing health care services due to an inability to pay. For example, women and children are typically dependent on a male breadwinner for some economic support, given that men remain the primary breadwinners in Peruvian society and that women who work are paid significantly lower wages. Households led by single women are clustered among the poorest in Peruvian society.[20] Thus, fees may impose a barrier for women. However, distribution is not just an individual consideration but is also interrelational. We must consider intrafamilial economic priorities and economic dependence that may affect an individual's access to needed services. Recognition politics often play out in the arena of intrafamilial power relations. Once fees for health services are introduced, at the level of the family, expenses are prioritized. Will girls be recognized as equally deserving as boys of health care in times of monetary scarcity? Will a woman internalize societal expectations that she be a self-sacrificing mother and forgo her own health in favor of that of her children?[21]

Given that women tend to be concentrated among the lowest-income quintiles, feminist analysts have hypothesized that women's access to health services would drop with the introduction of fees to public health systems (Standing 1997). My survey data showed that more than half of all poor Peruvians surveyed could not afford basic health care: 51 percent did not have enough money to pay for both medicines and the health center consultation. My survey also showed that a similar percentage of women as men believed that health services were expensive: 51.6 percent of women said that they did not have enough money to pay for a medical consultation and medicines versus 50.7 percent of men.[22] Women appeared to be slightly more affected, but this was not a statistically significant difference. Yet, we know that fewer women than men in Peru are wage earners, that women in Peru are paid less than men, and that women are concentrated in lower-paid jobs and the informal and subsistence sectors.[23]

The explanation for the discrepancy between women's reported ability to pay and the knowledge that women earn less likely lies in two factors. First, women depend to a greater degree on other family members to help them meet health expenses. Second, women tend to prioritize payment for expenses related to family well-being over other expenses, and thus may be able to pay, but at the expense of

other needs. These issues lead us directly into the arena of intrafamilial power relations and recognition politics. Though women may report the ability to pay for health care, can women afford all of the services that they need or desire? For example, if she and a child are ill, will the mother put off her own illness in order to assure that the child's is paid for first? If a woman receives monetary help from a family member, will that person help her with all types of care—even, for example, gynecological care? Many of these questions relate to the power of male family members within the household, who often control cash assets, and to households as an arena where distributive and recognition issues are intertwined.

My survey did not probe all of these questions, many of which require more intensive qualitative work. However, some of my survey data does provide insight into gender and economic dependency. Responses to the question of who pays for children's health care reveal women rely to a greater degree than men on spouses to pay for their children's health services (table 1).

Many Peruvian families do not pool incomes—in fact, worldwide the majority of households do not pool their incomes (Dwyer and Bruce 1988; Haddad, Hoddinott, and Alderman 1997). Even when income is pooled, in Peru it is common for men to withhold some of their income for personal expenses, thus reducing the amount that goes to family needs such as health care. Women's limited income by contrast tends to go entirely to family needs.[24]

Regarding intrafamilial priorities, my survey attempted to determine if males and females of the same family attended different health centers of differing levels of quality, under the hypothesis that boys or men may be sent to higher-quality health centers. All family members usually sought health care at the same health establishment. There are indicators from other sources, however, that show that

Table 1. Male and female economic responsibility for health care

	Who pays for the health consultation and medicines for your children?					
	I pay	My spouse pays	My spouse and I pay	We don't pay (insurance or exonerated)	Another relative pays	Total
Male	52.4%	7.1%	29.8%	7.1%	3.6%	100%
Female	47.1%	28.4%	20.6%	1%	2.9%	100%
Total	49.5%	18.8%	24.7%	3.8%	3.2%	100%

Note: Males and females in the sample are not married to each other; $N = 186$.

within families, male members' health is prioritized over female members'. Among children with diarrhea, for example, only 24.9 percent of girls are brought to a health care provider, while 31.2 percent of boys are. Among boys, 59 percent will receive medical therapies, while 67 percent of girls are treated with less expensive home therapies (Blondet and Montero 1995, 75). The birth of male sons is also preferred, as one doctor who had worked in a rural village explained:

> [The village members] continue to value the man more than the woman. For example, when a midwife assists a birth, they know that the charges will depend upon if it is male or female. If it is male it will cost 90 soles; if it is female it will be 50 soles. So if it is male, they pay 90 soles, and on top of that they give them a sack of potatoes and corn.[25]

Thus, there is evidence that males are valued more than females in Peruvian society and boys' health more than girls'. It is likely, then, when faced with difficult choices of whether to pay for health care for a boy or a girl, that recognition politics within families will lead to scarce funds being used to pay for males' health needs over females'.

The fee-based system also has the potential of denying women coverage of their gender-based health needs—another point where this single policy combines issues of recognition and redistribution. For example, if a husband who controls the family income deems health care to be unnecessary, a wife may not be able to access this care. According to obstetric nurses I interviewed, many men did deny their partners access to birth control because they believed birth control would allow them to be promiscuous. The fact that Peru's family planning program was free in the 1990s was important, in that economic dependency on male partners did not jeopardize access to this particular service. The connection between fees and access to reproductive health care must be kept in mind, however, should family planning become fee-based and in relationship to other gender-based health needs. For example, we do not know how many women are denied exams for cervical cancer because their partners do not see this as a worthy expense. While fees are not the only potential barrier to women's receiving reproductive health care—husbands may still forbid women to visit clinics, or health providers may demand a husband's consent—fees are an important barrier.

Means-Testing

In a system that charges fees to poor populations, an exoneration system is an important way of providing the poor with economic

access to health care. Though clearly a redistributive policy, means-testing also plays into societal recognition patterns. Means-testing, compared with a universal system in which care is received based on citizenship rights, can have a negative impact on the recognition aspect of equity by producing stigmatization rather than valuation.

In Peru's public health establishments in the 1990s, there was no uniform exoneration policy. Some establishments did not allow for exoneration; others had an upper limit on the number of persons exonerated per month, and still others had no limits. A separate study of sixty health establishments in five departments of Peru, offering all levels of care and spanning CLAS and non-CLAS establishments, showed that, on average, 15 percent of patients were partially or fully exonerated from fees. When only primary health posts were considered, the number exonerated rose to 28 percent (Francke 1998, 25). Even with the more generous rate of exoneration, there was a significant gap between the exoneration rate and the percentage of persons that my survey found who could not pay for both health services and medicines—51.3 percent. Based on these numbers, over 20 percent of the poor were left without economic access to health care, despite the exoneration safety net.

On top of this gross distributional inequity, standards of means-testing were entirely nonexistent. Decisions regarding need were made by one or two untrained staff members using their own criteria. Some of the CLAS centers developed their own systems, and those health centers that had a social worker on staff had at least some system for exoneration. Social workers' education included identifying persons who could not pay, but just like the doctors and nurses charged with these decisions in centers with no social worker, they were left to their own discretion in choosing a procedure. Each of the three health centers in my study with social workers had very different assessment forms. These ranged from a small card with only a space for "pre-diagnostic" and "intake" (and no more specifications) to a two-page form asking questions ranging from educational level to the frequency the individual attended parties.

The absence of either a social worker or an alternative CLAS system meant that there was no exoneration policy or procedure. The lack of a policy or procedure leaves room for wild judgment calls on the part of untrained staff members. Consider this response from one head doctor of a rural health center, charged with deciding exonerations at that center. She had been working at the health center for two weeks when I asked her how she determined exonerations. She stated, "I have already heard stories that the people here even have family members that live in the United States, who send them money.... So far I have seen [fewer] indigent people here than in [my

previous health center].” Yet, by all government poverty indicators, the community in which her health center was located was extremely poor, and much poorer than her previous post. I brought her back to the question, “So, how do you decide if someone should be exonerated?” She answered, “I simply look at them.”[26] Similarly, the doctor charged with exoneration decisions at another rural center said when it comes to deciding who receives exoneration, “It depends on personal criteria.”[27] Not all doctors or nurses responsible for means-testing did so without any criteria; some devised their own systems based on where the patient lived, for example, or whether a mother had financial support from a father. However, the norm, as one urban clinic nurse stated, was “there are no norms.”[28] Although formal procedures do not necessarily protect applicants from administrative caprice, Peru’s lack of procedures altogether left much more room for snap judgments, which often served to reinforce negative valuations of particular racial or gender categories, as I discuss below.

The lack of a means-testing procedure was aggravated by pressures faced by local care providers to generate income through fees. Regional health authorities depended on fees generated by the health centers for covering their costs—as stated previously, nearly 20 percent of state public health costs were covered by fees. The head doctor of one rural health center explained that he needed to generate at least one hundred Peruvian soles a month from fees to pay the center’s electric bill, among other basic expenses.[29] The pressures to generate funds, in turn, provided a disincentive to exonerate deserving persons and an incentive to provide better services to fee-paying users.

In contrast to a citizen rights–based system, means-testing often relies on stigmatizing forms of inquiry, in which users face embarrassment or degradation when asking for economic aid in order to receive basic human services. These methods also may rely on negative recognition judgments based on gender, class, or race. Peru has a long history of viewing the poor, the indigenous, and immigrant groups as the carriers of disease (Cueto 1997). Means-testing has invited a continuation of these negative recognition practices and has inhibited at least some of those in need from accessing health care. One female health care client whom I interviewed commented, “I don’t like the social worker; she asks me a ton of questions before exonerating me.”[30] Also, consider this comment by a head doctor, regarding the cashier of his local health center:

> The cashier is owner—many times she also decides if a person will be exonerated or not. Even if the social worker exonerated

> the person, [she'll say,] "But you come every time to be exonerated. No, this time you have to pay." There are many things that influence [economic access] so that one who is exonerated, one who is in need, thinks twice "do I go or not?"[31]

A need to ask for exoneration can also keep away the very poor until it is too late. As two staff members I interviewed noted, one criterion they used to determine exoneration was whether the infirmity constituted an emergency.[32] Emergencies often indicate that due to a lack of economic resources and fear of asking for exoneration, the person has waited until a mild sickness has become serious. As one doctor explained, "In the cases in which I have to give exoneration, they are people who come in a state of emergency, after the illness has gone on for a week or more. They haven't come in [sooner], first, because they don't have money for the consultation, or second, because they don't have money for the medicine."[33]

The ideology behind means-testing in Peru and elsewhere relies on highly gendered recognition politics.[34] Among the staff members and social workers who carried out means-testing in the eight health centers, the absence of a male breadwinner in the household was a major criterion in favor of granting exoneration.[35] While it can be argued that this system favored more economically vulnerable single mothers, it also overlooked the potential intrafamilial power issues discussed previously. Moreover, this system overlooked the possibility that the male may not be a primary income earner. This means-testing was also feminine in character; the majority of public health system users were adult women who either came for their own health care or for the care of their children. Thus, it was primarily women who asked for exoneration, making women the primary "dependent" client.

Some of the questions that I observed social workers ask female clients who were seeking fee exoneration were quite invasive. For example, one social worker's intake form included detailed questions regarding the person's sexual relations, including "age of initiation of sexual relations" and "type of sexual relations." The social worker also routinely asked if all of the children had the same father.[36] The implication was that "promiscuous" women were less deserving of exoneration. Such questions cause embarrassment and an invasion of privacy that only those without money, and primarily women, must face. This invasive questioning is based on gendered ideological assumptions that women who are poor are of poor moral character. Such questioning also reinforces the double standard that women should not be promiscuous, while this is accepted behavior for men. (By contrast, in my field work in rural areas, I witnessed health

workers handing out condoms to men at a community festival—"Don't forget your rain poncho!" they hooted as they passed them out from the windows of the ambulance. Through this action, the workers displayed their acceptance of male promiscuity and reinforced this gendered norm by assuming that the men would be promiscuous that night.) The social worker's questioning was followed by surveillance: visits to the home to ensure that the client was telling the truth about her economic and sexual life. Both the questioning and surveillance further reinforced gendered assumptions of normality and abnormality, discursive aspects of power that lead to lack of recognition of women as equal citizens.

Basic Health Care Package

Whether a basic health care package promotes gender equity hinges on whether it effectively distributes needed health care, whether it recognizes specific gender-based health needs, and how it may affect the distribution of care work in local communities—a combination of distribution and recognition criteria. When I asked residents what needs their local health center did *not* fulfill, they noted distributional issues such as a lack of medicines, medical specialists, and medical equipment.[37] These responses reflected dissatisfaction with the very basic level of care provided by a basic package approach. The package guaranteed, at low cost, service of each package element. Care beyond the package elements cost more and may not have been locally available. While most community members also cited basic infirmities such as colds as their communities' greatest health concern, their desire for greater specialization in their local health clinic reflected their concerns with accessing complex health services when needed. Men and women provided similar responses to these questions.

Based on analysis of the package itself, were men's and women's health care needs equally recognized? The basic health care package did provide for women's basic health needs related to reproductive health (see table 2). It also provided alcoholism counseling, key for men's health in both rural and urban Peru, where alcoholism affects men to a greater degree than women. Some package elements addressed some of Peru's most pressing health needs. For example, the emphasis on pregnant women's health was appropriate, given Peru's high rate of maternal mortality (185 per every 100,000 births nationally, but significantly higher in rural areas). Emphasis on cancer detection in women was also important, given that cancers of the uterus and breast were the main cause of death for women aged twenty to fifty-nine from 1996 to 2000.[38]

There were a number of primary-level health concerns important to gender and health care not addressed by the package. One was

Table 2. Basic health care package

Category	Components
Children's Health	Universal immunizations Adequate management of infant infectious diseases Prevention and recuperation from nutritional deficiencies Preventative and reparative dental care Detection and treatment of tuberculosis Detection and treatment of other illnesses of epidemiological importance Information and referrals
Adolescent and Adult Health	Counseling and voluntary and informed access to family planning methods Detection and treatment of sexually transmitted diseases, tuberculosis, and illnesses of epidemiological importance Prevention and recuperation from nutritional deficiencies Prevention of alcoholism and drug addiction Information for the development of healthy lifestyles Information and referrals
Women's Health (in addition to that of the adult)	Detection of breast and uterine cancer Early detection of pregnancy Treatment of gynecological infections Tetanus vaccination Information and referrals
Pregnant Women's Health	Prenatal controls Detection and management of obstetric risk Safe childbirth Control and management of postpartum complications Information and referrals

Source: Ministerio de Salud (MINSA) 1994.

violence against women. Between 1989 and 1993, 56.4 percent of all police reports of violent crime filed in Peru were made by women against their husbands or male partners regarding mistreatment.[39] Second, while detection of sexually transmitted diseases was included in the basic package, I observed little attention paid to AIDS in the local health clinics, whereas several other components of the package were vigorously applied. AIDS in Peru began as a disease that affected mostly males, but the male to female ratio for the disease declined from 11:1 in 1990 to 3:1 in 2000.[40] Men's cancer, such as prostate cancer, a leading health problem for men in Peru, was also

not addressed by the basic package. Finally, while prevention of alcoholism and drug addiction was listed as part of the basic package, such prevention, similar to the case of AIDS, did not occur in practice. My observations at one rural health clinic included witnessing doctors and other staff drinking to excess at community festivities, while alcohol and drug prevention was virtually absent at all the observed centers.

Finally, the family planning and sexually transmitted disease elements of the basic package were important but were far from an attempt to cultivate reproductive health, as agreed upon at the 1994 International Conference on Population and Development (ICPD) held in Cairo, whose accords instruct governments to promote overall healthy and satisfying sexual relations free of coercion. While reproductive health counseling is listed under "Adult Health Care" as opposed to "Women's Health," in practice in the 1990s women were the almost exclusive target of family planning initiatives, and at times they were coerced into tubal ligation, according to investigations by Peru's own human rights ombudsperson's office, the Defensoría del Pueblo (Defensoría del Pueblo 1998).[41] Thus, several important needs were recognized by the basic package, while others were either overlooked entirely or ignored in practice.

The basic package also greatly depended on women's unpaid labor for the success of several package elements. In this regard, it played on the preexisting gender division of labor and cultural suppositions that women's time is "free" to place a greater burden of social reproduction on women, rather than on the state or male community members. For example, in the children's basic package, universal immunizations depended on women's voluntary labor during vaccination campaigns. In order to meet their quotas for vaccinations, health center professionals mobilized the voluntary labor of women to help reach the population. Second, the management of infant infectious diseases was achieved by training neighborhood women volunteers to watch for these illnesses and to serve as a local resource in dispensing oral rehydration therapies when health centers were closed. Finally, prevention and recuperation from nutritional deficiencies was heavily dependent on mothers charged with family nutrition. The package depended on the health-related labor of women, thereby reinforcing gendered inequities in care work distribution and shifting a substantial burden for care work from the state to poor women. This finding confirms the conclusions of researchers in other Latin American countries that neoliberal policies increasingly look to poor women "as the 'answer' to a weak welfare state as well as a source of cheap labor" (Lind 2002, 229).

Administrative Decentralization: Local Health Administration Committees

Administrative decentralization also impacted distributive and recognition aspects of gender equity. The CLAS reform in Peru subcontracted out administration to community boards and thereby provided incentives for greater efficiency in the use of health resources. The state enjoyed a major cost savings by having community members carry out clinic administration free of charge. The community boards, moreover, proved effective in stimulating greater productivity among health center personnel (Altobelli 1998). The CLAS also competed with one another, and out of this competition a few CLAS became "model" health centers—viewed by policy-makers as particularly successful due to the high number of patients they attracted and their creative programming.

The CLAS program also had some unintended effects in terms of both redistribution and recognition. A first consideration is the gendered composition of the boards themselves. The rural CLAS boards were dominated by men, reflecting these communities' patriarchal recognition politics and reinforcing men's greater community decision-making power. Only one of the six community board members of the rural CLAS included in this study was a woman, a pattern that ministry staff confirmed was true for most rural CLAS.[42] The status of this sole female board member helps to explain how she became the exception to the rule.[43] Miriam Barboza became a member and then the president of this CLAS. Barboza, a single schoolteacher in her late twenties, was elected to the CLAS board because of her prior leadership in her community's *ronderos*. The *ronderos* are local militias organized with government support to defend rural communities from the violence of the Shining Path guerrillas.[44] Barboza was one of few women active in the *ronderos* in her village and among very few who held a leadership role in the militia. As a schoolteacher she was more educated than the majority of women in her district. Her education, her position as a single woman, and her participation in the male-dominated rural militia gave Barboza an elevated community status. Other women in this community not only did not have the education of Barboza but also lacked the status, respect, and leadership experience that she gained through participating in the male-dominated militia. Barboza was thus an exception to the recognition rules in rural Peru: to privilege male leadership and prioritize the education of males over females. These unwritten rules prevented most women from taking part in the rural CLAS boards. The CLAS, by (wittingly or unwittingly) accepting these rules, served to reinforce negative forms of recognition.

The urban CLAS boards, by contrast, were dominated by women. During Peru's economic crisis of the 1980s, urban women became highly organized through survival-oriented organizations such as community kitchens and mothers clubs. Urban poor women therefore had the leadership experience and social networks that allowed them to take advantage of the participatory administration offered by the CLAS. Poor women in Peru's major cities were also better educated than poor rural women—65 percent of the urban women I surveyed had at least a partial high school education, compared with 12.8 percent of rural women.[45] Urban poor women were therefore better prepared to take on the administrative responsibilities of CLAS membership, and they had already gained community acceptance of their leadership in certain "feminine" areas, such as nutrition and health.

When gender equity is considered, the CLAS allowed opportunities for the empowerment of urban women but largely failed in providing the same opportunity for rural women. By "empowerment," I refer to the real decision-making and agenda-setting powers that were bestowed on these women as board members. Moreover, these women gained positive community recognition for the leadership role they played as CLAS members. Part of the reason behind the failure to empower rural women is that policy-makers did not consider the gender recognition dynamics in rural communities that effectively excluded women from public leadership positions. Moreover, this reform did not account for the fact that a large percentage of rural women are monolingual Quechua speakers, lacking the Spanish skills necessary for fluid communication with the health personnel. Nor did these women have sufficient formal education for carrying out the required human resource and financial administration. Using literacy rates as a proxy for Spanish language skills, in rural areas of Peru 43 percent of women are monolingual Quechua speakers, compared with 17 percent of men (Blondet and Montero 1995, 61). Rural women's lack of Spanish capability and low levels of education also have their roots in local patriarchal gender relations, which favor boys' education over girls'.

A second unintended consequence of the CLAS program was its effect on interethnic recognition between the urban, mestizo (mixed Spanish and indigenous descent) health personnel and the largely indigenous populations they served in the rural areas. The CLAS shared-administration model provided staff members with some incentives to be more culturally sensitive and, as a correlate, more gender sensitive. The CLAS members, because they hired staff from a pool of candidates presented by the regional authority, were able to make language and cultural understanding a job requirement. One nurse described his hiring experience this way:

> It shocked me when part of the hiring committee was a community member. He would ask you things not necessarily related to health. . . . He asked me for example, "Do you know how to speak Quechua?" and "What would you do if a resident was a monolingual Quechua speaker?" . . . He also asked me questions about their general culture.[46]

By hiring staff that spoke Quechua and understood Quechua health concepts, these CLAS members addressed severe inequities in access to health care based on recognition. For example, the Quechua culture has its own health concepts, which were often not understood by the medical professionals who were serving these communities, leading many community members not to seek care at the health center. "They don't understand those sicknesses," community members would tell me.[47] For that reason, some preferred local traditional healers: "Here we cure ourselves with a medicine man. In the health center they don't know this sickness—if they give you an injection you'll die. Here we get sick with *susto*, but we cure ourselves with our herbs."[48] CLAS board members' demand that their local health professionals spoke their language and understood their culture was a major step in improving equity along the dimension of recognition.

Sensitivity to cultural practices also has a gender correlate in rural Peru: women are more likely to maintain their native language and dress than are men (de la Cadena 1996). When I would ask a resident to explain why she or he felt comfortable or uncomfortable in the non-CLAS health center, many of the rural women would respond that they felt "uncomfortable, because I am scared, I do not know how to speak, nor do I understand Spanish."[49] This inability to communicate, and resultant fear, kept some community members—mostly women—away from the health post altogether, and it inhibited many from asking questions or receiving important information. When I asked one woman if she could talk in confidence with the health professionals, she said, "No, they don't understand you in Quechua. For that reason, you can't express all that you feel. I have difficulties with Spanish, I know a few words, no more."[50] The efforts of the CLAS to bridge the cultural divide in rural areas between staff and clients are of even greater consequence to rural Peruvian women due to women's greater maintenance of indigenous cultural practices than men. Respect for culture does not always promote gender equity, and in fact may work against gender equity, as recent debates over gender and culture have highlighted (e.g., Okin et al. 1999; Phillips 2002; Shachar 2000). Rather, what the case of gender, culture, and the CLAS in Peru shows is the importance of considering how culture and gender can interact and create barriers for

particular people. In evaluating policies, we must keep in mind how policies may affect different women differently.

The final consequence of the CLAS program on gender equity relates to distribution of care work. Although a zeal for efficiency can be undesirable in a human relations field such as health care, to the degree that CLAS efficiency reduced clinic waiting times, it positively impacted women by reducing some of their care work burden. Because women are most often responsible for children's health, as well as their own, waiting times and clinic hours are key to alleviating women's care work burden. Unfortunately, this women's unpaid work is often unrecognized and undervalued. As one doctor commented:

> Women are the ones that have to look after nutrition, clothing, health, education . . . . If you look at the work of the women here, it is tremendous. But it is not valued because it does not have an economic benefit. It seems we opt to think that they don't work. . . . When a woman comes in, they say, "The Mrs. has all the time in the world, she doesn't work." When a man comes in, they try to attend to him more quickly because they think that he is missing work.[51]

This attitude may explain why 46.2 percent of the women I surveyed felt that the waiting times were long or very long, while only 25.7 percent of men felt they were long or very long. A gender-positive distributive side effect of the CLAS shared administration was that the CLAS had overall shorter waiting times than non-CLAS centers, according to survey respondents. The average waiting time at a CLAS center was reported to be thirty-four minutes compared with forty-six at the non-CLAS centers, with 46.4 percent of non-CLAS clients feeling that their wait was long or very long, compared with 27.1 percent of CLAS clients.

Clinic hours can also alleviate care work burdens or provide the potential for redistribution to men. Paid work in urban Peru is usually performed from eight to five, Mondays through Saturdays.[52] Because most health clinics were also open only during these hours, working women and men had to take off of work to access health care for themselves or their children. Expanded hours could help alleviate this burden and would offer the opportunity for men who work to take a greater role in family health care work. Only one urban center in my study, a CLAS center, offered expanded hours of operation. In the rural areas the centers were open on Sundays, market days, and these tended to be their busiest days of the week. But, they were open only half a day Sunday, and often clients were turned away at closing time, after having walked up to five hours to reach the health clinic.

A related problem was staff absenteeism, which was chronic in rural isolated areas. Absenteeism presented a particular problem when patients had traveled long distances only to find the health center closed, even during regular working hours. The vigilance of community CLAS members was effective in deterring absenteeism. CLAS members stopped in to make sure that staff members were at work and arrived punctually. In one CLAS, a punch clock was introduced by the board to counteract tardiness. Reduced waiting times, expanded hours of service in some CLAS, and the CLAS's success in deterring staff absenteeism and tardiness helped to relieve some of women's care work burdens and the distributive inequities that these entail.

Conclusion

While scholarship on the effects of neoliberal economic reforms on women and gender relations has shown that economic adjustment had a negative impact on women, this investigation into the effects of neoliberal health reforms on gender equity demonstrates more nuanced effects. Fees and means-testing clearly worked against gender equity along both redistributive and recognition dimensions. Compared with a universalistic citizenship-based system, a fee system presented a barrier to accessing health care for the poor, and for women and girls who are concentrated among the poor. Moreover, when fees were introduced, recognition politics within families potentially led to the prioritization of male over female health care. Exoneration in Peru was not only insufficient, but means-testing also caused increased negative recognition between social groups along class and gender lines. The basic health package, while it recognized some of men's and women's specific health needs, ignored other important needs, reified existing unequal gendered patterns in the distribution of care work, and distributed only the most basic forms of health care. Administrative decentralization through the CLAS had a number of unintended positive consequences for gender equity, including recognition aspects such as opening up spaces for new patterns of community leadership and responding to culturally specific health needs, and for distributional aspects such as greater levels of efficiency, which translated into lesser care work burdens. The degree to which the program succeeded in these, however, depended crucially on context.

Though some surprising benefits have resulted from some health reforms, these were not intended. Neoliberal social policy reforms continue to ignore the importance of the social reproductive role that women play and its costs. While the CLAS's shorter wait times helped alleviate some of this burden, this was not due to policy-makers'

recognition of this burden; instead, it was an unintended side effect. The basic package was more representative of the way neoliberal reforms play on gender divisions of labor, in that it depended on women's unpaid labor for its success.

These reforms and the policy-makers who designed them also heeded little attention to another key area of feminist inquiry: intrafamilial power relations and dependency. Although neoliberal reforms may have led to the "self-sufficiency" of health centers, these reforms failed to recognize that human life is inherently interdependent. Their definition of self-sufficiency does not account for the degree to which these centers depend on women and communities for their success. Nor do they recognize that it is not entirely possible (nor necessarily desirable) for individuals to be self-sufficient. Women, due to structural and familial issues of interdependence, are often less able to independently pay for health services or for particular gender-based health services. How policies may be reinterpreted through relations of dependence and intrafamilial power-relations needs to be contemplated.

This research also reaffirms the feminist principle of recognizing differences among women. My examination of rural health clinics brings to light the ways in which gender and culture interact; some women face different barriers to health care than others. Women in Peru, as Marisol de la Cadena (1996) writes, "are more indigenous," thus making the relationship between cultural recognition and gender recognition in the Peruvian context tight. Policy-makers need to be attentive to the ways in which ethnicity or race and gender may work together. Indigenous women in Peru face particular needs that are a product of their culture. Recognition of the different needs of different women is crucial for achieving gender equity in health.

Finally, each of the specific health policies examined in this article had ramifications for both redistribution and recognition. Policies do not usually affect just one component of justice; most of the time they affect both, and it is the job of the researcher to parse out the effects of a policy on both dimensions of justice and the relative impact it has on each. In the case of health sector reforms in Peru in the 1990s, it is clear that women lost out in terms of distribution. They were less likely to be able to access services in a fee-based system, and the basic package generated more unpaid health-related care work, the burden of which fell on women. In terms of recognition, the effects of neoliberal reforms were more complex. Fees and means-testing had clearly negative implications, while decentralization opened some spaces for the recognition of urban women in community leadership and for recognition of culturally specific health needs in rural areas. However nuanced, the bulk of the evidence points toward a negative impact of

neoliberal health reforms on women and gender equity. Of the four reforms, the only the CLAS had some (unintended) positive effects for gender equity. The CLAS was a product of the peculiar alignment between democracy advocates and neoliberal thinking in the post–Washington Consensus period. Nevertheless, even this reform was not entirely positive for gender equity.

NOTES

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1. On gender and general health reforms see Beall 1997; Gideon 2001; and Hanmer 1994a, 1994b. On reform and reproductive health see Evers and Juárez 2002; Petchesky 2003; and Berer 2002.

2. On gender and economic adjustment see Benería and Feldman 1992; Elson 1992a, 1992b; González de la Rocha 1995; and Tinker 1990.

3. Peru's experience of civil war is also not unique. Other Latin American countries have similar experiences, such as Colombia's ongoing civil war.

4. On the politics of Peru's health reforms see Ewig 2004.

5. More recent figures show little change. In 2000 only 30 percent of Peruvians had health insurance; the rest pay out of pocket for health care or depend on the public system. Figures from the Ministry of Health, available online at http://www.sis.minsa.gob.pe/index1 (accessed 15 February 2006).

6. Since I completed this research, Peru introduced new reforms—most notably in 2001, targeted insurance for the poor, the "Seguro Integral de Salud" (SIS, Integral Health Insurance). Because SIS was implemented after the time of my research (1998–99), I will not discuss it in this article.

7. For a review of gender analysis frameworks see March, Smyth, and Mukhopadhyay 1999. For approaches to gender equity and health see Currie and Wiesenberg 2003; Doyal 2000, 2002; Organización Panamericana de la Salud (OPS) 1999; and Standing 1997, 1999. I am influenced by these but prefer to modify Fraser's theory of justice because of its parsimony.

8. Fraser (1997) argues against an overemphasis on identity-based claims and sets out to reemphasize material claims. Such reemphasis is not necessary

in developing countries or in health policy, where socioeconomic factors are considered paramount.

9. Fraser has advanced this theory of justice; see Fraser and Honneth 2003.

10. I use (Bakker's 2003, 67) definition of social reproduction: "the social processes and human relations associated with the creation and maintenance of the communities upon which all production and exchange rests."

11. Chile was a forerunner, implementing neoliberal reforms in 1974.

12. A health ministry official described the policies of fees and means-testing: "In Peru, the majority of [public health] establishments charge fees . . . but without an explicit, discriminant policy, rather with criteria that they develop including whom to charge, who not to charge, and the amount of the fee." (Anonymous 5, interviewed 17 April 1998, Lima). All interviews were conducted by the author, and all translations from Spanish are my own.

13. This generalization is based on my interviews with policy-makers and my observation of meetings of health sector analysts that I attended in Peru in 1998.

14. For more on Bamako, see McPake, Hanson, and Mills (1993).

15. Mothers clubs are a prevalent community organization in Peru's poor, urban communities. Composed of local women volunteers, these administer the government "Glass of Milk Program," which provides a daily glass of internationally donated milk to children and the elderly.

16. User fees from non-CLAS centers were sent to regional health authorities.

17. Because 72.2 percent of Peruvians live in urban areas, I included more urban than rural centers in my sample (Instituto Nacional de Estadística e Informática [INEI] 2002b).

18. Figures from 2001 estimate that 54.8 percent of Peruvians are poor, and 24.4 percent are extremely poor (INEI 2001). A person is considered poor if total household spending does not cover all basic needs (food, water, shelter). An extremely poor person lives in a household that does not spend enough to provide a basic food basket.

19. My sincere thanks to my three survey assistants: Claudia Gianella, Rocío Malpica, and Madeleine Pariona Oncebay.

20. One in five Peruvian households is female-headed. Of these, 93.3 percent are single parent, female-headed households. The incidence of poverty in single parent, female-headed households is 42.6 percent, compared with a 24.3 percent incidence of poverty in single parent, male-headed households (INEI 2002a, 152–53).

21. The self-sacrificing mother is a strong cultural theme in Latin America; see Chaney (1979) and Craske (1999).

22. $N = 160$; Pearson's $\chi^2 = .013$; asymptomatic significance (two-sided) = .908.

23. In 2006 women who worked in Lima earned on average 67 percent of what men earned, and only 51.4 percent of women of working age were employed (INEI 2006, 84, 78). Most rural women work in subsistence agricultural or other nonpaid productive tasks.

24. This pattern was brought to my attention by several health workers (Mimi Lily Rojas Silva, obstetric nurse in an urban health center, interviewed 17 July 1998, Lima; and Anonymous 35, doctor in an urban health center, interviewed 15 July 1998, Lima). Dwyer and Bruce (1988) and Haddad, Hoddinott, and Alderman (1997) also find this pattern in other developing nations.

25. Anonymous 13, head doctor of an urban health center, interviewed 18 November 1998, Lima.

26. Anonymous 70, head doctor of a rural health center, interviewed 1 February 1999, Ayacucho.

27. Anonymous 37, head doctor of a rural health center, interviewed 23 February 1999, Ayacucho.

28. Marlena Rojas, nurse at an urban health center, interviewed 18 November 1998, Lima.

29. Anonymous 38, doctor at a rural health center, interviewed 15 May 1998, Ayacucho. At that time, one hundred soles was about thirty U.S. dollars.

30. Survey ID 148, woman resident of a poor urban community.

31. Anonymous 13, head doctor of an urban health center, interviewed 18 November 1998, Lima.

32. Carlos Camacho Gallardo, head doctor of an urban health center, interviewed 23 July 1998, Lima; Jeanette Maulaui Cahuana, nurse at an urban health center, interviewed 11 December 1998, Lima.

33. Carlos Camacho Gallardo, head doctor of an urban health center, interviewed 18 November 1998, Lima.

34. See, for example, Fraser (1989).

35. David C. Aguinaga, coordinator of community participation at an urban health center, interviewed 22 July 1998, Lima; Anonymous 24, social worker at an urban health center, interviewed 14 July 1998, Lima; Mariella Marín, social worker at an urban health center, interviewed 16 July 1998, Lima.

36. Personal observation of social worker interviews.

37. A need for specialists was cited 17.9 percent of the time, for medicines 13.4 percent of the time, and for equipment 10.6 percent of the time. This was an open-ended question, with the largest frequency of response being "nothing" (24.6 percent) or "I don't know" (21.8 percent). $N = 179$.

38. Statistics in this paragraph are from the Pan-American Health Organization Core Country Data Analysis, Basic Country Health Profiles for the Americas, 2002, Peru, available online at http://www.paho.org/English/DD/AIS/cp_604.htm (accessed 3 July 2006).

39. Data from the Women's Delegation of Lima, cited in the Peru report of United Nations Inter-Agency Campaign on Women's Human Rights in Latin America and the Caribbean, available online at http://www.undp.org/rblac/gender/peru.htm (accessed 6 April 2005). In this time period about 45 percent of all crimes were reported to police.

40. Pan-American Health Organization Core Country Data Analysis, Basic Country Health Profiles for the Americas, 2002, Peru, available online at http://www.paho.org/English/DD/AIS/cp_604.htm (accessed 3 July 2006).

41. For a full discussion see Ewig 2006.

42. Telephone communication by author with the former director of the CLAS program, Ricardo Díaz Romero, 19 February 2001.

43. Miriam Barboza Merino, president of a rural CLAS, interviewed 6 February 1999, Ayacucho.

44. For more on the *ronderos* see Degregori (1996); and Starn (1999).

45. My survey percentages are consistent with gender differences in general rural and urban education levels reported by national surveys.

46. Fredy Medina Bermudo, nurse at a CLAS health center, interviewed 2 February 1999, Ayacucho.

47. Survey ID 30, rural woman.

48. Survey ID 72, rural woman. *Susto* is identified by a lack of energy, restless sleep, high fever, and droopy eyes (Proyecto Andino de Tecnologías Campesinas [PRATEC] 2002, 195).

49. Survey ID 71, rural woman.

50. Survey ID 45, rural woman.

51. Anonymous 13, head doctor of an urban health center, interviewed 18 November 1998, Lima.

52. This is based on my observation of formal and informal sector work habits during my eighteen-month residence in Peru.

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